

# North Cumbria Services reprovizion Review (Phase 1)

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*Northern Clinical Senate Review*

November 4&5, 2014

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## Summary

This report presents the Northern Clinical Senate's suggestions to NHS Cumbria Clinical Commissioning Group (CCG) on the developing high risk clinical pathways in North Cumbria University Hospitals NHS Trust (NCUHT).

The Clinical Senate was asked to give assurance on the pathways for high risk cardiac cases including high risk cardiac cases including transfer for urgent or emergency percutaneous intervention (PCI), acute stroke, management of acute gastro intestinal bleeds and emergency high risk acute medicine providing external challenge and checks in the system to ensure that proposals that are developed are clinically robust.

A review team drawn from the senate council and assembly for their relevant expertise in the areas under review, explored the issues and formulated this advice. We are very grateful to everyone involved for the time they committed and the level of enquiry, expertise and objectivity that they brought. Over the course of two days we met many clinicians, CCG Leads, Trust Management Officers as well as members of the Overview and Scrutiny Committee, Health Watch and patient groups including the West Cumberland Hospital (WCH) campaign group and we are very grateful to them for the flexibility they showed in making time to see us and for the openness with which they shared their views.

There are very considerable challenges facing North Cumbria, due to the area covered, the isolation of the significant population centre of Whitehaven, poor staff morale and retention and a history of many management teams in the last 7 years. Both CCG and NCUHT have made great efforts to improve things, despite severe financial constraints. We recognise that CCG and NCUHT 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, acute medical services for example being deemed inadequate by the Chief Inspector of Hospitals, which gives an urgency to the need for a change in the way patients are cared for. The new pathway for primary PCI seems well thought through and offers real benefits for patients. Data from elsewhere in the UK suggests there is potential for similar benefits for acute stroke patients if the acute management were to be centralised on one site in a unit that was equipped and staffed to fully meet the needs of these patients ; there would also need to be good rehabilitation services on both sites, the assessment, transport and bed management issues need to be robustly addressed, and public fully consulted and engaged .Similarly, the small number of patients with acute GI bleeds could benefit from a safer single site service. The management of acute medical emergencies and the use of the National Early Warning Score (NEWS) score to determine the management pathway needs considerably more work. It is not clear that the NEWS score is designed to be used in this way as the score may change in response to the immediate treatment given in A&E and assessment units. There also seemed to be a lack of clarity as to what proportion of acutely ill medical patients from WCH would be transferred to Cumberland Infirmary, Carlisle ( CIC ) if a high NEWS score was a trigger for transfer to the CIC site. Elderly frail patients with significant co-morbidities might score highly and yet might not benefit from the most intensive therapies. Furthermore, notwithstanding the difficulties in staffing, the opening of the new hospital on the WCH site with the dedicated emergency floor should offer the potential for caring well for these patients if innovative staffing

models were adopted. Underpinning all these considerations there needs to be more detailed work on transport arrangements for patients and robust bed modelling, particularly at CIC. Despite considerable effort, and notwithstanding real issues of sustainable safety and financial balance, more work is needed to ensure public and staff buy into service development plans with a shared vision of benefits, particularly for patients from Whitehaven. The members of the local community we spoke to seemed to have some understanding that some services needed to be centralised to ensure better and safer outcomes, but they perceived there to be a lack of openness as to exactly which services would be affected, how many patients would be transferred and whether greater changes were planned than had been discussed.

## Background

There is a Cumbria Primary Care Trust document 'Closer to Home' *An NHS consultation on providing more healthcare in the community in North Cumbria* which was developed and publically consulted on strategy published in 2008. In 2011 NHS Cumbria and North Cumbria University Hospitals NHS Trust produced a Clinical Strategy for North Cumbria after an engagement process to discuss and agree the clinical models of care. Since then health and care organisations across North Cumbria have been working together as part of the 'Together for a healthier future 2014' programme to develop a five year plan for better health and care services based on the principles of delivering the 'right care, at the right time, and in the right place'

**(Appendix 1: Care Closer to home 2008, North Cumbria Clinical Strategy 2011, Together for a Healthier Future 2014, North Cumbria Strategy 2014 -2019, North Cumbria Trust paper on clinical options appraisal - October 2014)**

The initial request from NHS Cumbria Clinical Commissioning Group asked the Clinical Senate to review proposals for changes to acute medicine high risk pathways at North Cumbria University Hospitals NHS Trust as part of the NHS England assurance process for service change, with a view to moving to consultation of any proposed changes in the near future. However it became apparent that plans were not sufficiently well developed to demonstrate how improvements would be delivered therefore the CCG would be unable to demonstrate how any major changes would meet the four tests set out by the previous Secretary of State. *The four tests, intended to apply in all cases of major NHS service change during normal stable operations, are:*

- i. strong public and patient engagement;*
- ii. consistency with current and prospective need for patient choice;*
- iii. a clear clinical evidence base; and*
- iv. support for proposals from clinical commissioners.*

*In addition to these four tests, the NHS England assurance toolkit also identifies a range of best practice checks for service change proposals, these include:*

- i. clear articulation of patient and quality benefits*
- ii. the clinical case fits with national best practice and clinical sustainability, and*
- iii. an options appraisal includes consideration of a network approach, cooperation and collaboration with other sites and / or organisations.*

*As part of the NHS England assurance process, clinical senates will be requested to review a service change proposal against the appropriate key test (clinical evidence base) and the best practice checks that relate to clinical quality.*

At the 'Together for a Healthier Future' programme board it was agreed the proposals were not at an 'assurance stage' therefore the senate were requested to undertake more of a listening and supportive role to ascertain the Trust's progress in developing its plans for the management of high risk cardiac cases, acute stroke care, the management of acute gastrointestinal bleeds, and emergency high dependency medical care. **(Appendix 2 – CCG Letter)**

Senate Council met and agreed a reposition of the review (phase 1) with a view to providing assurance at a later date (phase 2).

## **Terms of Reference**

The process to formulate advice was led by Professor Andrew Cant, Chair of the Northern Clinical Senate. Draft terms of reference were developed in discussion with the NHS Cumbria Clinical Commissioning Group and the 'Together for a Healthier Future' programme board. The terms of reference were discussed and agreed at Senate Council 6<sup>th</sup> October 2014. Terms of reference were also shared with Medical Director of NHS Cumbria, Northumberland, Tyne and Wear Area Team. **(Appendix 3)**

## Review Process

The following review team members were drawn from the senate council and assembly

Andrew Cant (Chair)	Clinical Senate Chair and Consultant in Paediatrics Immunology and Infection , Newcastle upon Tyne Hospitals Foundation Trust
Robin Mitchell	Clinical Director, North of England Strategic Clinical Networks
Hilary Lloyd	Director of Nursing, Gateshead Health NHS Foundation Trust
Paul Fell	Consultant Paramedic, North East NHS Ambulance Service Foundation Trust
Lesley Kay	Clinical Senate Vice Chair and Consultant Rheumatologist, Newcastle Upon Tyne Hospitals Foundation Trust
Lynda Dearden	Network Manager of the Northern Clinical Networks and Senate
Jon Scott	Stroke Consultant, South Tyneside NHS Foundation Trust
Phil Adams	Consultant Cardiologist (retired)
Chris Plummer	Consultant Cardiologist, Newcastle upon Tyne Hospitals Foundation Trust
Mark Hudson	Consultant Hepatologist & Gastroenterologist, Newcastle upon Tyne hospitals Foundation Trust
Andrew Simpson	Consultant in Accident & Emergency Medicine, North Tees & Hartlepool NHS Trust
Roy McLachlan	Associate Director, Northern England Clinical Networks & Senate, NHS England

Background Information collated by the sponsoring organisation and was presented to the senate review team before the visit including demographic data, organisational information, site maps, and other information that the sponsoring organisation felt would help the reviewers understand the issues surrounding the services under review.

The review team came together in Cumbria on the evening of 3<sup>rd</sup> November 2014 to meet the sponsoring organisation and to discuss the information received Over the following 2 days Reviewers met with Clinical Directors and clinical colleagues across both hospital sites ( CIC and WCH ) and met the Trust Chief Executive, Medical Director, Nurse Director, CCG leads, Overview and Scrutiny Committee (OSC) Chair and vice chair, Healthwatch, and patient groups.



## **The Senate Review panel met with the following people:**

- Nigel Maguire, Chief Officer, NHS Cumbria CCG
- Rosemary Granger , Programme Co-ordinator, Together for a Healthier Future Programme
- Emergency Department Staff at CIC , Dr Peter Weaving GP Clinical Director and Elizabeth Klein, Matron Emergency Care, Ruth Reed, Emergency Medicine Consultant, Emma Farrow, Emergency Medicine Consultant, a number of nursing colleagues
- Lynn Anderson, Paul Davies, Roger Moore, Jon Sturman, Judith Brannen (Consultants from different specialties, senior matron from Medical Business Unit and cardio nurse)
- Claire Summers A&E Consultant, Lesley Carruthers Deputy Director of Nursing , Dave Glover, Operations and Services Manager, Emergency Medical Unit, Les Morgan, WCH Director
- Joanna Cox, Consultant in Elderly Care, Rachel Glover – Stroke Nurse, Olu Orugun, Consultant in Elderly Care Medicine, Joanne Pickering, Matron Emergency Medicine
- Dr Debbie Freake, Director of Strategy, North Cumbria University Hospitals NHS Trust
- Dr Jeremy Rushmer, Medical Director, North Cumbria University Hospitals NHS Trust Gail Naylor, Director of Nursing, North Cumbria University Hospitals NHS Trust
- Helen Reay Chief Operating Officer, North Cumbria University Hospitals NHS Trust
- Ann Farrar, Chief Executive, North Cumbria University Hospitals NHS Trust
- Dr David Rogers, NHS Cumbria CCG Medical Director and Dr Hugh Reeve, NHS Cumbria CCG Clinical Chair
- Caroline Rea, CCG Network Director for North Cumbria
- Cllr Rod Wilson, Chair of Cumbria OSC
- Cllr Geoff Garrity, Vice Chair of Cumbria OSC
- David Blacklock, CEO of Healthwatch Cumbria
- Siobhan Gearing, Christine Wharrier and Mahesh Dhebar, West Cumberland Hospital campaign group

## **Timescales**

Review visit 3<sup>rd</sup>, 4<sup>th</sup> and 5<sup>th</sup> November 2014

Draft Report to sponsoring organisation by 21st November 2014

Final report first week December 2014

### **(Appendix 4 - Pre Review agenda and Visit Agenda)**

## **Limitations**

The pathways reviewed were:

- High risk cardiac cases
- Acute Stroke Care
- Management of Acute GI Bleeds
- Emergency care

Out of scope

- Obstetrics and midwifery
- Paediatrics
- Planned care and outpatients

Unfortunately the review team were unable to meet with representatives from the North West Ambulance Service (NWAS).

## Clinical Senate Review of North Cumbria Services Re-provision (Phase 1 visit)

### Comments on Pathways : Cardiology

Features of the pathway	Assessment of progress to date	What is needed
Patients with STEMI suitable for PPCI	<ul style="list-style-type: none"> <li>• PPCI performed in CIC from 2012 (BCIS audit data)</li> <li>• NICOR audit data from 2011-12 show 0%, and in 2012-13 show 9.4% of STEMI patients receiving PPCI with performance not reaching national standards (median call to balloon 195.5min, median door to balloon 124min)</li> <li>• STEMI pathway established with systematic 24h service started in June 2013</li> <li>• Local data were presented from June 2013 to March 2014 showing much improved performance - meeting national targets</li> <li>• The pathway includes only patients attending West Cumberland Hospital</li> <li>• Perception of benefit to local population from all stakeholders – a “state-of-the-art” treatment delivered closer to home than the previous services in Newcastle and Middlesbrough</li> </ul>	<ul style="list-style-type: none"> <li>• A pathway for all patients with STEMI should be developed</li> <li>• Up-to-date audit data to support pathway success should be collected and presented               <ul style="list-style-type: none"> <li>○ MINAP data for 2013-14 is due to be published on 15<sup>th</sup> December 2014</li> <li>○ the Trust will already have access to local data</li> <li>○ analysis of STEMI patient numbers which are 85% higher than those reported to have received thrombolysis (incoming patients from north of N Cumbria may explain this)</li> </ul> </li> <li>• Presentation of key performance indicators (call to balloon and door to balloon) for each locality to demonstrate performance within targets across the county</li> <li>• Full consideration of the impact of the service on ambulance performance</li> <li>• Decision support for ambulance crew and GPs for pre-hospital triage to avoid unnecessary inter-hospital transfers               <ul style="list-style-type: none"> <li>○ ECG acquisition in ambulance with wireless transfer to CCU nursing staff in CIC ± WCH<sup>1</sup></li> <li>○ single point of immediate telephone contact for difficult case discussions</li> </ul> </li> </ul>

<sup>1</sup> NWAS reported to use ECG transmission previously

Patients with STEMI unsuitable for PPCI	<ul style="list-style-type: none"> <li>The treatment of these patients was not discussed – they are not included in pathways reviewed</li> </ul>	<ul style="list-style-type: none"> <li>A pathway for these patients should be developed - all ACS patients must be considered</li> </ul>
Patients with NSTEMI suitable for angiography	<ul style="list-style-type: none"> <li>Elective PCI performed in CIC from December 2011 (BCIS audit data)</li> <li>NICOR audit data from 2011-12 show 64.3%, and in 2012-13 show 79.8% of NSTEMI patients undergoing angiography during their admission</li> <li>Perception of benefit to local population from all stakeholders – a “state-of-the-art” treatment delivered closer to home than the previous services in Newcastle and Middlesbrough</li> </ul>	<ul style="list-style-type: none"> <li>Up-to-date audit data to support pathway success <ul style="list-style-type: none"> <li>MINAP data for 2013-14 is due to be published on 15<sup>th</sup> December 2014</li> <li>the Trust will already have access to local data</li> </ul> </li> </ul>
	<ul style="list-style-type: none"> <li>A new NSTEMI pathway has been developed and was presented</li> <li>The pathway considers only “Patients Attending West Cumberland Hospital with a Non ST Elevation Myocardial Infarction”</li> </ul>	<ul style="list-style-type: none"> <li>A comprehensive pathway should be developed to include all patients presenting with chest pain with guidance on defined sub-groups</li> <li>This should include decision support for ambulance crew and GPs for pre-hospital triage (clear criteria e.g. symptoms, duration, ECG changes, past history, age) to avoid unnecessary inter-hospital transfers <ul style="list-style-type: none"> <li>ECG acquisition in ambulance with wireless transfer to CCU nursing staff in CIC ± WCH<sup>2</sup></li> <li>single point of immediate telephone contact for difficult case discussion</li> <li>discussion with GPs about their role in ACS</li> </ul> </li> <li>Full consideration of the impact of the service on ambulance performance <ul style="list-style-type: none"> <li>consider ambulance or GP diversion to CIC to avoid long/multiple ambulance journeys</li> </ul> </li> <li>An assessment of the impact on CIC to ensure</li> </ul>

<sup>2</sup> NWAS reported to use ECG transmission previously

		appropriate resources - an activity assessment may be helpful.
	<ul style="list-style-type: none"> <li>Calculation of TIMI and GRACE risk scores are both required in the pathway</li> </ul>	<ul style="list-style-type: none"> <li>It is unclear why both scores are needed - including TIMI renders the criteria highly sensitive. Most admissions (of all sorts!) to WCH will have TIMI of 3 meaning that all elderly patients, many of whom have raised TnT, will have TIMI 4.</li> </ul>
Patients with NSTEMI unsuitable for angiography	<ul style="list-style-type: none"> <li>The current NSTEMI pathway includes only patients "suitable for angiography"</li> </ul>	<ul style="list-style-type: none"> <li>A pathway is required for "unsuitable" patients</li> <li>In Appendix 2 of flow chart, patients unsuitable for angiography are discharged without cardiology input. We doubt this was the intended outcome.</li> </ul>
Timing of transfer for NSTEMI patients for angiography	<ul style="list-style-type: none"> <li>The NSTEMI pathway states a transfer target of 96h based on NICE Clinical Guidance 94 (March 2010)</li> <li>Transfer of NSTEMI patients is described in the pathway</li> <li>The review panel were told that current NSTEMI transfer may be delayed by bed availability at CIC but no data were presented</li> </ul>	<ul style="list-style-type: none"> <li>The NICE Quality Standard 68 (September 2014): <a href="http://www.nice.org.uk/guidance/qs68/resources/information-for-the-public-nice-quality-standard-for-acute-coronary-syndromes-including-myocardial-infarction-pdf">http://www.nice.org.uk/guidance/qs68/resources/information-for-the-public-nice-quality-standard-for-acute-coronary-syndromes-including-myocardial-infarction-pdf</a> states that 72h is the current quality standard. This should be addressed in the pathway and audit data.</li> <li>Transfer times should be audited and presented</li> <li>Consider ways to facilitate timely transfers <ul style="list-style-type: none"> <li>potential benefits across the Trust</li> <li>potential disadvantages to other services must be considered</li> </ul> </li> <li>Resources should be reviewed: <ul style="list-style-type: none"> <li>CIC bed numbers</li> <li>Ring-fencing of beds is being considered</li> <li>CIC timely discharge</li> <li>CIC admissions policy</li> </ul> </li> </ul>

		<ul style="list-style-type: none"> <li>○ ambulance availability</li> <li>• imaginative solutions may be required (e.g. transferring more than one patient per ambulance)</li> </ul>
Patient management – NSTEMI	<ul style="list-style-type: none"> <li>• A flow-chart has been written and made available to staff</li> <li>• It is considered complex by WCH A&amp;E</li> <li>• WCH A&amp;E have produced alternative flow-chart</li> </ul>	<ul style="list-style-type: none"> <li>• Consider simplification for non-specialists in collaboration with WCH staff (A&amp;E staff are enthusiastic)</li> </ul>
	<ul style="list-style-type: none"> <li>• Use of troponins in diagnosis described</li> <li>• Current practice regarding timing of samples is not fully defined</li> </ul>	<ul style="list-style-type: none"> <li>• It is not clear whether TnT assays are available 24h in WCH - if not, consider a “Point of Care” assay</li> <li>• Consider early rule out using paired samples up to 6h to avoid overnight stay for a 12h test</li> </ul>
Availability of expert advice at WCH	<ul style="list-style-type: none"> <li>• The draft pathway for cardiology patients at WCH dated 04/09/14 states that “A cardiologist will be available 9-5pm Monday to Friday for support either at WCH or by phone from CIC”</li> </ul>	<ul style="list-style-type: none"> <li>• In a 24h service, support may be required at any time</li> <li>• Some documents suggest advice is available 24h, but this is not explicit</li> <li>• Despite vacancies and other resource issues, telephone advice ± remote ECG review (e-mail or fax) should be available 24h</li> <li>• Additional resources may be required</li> </ul>
Patients with pericardial tamponade	<ul style="list-style-type: none"> <li>• Defined in the pathway as diagnosed on echo</li> <li>• The availability of echo at WCH or CIC was not clarified</li> </ul>	<ul style="list-style-type: none"> <li>• A more detailed pathway taking into account the availability of echocardiography should be developed</li> <li>• Alternative imaging modalities should be considered</li> <li>• Transfer to CIC for further investigation and treatment should be considered for “high risk” patients with large effusions without echocardiographic evidence of</li> </ul>

		tamponade <ul style="list-style-type: none"> <li>Consider collaborative discussion with WCH staff</li> </ul>
Patients with infective endocarditis	<ul style="list-style-type: none"> <li>Defined in the pathway as diagnosed on echo</li> <li>The availability of echo at WCH or CIC was not clarified</li> </ul>	<ul style="list-style-type: none"> <li>A more detailed pathway taking into account the availability of echocardiography should be developed including clinical and microbiological criteria</li> <li>Consider collaborative discussion with WCH staff</li> </ul>
Patients with bradycardia HR < 40	<ul style="list-style-type: none"> <li>The pathway suggests transfer to CIC of those with             <ul style="list-style-type: none"> <li>sinus bradycardia with HR&lt;40</li> <li>2<sup>nd</sup> or 3<sup>rd</sup> degree heart block with HR&lt;40</li> <li>&gt;=3s pauses</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>The sensitivity and specificity of these transfer criteria should be reviewed, for example:             <ul style="list-style-type: none"> <li>asymptomatic sinus bradycardia on <math>\beta</math>-blocker</li> <li>symptomatic complete heart block with HR 50</li> </ul> </li> <li>Consider more sensitive criteria for discussion with cardiologist on-call in CIC</li> <li>Consider collaborative discussion with WCH staff</li> </ul>
Patients with ventricular tachycardia	<ul style="list-style-type: none"> <li>Defined for transfer to CIC</li> </ul>	<ul style="list-style-type: none"> <li>More specific criteria for transfer are required, for example:             <ul style="list-style-type: none"> <li>duration, symptoms, LV function, clinical situation</li> </ul> </li> <li>Consider criteria for discussion with cardiologist on-call in CIC</li> <li>Consider collaborative discussion with WCH staff</li> </ul>

## **Clinical Senate Review of North Cumbria Services Re-provision (Phase 1 visit)**

### **Comments on Pathways : Stroke**

Features of the Pathway	Assessment of Progress to date	What is needed
<p>It is noted that the geography and population distribution of North Cumbria is unique in the UK with 2 population densities approximately 40+ miles apart in Carlisle and Whitehaven (and environs) in an otherwise sparsely populated region, with the 2 populations connected by a poor single carriageway road (A595). Also noted that there is a small but significant population to the south of Whitehaven whose transfer time to Carlisle is greater than 1h</p> <p>There are currently 2 under performing units (see SSNAP data) in Whitehaven (WCH) and Carlisle (CIC), both with staffing issues at all levels but particularly consultant level.</p> <p>Recruitment issues are not likely to be resolved in the short to medium term.</p> <p>Given the junior doctor staffing and training issues, it must be assumed that any stroke model should not be dependent on junior doctor recruitment but must be stroke specialist nurse led on site (24/7) with immediate access to a consultant either on site or via phone / telemedicine.</p> <p>Stroke patient numbers are approx 360 stroke discharges per annum at CIC and 240 stroke</p>	<p>The Trust proposes to centralise hyper acute stroke services at Carlisle (CIC) and repatriate patients to Whitehaven for rehabilitation who live in the locality. This overall proposal is contained within a recent Trust publication and the basis for this is improved clinical outcomes by meeting national targets.</p> <p>There has been little practical progress in terms of detailing the exact clinical pathway despite considerable modelling work although the Trust CE states the Trust may be in a position to implement a stroke redirection model by April 2015 depending upon various factors which may include public consultation and/or service improvement work if agreed by commissioners. (verbal communication, Senate Visit).</p> <p>There does not appear to have been any patient or public consultation as yet on the stroke redirection proposal.</p> <p>Patient groups appear not to agree with the proposed re-direction (feedback from patient group at the Senate Visit) and would prefer 2 stroke</p>	<p>Trust and patient groups and clinical lead all for stroke all agree the status quo for stroke services is not an option. There are 2 broad models that need to be considered. It is not clear from Trust documentation how detailed this internal options analysis has been although there has been considerable internal modelling and analysis of various models .</p> <ol style="list-style-type: none"> <li>1. 2 hyper acute units, one at each site, with each providing hyper acute stroke services and in-patient rehabilitation services, with in person thrombolysis during office hours and telemedicine supported thrombolysis assessment. This is the current model with poor performance.</li> <li>2. Redirection of patients from one site to the other to a single hyper acute stroke unit, with repatriation for rehabilitation for this patients who need it after 48/72h. This is the Trust's preferred model and has the hyper acute unit placed at CIC.</li> </ol> <p>There are 2 versions of Option 2.</p> <ol style="list-style-type: none"> <li>1. Redirection of all stroke patients irrespective of time of onset</li> <li>2. Redirection of stroke patients who may be potentially suitable for thrombolysis</li> </ol> <p>The Trust documentation gives little detail as to which version of Option 2 is preferred, nor where thrombolysis for suitable patients would occur.</p> <p>Questions to ask.</p> <ol style="list-style-type: none"> <li>1. What will be the benefit of significant transfer times</li> </ol>



<p>discharges per annum at WCH. (N=600 pa total).</p> <p>No numbers presented for the number of non-stroke admissions seen by the stroke service although most evidence suggests that for each confirmed stroke patient presenting to a service there is one suspected stroke patient whose ultimate diagnosis is non stroke but who still requires specialist assessment +/- imaging. The Trust however has subsequently confirmed that both stroke cases and stroke mimics are included in their service planning</p> <p>Vey long DTN times for thrombolysis at both units. Relatively low thrombolysis rates.</p> <p>On site stroke consultant during office hours at both sites.</p> <p>Out of hours thrombolysis assessment at both sites using telemedicine within a network of on call consultants extending down into South Cumbria and Lancashire rather than the North East.</p> <p>No provision for weekend review of new stroke patients at either site.</p> <p>No provision for weekend TIA at either site.</p>	<p>units providing all services, one in WCH and one in CIC.</p> <p>Main issues for patients are the transfer time and the accessibility of CIC for patients and relatives in the WCH catchment area and uncertainty what benefits the redirection of patients would deliver given the transfer time and time dependant nature of stroke thrombolysis.</p>	<p>for a large proportion of stroke patients and suspected stroke patients?</p> <ol style="list-style-type: none"> <li>2. Will a centralised stroke unit be adequately staffed and resourced in order to deliver the improved outcomes envisaged in the Trust documentation and to reassure the population that the benefits of redirection outweighs the risks. I.e. Will the population understand and see the benefit</li> <li>3. How will redirection work and who will be the decision maker? Paramedic, A&amp;E staff? The worst possible pathway would be admission to one hospital and A&amp;E followed by transfer to a second hospital A&amp;E</li> <li>4. Following on from Point 3, and acknowledging the patient flow issues within CIC, Will the Trust be able to offer direct access to the hyper acute stroke unit?</li> <li>5. 6 consultants would be required to provide a 24/7 hyper acute service with weekend review and weekend TIA clinic, whilst maintaining clinical input into a rehabilitation unit at the second site. Given the recruitment issues how will this be achieved?</li> <li>6. Will the Trust invest in appropriate nursing and AHP staff according to national guidelines for nurse and AHP staff/ patient ratios?</li> <li>7. Will the Trust give an assurance that the level of service offered on the 2 inpatient rehabilitation units will be identical?</li> <li>8. Has the Trust given any thought to development of an early supported discharge team and community stroke team to facilitate patient flow through the stroke pathway? There is no mention of this in any documentation.</li> </ol>
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## **Clinical Senate Review of North Cumbria Services Re-provision (Phase 1 visit)**

### **Comments on Pathway : Gastrointestinal bleeds**

Features of the Pathway	Assessment of Progress to Date	What is needed
<p>Outline of Pathway is sound. (Devil in the detail)</p> <p>Lack of critical mass of Gastroenterologists to provide on site or cross site OOH care for Upper GI bleeding</p> <ul style="list-style-type: none"> <li>Who is the "experienced Clinical decision maker" on WCH site?</li> <li>Sengstaken tube training on WCH site?</li> </ul>	<p>Implemented 6 months ago (March)</p> <p>OOH UGI Endoscopy at CIC dependent on Surgical cover. Therefore NOT possible to provide remote cover for WCH site.</p> <p>Dr. Denis Burke not available at the time of visit. It would be helpful to discuss outcome of Summer workshops for Endoscopists....competencies.</p> <p>Guidelines in place for management of variceal bleeding and placement of Sengstaken tube.</p>	<p>Clarify escort arrangements for haemodynamically unstable patients</p> <p>More detail of Initial Risk Assessment</p> <p>Transfusion arrangements for patients requiring ongoing resuscitation during transfer</p> <p>Overview/Report from Dr Burke of experiences and outcomes to date</p> <p>Are current arrangements for endoscopy cover safe and sustainable?</p> <p>Endoscopy arrangements for patients with suspected bleed not triaged from WCH site</p>

Further comments:



Mark Hudson's  
comments.docx

## Clinical Senate Review of North Cumbria Services Re-provision (Phase 1 visit)

### Comments on Pathway : Emergency Care

Transfer of patients based on National Early Warning Scores

Features of the Pathway	Assessment of Progress to date	What is needed
<p>The detail of this proposed pathway is unclear from the documentation received. Interpretation is that it could either function in conjunction with the three other pathways under consideration (MI, GI bleed and Stroke) or could be used as a catch all and include other patient groups e.g respiratory and sepsis.</p> <p>The pathway suggests that patients with NEWS scores the are greater than and equal to seven should be transferred and those with scores equal or greater than five should be transferred unless their pre-existing morbidity indicates that they would have high scores or that they are on a palliative care pathway</p>	<p>It would seem that this is currently a “proposal” and has not been implemented as a formal pathway or consulted on.</p> <p>There is criteria (currently proposed) for admission to ITU that would suggest that it would be possible to have a NEWS equal to or in excess of 7 but not meet the clinical criteria for level 2 care.</p>	<p>The pathway appears simple but there are many possible variables it would therefore require the incorporation of formal exclusion criteria.</p> <p>Although recommended by the Royal College of Physicians a tool to be used in the pre hospital assessment of patients it appears not to have been validated as a screening tool to recommend transfer to a particular hospital (although this may come in the future)</p> <p>An evidence base for the use of physiological triggers to aid transfer in non-trauma patients would seem important prior to introducing this pathway</p> <p>The transfer guidelines for Hexham hospital indicate that a NEWS of 5 would result in;  <i>Nurse to request urgent assessment using SBAR from:  F2 doctor or Nurse  practitioner  Consider escalation to  specialty consultant</i>  There is no indication in this document that NEWS plays any further part.</p> <p>In regard to patients in the ED many have scores of 7 or above when they arrive the pathway suggests that a score of 5 or above post appropriate treatment would again trigger transfer. At what time would this be and what is the definition of “appropriate treatment”. Clearer definitions are required.</p>

		<p>It would be inappropriate to transfer from A&amp;E to A&amp;E rather than being admitted directly to a speciality bed unless there is a clear indication that the best place for the patient is the resuscitation room.</p> <p>Who would transfer the patient if members of hospital staff are involved they will be offsite for upwards of 2 1/2 hours</p> <p>There should be a formal assessment to ensure the response to NEWS score is proportionate Currently the recommended response by the Royal College of Physicians to a NEWS of 7 or more is</p> <div> <div>Continuous monitoring of vital signs</div> <div> <ul style="list-style-type: none"> <li>Registered nurse to <b>immediately</b> inform the medical team caring for the patient – this should be at least at Specialist Registrar level;</li> <li>Emergency assessment by a clinical team with critical care competencies, which also includes a practitioner/s with advanced airway skills;</li> <li>Consider transfer of Clinical care to a level 2 or 3 care facility, i.e. higher dependency or ITU;</li> </ul> </div> </div> <p>Overall much more evidence is needed to ensure that a transfer policy based around NEWS is both appropriate and reliable.</p>
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## **Clinical Senate Review of North Cumbria Services Re-provision (Phase 1 visit)**

### **Comments on Pathways : Transportation**

Features of the Pathway	Assessment of Progress to date	What is needed
Transportation	Currently transporting some patients i.e. surgery from one hospital to another without a dedicated transport service	<p>To develop a robust, commissioned transport service for both Blue light and non-blue light transfers mainly from Cumberland to Carlisle, however also from Carlisle to West Cumberland for non-blue light transfers.</p> <p>The issue is they need to collate the number of potential transfers in both direction and for this to be mapped effectively.</p> <p>There is also a concern that critically ill patients will be transported for over an hour and what is the skill level required for the transportation of these patients.</p> <p>Need a robust action plan for transportation</p>

## **Clinical Senate Review of North Cumbria Services Re-provision (Phase 1 visit)**

### **Comments on Pathways : Nursing elements**

Features of the Pathway	Assessment of Progress to date	What is needed
<p>Stroke pathway Proposal for hyperacute stroke unit at CIC - one unit with return of patients after 72 hours to WCH</p>	<p>This had not been implemented which means that currently no patients are benefiting from acute stroke care. Some talk of the care being provided in Critical care, but not sure how this ensure acute stroke care is being delivered</p>	<p>All stroke patients should have care in a stroke unit with specialist input.</p> <p>My main concern is that if all patients go to CIC, when they return will they go to a general ward or still have stroke unit care – the response was that they would go to a second stroke unit at WCH, but I am not sure this is reflected in the modelling for nurse staffing and OT and Physio input at the WCH site. I think if they cost this up, it may be quite expensive and I don't think it was clear in the plans. There is a risk of inequity in that patients at CIC get a better service than patients at WCH. Nurses would need stroke training to be able to deliver optimum care on both sites.</p>
<p>Cardiac Pathway</p>	<p>This seems well developed</p>	<p>The plan was generally agreed to be sound. Main nursing points would be around cardiac rehabilitation and managing chest pain of inpatients particularly if nurse practitioners are performing F1 jobs. Are there sufficient skills to identify patients would need to be transferred from current inpatient areas.</p>
<p>GI Pathway</p>	<p>Unclear how much this is already happening</p>	<p>No real nursing issues, just wondered if they had thought about the use on nurse endoscopists.</p>
<p>General points Clear passion and enthusiasm from both</p>		<p>The role of the nurse practitioner was reported very</p>

<p>medical and nursing staff that we met and a desire to make things better for patients.</p>		<p>positively and well respected. This seemed an innovative and forward thinking approach to some of the medical staff shortages. Experienced nursing staff have shown to make a positive difference in these type of roles and this is well documented. Very supportive of this approach, but would like the following points to be considered:</p> <p>These roles are not for everyone, is there a way back to 'nursing' for those nurses who do not feel that this role is right for them?</p> <p>Is there the right level of clinical supervision available, especially in terms of clinical decision making?</p> <p>How are the nurses supported when things go wrong?</p> <p>Doctors are used to complex decision making but nurses have not been trained in this way and need the right level of support.</p> <p>How is the role being evaluated?</p> <p>Also, we did not have a chance to speak to any of these nurses themselves, so the information is only from others.</p>
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## Overall Review

The review team explored with the clinicians the proposed pathways looking at improvement in outcomes and standards that the proposals are intended to deliver and how the teams were considering the issues facing them. Consideration of the safety and quality of services were paramount throughout all of the discussions. A view that consolidating acute out of hours surgical services to the CIC site had allowed surgeons to give a safer service which could not be assured in any other way. It also supported the maintenance of surgical skills and the further development of new techniques by having a concentration of resources and expertise serving a critical mass of patients; thus supporting innovation and research and increasing resilience. The concentration of Primary Percutaneous Coronary Intervention (PCI) on the CIC site seemed to be well accepted and brings significant benefits to patients, not least as previously many patients were transferred to Middlesbrough or Newcastle. Having said this, the availability of beds at CIC seemed to pose challenges, especially for urgent rather than emergency cases needing PCI. The case for change for acute stroke care and high risk medical emergency management was less well developed and the review team was concerned that transport and bed availability at CIC needed further work. Travel and transport issues were clearly identified in almost every discussion. However there was insufficient information available to the review team on what work had been carried out by the Trust and ambulance services to estimate the impact on patients and their relatives travelling across sites and what, if any, consideration had been given to the use of patient hotels and additional parking space at Cumberland Infirmary.

*(To get a better understanding of the challenges posed by geography the review team travelled back and forward between both sites and across to Penrith by mini bus over the course of the 2 day visit)*



## Emerging Themes

### 1. Geography/demography

The review team were particularly struck by the challenging nature of the geography of North Cumbria. The distance between Carlisle and Whitehaven is probably the largest distance in England between two small/medium sized District General Hospitals managed by the same NHS Trust. The review team understand the catchment populations of the two hospitals are quite similar with Whitehaven serving 150,000 people and Carlisle 170,000. This brings real issues of equity of access for a relatively deprived population and challenged local health economy. We were informed of plans to expand British Nuclear Fields Limited with a potential 6,000 people predicted in the coastal conurbation.

### 2. Transport

Given the distances involved between hospitals, any centralisation of service will require close collaboration with the North West Ambulance Service (NWAS). A request will be made for some of the Senate Review team to meet with colleagues from NWAS to assess from their perspective how much progress has been made in specifying any changes to the transport system.

### 3. Communication

It is fully acknowledged that considerable effort has been put in to communicating with people in North Cumbria, particularly in and around Whitehaven. In spite of this effort the impression gained by the Senate Review Team is that there is more to do. Although we only met a small number of representatives of local campaigns, Healthwatch and the Overview and Scrutiny Committee there is clearly now a degree of suspicion developing, particularly around the motivation for the recent, unexpected publication of a Draft Clinical Strategy by NCUHT. In particular, the case for change and the benefits of centralisation of acute stroke care need to be articulated, ideally by trusted local clinicians. The issue of the management of acutely ill patients with other medical conditions needs to be explained with a clear vision of how the emergency and “acute” floor at WCH will operate and be staffed. The use of the NEWS scoring system and how this will benefit patients’ needs to be explained. Many frail elderly patients may trigger a score of 7, and the ways and means by which these patients will be managed need to be articulated together with a clear explanation of which patients will be managed at WCH and which it is proposed to transfer to CIC. For the latter, the risks/benefits need to be put forward together with robust modelling of the transport arrangements and the means by which bed availability at CIC will be answered.

### 4. Engagement

As with Communications it is acknowledged that considerable effort has been put into engaging the public and staff, particularly around the role of the redevelopment of the hospital. The Senate Review Team did, however, come away with a sense that even more work is needed to persuade, for example, Whitehaven consultants whose services might be affected by change, of the need to do so. It was not felt that there was a ‘champion for change’ amidst the admittedly few consultants we met.

## **5. Patient Safety v Patient Experience**

The Senate Review Team welcomed the very clear focus on patient safety inherent in the potential changes to clinical pathways. On several occasions, however, the team's attention was drawn to the need to consider the full experience of patients during their treatment as well as their safety. Given the geography and travel implications in North Cumbria we know this will be a difficult balance to achieve.

## **6. Recruitment/retention of medical staff**

It is acknowledged that considerable effort has been put into finding new ways of recruiting and retaining medical staff. However services were reliant on locums and there appeared to be a large number of vacancies, we wondered if the time had come to consider very radically different roles combining primary and secondary care professional responsibilities. Some staff at WCH spoke enthusiastically of the recruitment and training of nurse specialists and the invaluable help provided by 2 GPs with extra training in emergency medicine. Whilst there were insufficient numbers of these staff to provide 24/7 care, a further development of this model, underpinned by the impressive commitment of the A&E Consultants we met could provide a resilient way of delivering viable acute medical care for a large proportion of patients seen at WCH. The timing of the publication of the *High quality care for all, now and for future generations NHS England five year strategy* is extremely helpful as it offers new thinking about solutions to local problems and we think North Cumbria is in such a difficult position it might be worth asking national colleagues to allow some radical experimentation in role design alongside new ways of recruiting.

## **7. Lack of project plans and details**

The late change in focus of the terms of reference for the visit was the right thing to do. Plans are not yet detailed enough to go through an assurance process. Indeed, some of the earlier changes to surgical pathways appear not to have been well effected with apparent lack of written pathways/protocols to help GPs. The role of the Programme Board will need to ensure the detail regarding how many patients will require to be transferred for each pathway, agreeing timelines for implementation and holding organisations to account for delivery. The review team had sight of a Health Gateway report (Health Gateway ID: DH811) which was shared with the programme board and OSC. This report only focussed on the programme governance arrangements and not clinical issues however it highlights that strengthened governance arrangements will enable the programme board to perform the role of holding organisations to account for delivery.

## Suggestions

1. It is pertinent for the role of the Programme Board to be revisited, to strengthen accountability, to develop a firm, detailed project plan with specific timelines and deliverables. Relationships appear strained and an opportunity to revitalise relationships with key stakeholders could helpfully be taken. Consideration could be given to the establishment of a programme office with responsibility for a major communications and engagement approach, potentially using independent specialist expertise to understand public and patient concerns, explore options for delivery models and design the key messages and media to be used.

A starting point might be having an open, transparent discussion about the impact of the publication of the Trust's Clinical Strategy document. There appears to be much agreement about a lot of the content and options but there are very important differences regarding some of the options in Maternity and Paediatrics. The programme Board needs to work these differences through and address the tensions in relationships that have been expressed to the Senate Review Team.

2. As part of the ongoing dialogue for this stage of the review it would be helpful to gain a full understanding from the Trust's perspective of the progress as we have understood it in implementing each of the pathways (pages 10– 22).
3. The planning timeframe for delivery of changes to pathways could also be usefully revisited. Given the concerns received about communications and engagement, it is unlikely that a smooth change in some of the pathways will be delivered in the next nine months. Consideration might be given to exploring the possibility of re-negotiating visit timetables with CQC and TDA as there is a distinct impression that the Trust senior managers are understandably spending a huge amount of time preparing for successive visits/inspections and fire fighting operational issues, possibly to the detriment of delivering on pathway changes.
4. Reflecting on the senate review team visit there is a sense that the health economy is focusing on solving the issue of the form of organisation (the acquisition) perhaps at the expense of getting properly functioning pathways in place (service models). This, linked to the timescales in para 3 above, may be skewing priorities.
5. An approach to NHS England might be considered to see if there is any interest in developing highly innovative ways of tackling the recruitment and retention issues being experienced in both primary and secondary care. The more traditional approaches, including payment of premia, do not appear to have worked leaving Whitehaven and its surrounding population being serviced by large numbers of locum medical staff. An analysis of the NHS England five year plan might conclude that North Cumbria could pilot some highly innovative approaches to workforce development including vertical integration.

6. The Trust might also want to re-examine its Human Resource support for medical staffing as references were made to this support having been withdrawn or about to be withdrawn, from Whitehaven.
7. Lack of project plans and details – the late change in focus of the terms of reference for the visit was the right thing to do. Plans are not yet detailed enough to go through an assurance process. Indeed, some of the earlier changes to surgical pathways appear not to have been well effected with apparent lack of written pathways/protocols to help GPs. The role of the Programme Board in driving the detail around consistent data (the possible range in number of patients who will require to be transferred for each pathway), agreeing timelines for implementation and holding organisations to account for delivery, could usefully be revisited.
8. Further work – As we move closer to the stage where clinical assurance is needed, the Senate Review Team would like to undertake the following further elements of work/analysis:
  - i. To explore and understand the implementation of high risk surgical pathways, to what extent the theme has been documented and communicated within Primary and Secondary Care.
  - ii. To hold dialogue with NWAS regarding transport issues.
  - iii. To hold dialogue with the Cumbria Partnership NHS Foundation Trust regarding rehabilitation.
  - iv. To hold dialogue with the CCG about GP services in and around Whitehaven.
9. The Senate Review Team, at the Clinical Assurance Stage would also anticipate being able to see all the proposed pathways fully documented with worked through protocols ready for communication across the North Cumbrian health economy. The Senate Review Team would like to undertake a joint analysis with the CCG (as the commissioners of this review) of the 2008 and 2011 public documents in preparation for the possible clinical assurance stage. Some initial analysis has been started. **(Appendix 8)**

# Appendix 1



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Appendix 1.2 - N  
Cumbria Secondary C



Appendix 1.3 - Final  
Cumbria Local Health



Appendix 1.4 - Final  
North Cumbria Syster



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Trust paper.pdf

## Appendix 2



Nigel Letter to Prof  
Andrew Cant 20 10 2

## Appendix 3



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## Appendix 4



Agenda 03 11 2014  
Pre-Brief Meeting.doc



FINAL timetable for  
clinical senate review



## Appendix 5

### Review Panel members

#### **Prof. Andrew Cant. Clinical Senate Chair**

After training in internal medicine, infectious diseases, paediatrics and neonatology at St George's and Guy's Hospitals in London, Professor Cant held a Medical Research Council Fellowship in immunology before completing his training in paediatric immunology and infectious diseases at the Hospital for Sick Children, Great Ormond Street, London and L'Hopital Necker, Paris. Professor Cant was appointed as a Consultant Paediatrician in Newcastle in 1990, to set up 1 of 2 national referral centres for the treatment of children with severe immunological disorders, and a regional paediatric infectious diseases service. In 1997 Professor Cant became Clinical Director for Children's Services within the Royal Victoria Infirmary. He has led the development of the £100 million 244 bedded Great North Children's Hospital (GNCH) which opened in 2009 and was fully completed in late 2010. In 2006 Professor Cant led a national review of UK children's specialist services on behalf of the RCPCH and the Children's Commission for England, entitled, "Modelling the Future". This survey highlighted current provision, defined need, proposed standards for networks. From 2006 to 2009 Professor Cant was President of the European Society for Paediatric Infectious Diseases (ESPID). Professor Cant was Chair of the Medical Advisory Panel of the UK Primary Immunodeficiency Association from 1998 to 2007; In 2005 he oversaw the national consensus document 'Diagnosis and management of C1 inhibitor deficiency'. In 2006 he led joint clinician/patient review/accreditation of primary immunodeficiency centres in the UK, setting and monitoring standards. From 2007 Professor Cant chaired the 'Children's Clinical Network' (initially the children's work stream of 'Our Vision, Our Future') for the North East of England. Professor Cant is very much enjoying his new role as Chair of the Clinical Senate and is fully

committed to lead the Senate's work, serving the Clinical Commissioning Group, Clinical Networks and wider community, in giving clear strategic clinical advice, operational development, and to oversee coherent and effective senate arrangements in the North East, in a way that facilitates in achieving the best possible outcomes for patients and benefits to the health of the population as a whole.

#### **Dr. Chris Plummer, Consultant Cardiologist**

Dr Plummer trained in Bristol and Oxford Universities and undertook his post-graduate medical education in the Northern Deanery. He works as a consultant cardiologist in the Freeman Hospital where he is clinical lead for implantable cardiac rhythm devices. His other clinical and research interests include the cardiovascular effects of cancer treatments including the early detection of toxicity with biomarkers and protective strategies for adults and children. He is also heavily involved in all aspects of medical education from medical student interviews and exam setting to working as training programme director for cardiology.

#### **Dr Jon Scott BMedSci BM BS FRCP MD**

Dr Scott graduated from the University of Nottingham in 1992 and after postgraduate training in various hospitals around the North East was appointed as a Consultant in Elderly Care/General Medicine with a Specialist Interest in Stroke Medicine at South Tyneside Hospital in 2003. In addition to leading on Trust stroke and TIA services, Dr Scott is one of 4 Consultant Acute Physicians within the Trust working on the Emergency Assessment Unit and shares responsibility for elderly care in-patient services. Dr Scott was appointed as one of 2 clinical advisors for stroke to the Northern Cardiovascular Network between July 2008 and April 2012. From an educational point of view, Dr Scott served as Foundation Programme Tutor for

the Trust between 2006 and 2013 before being appointed to the role of Foundation School Director for Health Education North East.

He maintains an active interest in teaching as a Clinical Lecturer for the Wear Base Unit of the University of Newcastle and in research, supervising recruitment into a number of stroke trials.

Dr Scott was appointed to the Northern Clinical Senate in 2013.

#### **Dr. Robin Mitchell, Clinical Director, Strategic Clinical Networks**

Dr Robin Mitchell graduated in medicine from the University of Edinburgh in 1980. He undertook training in Anaesthesia and Intensive Care in Edinburgh and Leicester. In 1989 he was appointed as Consultant Anaesthetist in Durham, and subsequently undertook the roles of College Tutor and Clinical Director. He maintained a wide range of clinical interests including obstetric anaesthesia and intensive care medicine. He was a member of the project team for the development of the new North Durham Hospital, and was chair of the Durham and Tees Clinical Advisory Group for maternity and children's services in 2012-13. Dr Mitchell was Director of Medical Services for North Durham Acute Hospitals Trust from 1996 to 2000, and Executive Medical Director for County Durham and Darlington NHS Foundation Trust from 2010 to 2013. In 2013 he took up the role of Clinical Director for Northern England Strategic Clinical Networks. He has a keen interest in patient safety and service design.

#### **Mr. Paul Fell, Consultant Paramedic**

Paul was appointed as the Consultant Paramedic in November 2013, prior to this appointment Paul was the Head of Clinical Care and Patient Safety for the Trust, Paul specialises in education and training as well as Research and Development for the Trust and has a specific interest in advanced pre-hospital care.

#### **Dr. Mark Hudson, Consultant Herpetologist & Gastroenterologist**

Mark Hudson is the current President of the British Association for the Study of the Liver (BASL). He was appointed Consultant Hepatologist & Gastroenterologist in 1995, Freeman hospital, Newcastle upon Tyne Hospitals NHS Foundation Trust Dr Hudson is the Chair of the North East & North Cumbria Hepatology Network and a member of the Northern Senate Council.

#### **Dr. Andy Simpson, MBBS, FRCS(Ed), FCEM, DCH, Dip Clin Ed.**

Qualified in 1988 Consultant in Emergency Medicine since 1999 initially in Hartlepool then Jointly with University Hospital of North Tees until Hartlepool A&E closed in 2011. Clinical Director of Emergency Care for North Tees and Hartlepool NHS Foundation Trust since 2006. Specific interests are Paediatric Emergency Medicine and Medical Education

#### **Dr. Phil Adams**

Clinical medicine, junior training posts Newcastle. Cardiology training Newcastle and Mount Sinai, New York, British-American Research Fellowship. Consultant cardiologist Royal Victoria Infirmary, Newcastle, 1987 to 2012. Research: acute coronary syndromes, amiodarone, prognosis CAD. NICE chest pain guideline group, chair of MI Secondary Prevention Update committee. Clinical Director Newcastle Cardiology '03-'07, chair Northern Network '08-'09.

#### **Dr. Lesley Kay**

Lesley Kay is a consultant rheumatologist and clinical director for patient safety and quality at The Newcastle Upon Tyne Hospitals NHS Foundation Trust. She trained in rheumatology and public health in the North East and Cambridge and did her undergraduate training in Oxford. Her clinical and research interests are in inflammatory arthritis, particularly ankylosing spondylitis, in national registers, education research and patient experience as well as clinical trials.

#### **Mrs. Hilary Lloyd**

Hilary Lloyd is the Director of Nursing, Midwifery and Quality and the Joint Director

of Infection Prevention and Control at Gateshead Health NHS Foundation Trust. She took up the role in September 2014, after three years working as the Deputy Director of Nursing, Midwifery and Quality also at the QE Gateshead.

Hilary first joined QE Gateshead in 2011 and has expert nursing knowledge, broad range of clinical experience, including stroke care, and a track record of excellent leadership. She has been a member of the Northern Clinical Senate for 12 months.

Hilary has previously worked as Head of Nursing Development and Principal Lecturer at City Hospitals Sunderland NHS Foundation Trust and as a Senior Lecturer at the University of Sunderland. She qualified as a nurse in 1989 from Bede School of Nursing in Sunderland. She has a BA (Hons) in Sociology and Psychology, a MSc in Advanced Practice and is currently studying for a professional doctorate in nursing practice.

She has several academic publications, including a text book on Nursing: Vital Notes on Principles of Care in 2009.

#### **Mrs. Lynda Dearden**

Lynda Dearden is the Network Manager for

the Maternity and Child Health Strategic Clinical Network (NESCIN) She also covers a programme of work around long term conditions and end of life care. Lynda has worked in the NHS for over 30 years, in a variety of clinical settings and senior management roles. She is also the acting Manager for Northern Clinical Senate.

#### **Mr. Roy McLachlan, Associate Director, Strategic Clinical Networks and Senate**

Roy joined the NECN in February 2009 on secondment from Northumberland, Tyne and Wear NHS Trust where he was Chief Operating Officer. Prior to that he was Chief Executive of a number of NHS statutory bodies - NHS Trusts, a Health Authority and a Primary Care Trust. He has spent most of his managerial career working in the North East but started working in Scotland on the graduate scheme having completed an M.A. in French at St. Andrews University. He subsequently became one of the first NHS managers in the North East to undertake an M.B.A. Roy has been the Associate Director of the SCN since April 2013.

## Appendix 6

### Glossary of Acronyms

<b>A&amp;E</b>	Accidents and Emergency
<b>ACS</b>	Acute coronary syndrome
<b>AHP</b>	Allied Health Professional
<b>BCIS</b>	British Cardiovascular Intervention Society
<b>CCG</b>	Clinical Commissioning Group
<b>CE</b>	Chief Executive
<b>CEO</b>	Chief Executive Officer
<b>CIC</b>	Cumberland Infirmary ,Carlisle
<b>CQC</b>	Care Quality Commission
<b>DTN</b>	Door To Needle
<b>ECG</b>	Echo Cardiogram
<b>ED</b>	Emergency Department
<b>GI Bleed</b>	Gastrointestinal Bleed
<b>GP</b>	General Practitioner
<b>GRACE</b>	Global Registry in Acute Coronary Events
<b>HR&lt;40</b>	Heart Rate
<b>LV</b>	Left Ventricular
<b>MI</b>	Myocardial Infarction
<b>MINAP</b>	Myocardial Ischaemia National Audit Project
<b>NCOR</b>	National Institute for Cardiovascular Outcomes Research
<b>NCUHT</b>	North Cumbria University Hospital Trust
<b>NEWS</b>	National Early Warning Score
<b>NICE</b>	National Institute for Health and Care Excellence
<b>NICOR</b>	National Institute for Cardiovascular Outcomes Research
<b>NSTEMI</b>	non-ST-segment elevation myocardial infarction
<b>NWAS</b>	North West Ambulance Service
<b>OOH</b>	Out of Hospital
<b>OSC</b>	Overseas Scrutiny Committee
<b>PCI</b>	Primary Cardiac Intervention
<b>PCI</b>	Percutaneous Coronary Intervention
<b>PIC</b>	Primary Coronary Intervention
<b>PPCI</b>	Primary Percutaneous Coronary Intervention (Primary Angena)
<b>SBAR</b>	Situation-Background-Assessment-Recommendation
<b>SSNAP</b>	Sentinel Stroke National Audit Programme
<b>STEMI</b>	ST segment elevation myocardial infarction
<b>TDA</b>	Trust Development Authority
<b>TIA</b>	Transient ischaemic attack
<b>TIMI</b>	Thrombolysis in Myocardial Infarction
<b>UGI</b>	Upper Gastrointestinal
<b>UHNC</b>	University Hospital North Cumbria
<b>UK</b>	United Kingdom

## **Appendix 7**

# **Clinical Senate Review Framework**



Clinical Senate Single  
Operating Framework

## Appendix 8



APPENDIX 8.pdf

Mark Hudson had spoken to Denise Burke on 18.11.2014 and comments are as below:

- There has not previously been a formal cover for upper GI bleeding for West Cumberland. The introduction of this pathway is an improvement from previously existing services
- On WCH site the anaesthetist covering ITU is competent to place a Sengstaken tube if required
- In hours, Monday to Friday there is consultant GI presence to assess and endoscope any patient with suspected GI bleed who has not been transferred
- There is a 24/7 rota in place in Carlisle. 2 of the colorectal surgeons are not confident in managing variceal bleeding and there is a second tier cover in place for this eventuality. This is to be bolstered with the addition of new consultant next week (I presume locum)
- In negotiation with Ambulance service regarding transfers
- If need required, the anaesthetist on WCH site could escort patient
- One part of region mentioned is Cockermouth which is equidistant between hospitals. Want GPs to be able to refer suspected GI bleed directly to Carlisle to avoid unnecessary delays in management at WCH
- Risk assessment on WCH site – on call medical team, Consultant and Trust doctor
- Although not formally audited only around 12 transfers out of hours since March, on these very few have require emergency endoscopy that night
- Denis Burke feels that although current situation not ideal it is an improvement from existing service but service in development as per the STEP process described. At this point they are at STEP 1 having established a 24/7 rota but procedures still in general theatres with theatre staff assisting

## **Contact Details**

**Northern Clinical Senate Office**  
**Waterfront 4**  
**Goldcrest Way**  
**Newburn Riverside**  
**Newcastle upon Tyne**  
**NE15 8NY**

Tel: 0113 825 3039

Email: [england.northernclinicalsenate@nhs.net](mailto:england.northernclinicalsenate@nhs.net)

Web: [www.nesenate.nhs.uk](http://www.nesenate.nhs.uk)

Senate Chair : Prof. Andrew Cant (Contact: [gale.roberts@nuth.nhs.uk](mailto:gale.roberts@nuth.nhs.uk))

Senate Manager: Lynda Dearden (Contact: [Lynda.dearden@nhs.net](mailto:Lynda.dearden@nhs.net))

Senate PA: Seema Srihari (Contact: [seemasrihari@nhs.net](mailto:seemasrihari@nhs.net))



# NORTH CUMBRIA SECONDARY CARE SERVICE CONFIGURATION PROPOSALS – 14<sup>th</sup> July 2014

## EXECUTIVE SUMMARY

The Cumbria Alliance has developed a North Cumbria Strategy 2014 – 2019. “Together for a Healthier Future” sets out the principles including *right care, at the right time, and in the right place*.

Secondary care needs to urgently address the regulatory compliance shortfalls in a way that is consistent with the wider health economies strategy. To do this it is proposed that there is:-

- 1) An increase in the number of people receiving services at the West Cumberland Hospital
- 2) An increase in the provision of specialist services at the Cumberland Infirmary Carlisle, consistent with the *NHS Services, 7 days a week forum – clinical standards*
- 3) A wider use of clinical networks across the 2 sites to optimise the use of the limited amount of medical staffing resources
- 4) This requires transformational changes to “blue light” services, obstetric and paediatric provision, and the provision of elective and outpatient services
- 5) The opening of the new West Cumberland Hospital in 2015 provides the ideal opportunity for newly configured services to be implemented

## CONTEXT

North Cumbria University Hospitals NHS Trust is the secondary care provider in North Cumbria. It provides services to 340,000 people predominantly from its 2 sites, the Cumberland Infirmary at Carlisle (CIC), and the West Cumberland Hospital (WCH) in Whitehaven. Whilst the geographical distribution of the population and the 2 hospitals is challenging, it is not unique in the UK.

The Trust and the health economy it operates within, is under significant pressure and is currently failing to achieve quality standards, operational performance and financial control. It is one of 11 “distressed health economies”. The services at WCH fall a long way short of the 7 day national standards.

The Trust is in “special measures”; was 1 of the 14 hospitals inspected under the “Keogh mortality review”, and in July 14 received the reports from a Care Quality Commission Quality Review that gave an overall rating of “requires improvement”, with 2 specific areas described as “inadequate” and a significant number of “must do” actions. “Are services at this Trust caring”

received a “good” rating which is encouraging for the staff and the organisation.

The current secondary care service provision with 2 “blue light” hospitals results in duplication of emergency services, resulting in extreme difficulty in providing medical and nursing capacity. An example of this is that there are only 6 medically led obstetric units in England with less than 2,000 deliveries per year. Two of them are located in this Trust.

There have been multiple plans to reform the health service provision for North Cumbria, but they have not succeeded in altering the underlying pattern of service delivery. The need for transformational change, delivered at pace, is clear and supported by the work of the Cumbria Alliance in developing a North Cumbria Strategy 2014 – 2019. There is a need to identify what this means in terms of secondary care service change, and this document sets out some proposals.

The vision is of the North Cumbria University Hospitals Trust working as a single entity, delivering services across North Cumbria, with clinical networks supported by flexible working of its staff. Wider clinical networks from outside the County will need to continue to be developed. The need for 7 day services consistent with the national clinical standards, with recognition of the interdependencies between specialties to deliver complex care is key. Measurement of quality, operational and financial performance in all parts of the Trust will drive improvement.

## **OUTCOME MEASURES**

These proposals for transformational change will require detailed assessment when implemented to provide assurance to the commissioners, regulators and the public that they have resulted in service improvement.

Key Performance Indicators (KPIs) could include:-

- 1) Mortality rate improvements with a decreased difference between sites. The Hospital Standardised Mortality Rates (HSMR)
- 2) Transfer rates between hospitals and audit of all transfers to ensure they are appropriate, against agreed criteria set prior to implementation
- 3) Overall activity at WCH demonstrating an increase
- 4) Compliance of services at CIC with NHS Forum 7 day services – clinical standards
- 5) A decrease in the number of locum doctors employed by the Trust
- 6) Compliance with regulatory standards e.g. CQC

Delivering these KPIs will provide the necessary high level assurance. In addition, each specialty should develop a small number of high level KPIs that can be measured, and report on internally and externally to provide assurance at service level. These are likely to be KPIs that are accepted measures of safety, quality, operational performance and financial delivery and are used in other parts of the NHS.

# WHAT COULD BE POSSIBLE AT WCH

## Principles

1. More people to receive their services locally than in 2014
2. To maintain and develop specialist skills in the staff based at WCH
3. Increase the provision of “one stop” services
4. Improve support to in patient activity at WCH from outpatient and elective service providers
5. Provide whole days of activity for visiting consultants and networked specialty services across the 2 sites

## Key Service Themes

### Outpatients (OPD)

- Increase the range of specialties
- Increase the number of one stop services
- Improve integration with the community provision and the Partnership Trust
- Development of tertiary OPD services e.g. bariatric to meet local needs

### Surgery

- Provide the maximum range of elective procedures that is possible in a safe and efficient way
- Consider what paediatric and semi urgent services can be provided
- Review in-patient beds for elective surgery with regard to specialty wards or general surgical wards
- A women's surgical unit for breast and gynae could be provided
- Development of a symptomatic breast service building on the breast screening that is already available

### Un-scheduled medical care

- “Selective” blue lights to WCH, with the name of the unit to be decided as it probably needs to change from A+E to an urgent care centre
- “Front of house” early review by clinical staff, from a team consisting of ED consultants, acute physicians, nurse practitioners and critical care doctors
- Clear admission and transfer criteria
- “Standard operating procedure” for transfers with competencies defined against patient acuity
- No predictive length of stay transfer criteria
- Use of 14 higher acuity beds including increased monitoring, inotrope support and NIV
- Transfer of all level 3 critical care patients

## Obstetrics

- A medically led unit is not sustainable for 1300 births per year for obstetric, anaesthetic or paediatric rosters
- There must be a provision for antenatal care, the delivery of low risk pregnancies and the safe transfer when complications arise
- Development of a mid-wife led unit for the West
- Can low risk elective LCSC be done e.g. for breech and “choice” sections?

## Paediatrics

- A 24/7 inpatient service is not viable due to medical staffing rosters and paediatric critical care support
- A paediatric “day hospital” with an acute assessment unit for children who might not need admitting should be considered
- Consideration of the “day hospital” being part of the front door services i.e. on the urgent care floor of the new WCH
- Clear plans for the transfer of children requiring admission and any that present in extremis
- Increase outpatient paediatric activity when possible
- Consider paediatric surgery with appropriately competent teams, supported by the on-site paediatrician
- Could the community paediatricians have a role in this day hospital model with a hub and spoke provision of services into the community e.g. neuro-disability services

# WHAT COULD BE POSSIBLE AT THE CIC

## Principles

1. There will be inevitable differences across North Cumbria in accessing secondary care services due to the geography
2. Clinical networks across the Trust will provide the best balance between centralised specialist care and outreach specialist care
3. Some specialist services do not have to be on the centralised site
4. 24/7 and 7 day services require significant additional resource but improve safety, quality and efficiency and are becoming nationally mandated. This will provide the best possible specialist care for North Cumbria

## Key Service Themes

### Outpatients

- Provision of most specialties to provide local access
- Centralised specialties where a distributed outpatient model is not feasible – usually dependent on diagnostic services
- Improve integration with the community provision and Partnership Trust

### Surgery

- All elective surgery that requires the support of critical care
- This relates to either complexity or co-morbidity
- All out of hours emergency surgery
- Day-case and less complex surgery for the Carlisle catchment area
- Re-configuration of the surgical bed base to support this

### Un-scheduled medical care

- All blue lights accepted (exceptions such as some major trauma which is diverted to trauma centre as per current network model)
- 24/7 7 day provision of “high risk” medical pathways e.g. PCI, hyper-acute stroke (initial assessment and treatment), GI bleed service, respiratory failure
- Access to comprehensive diagnostic facilities e.g. cardiac cath lab, echo services, interventional radiology, ultrasound, CT angiography and MRI
- Pathways agreed prior to implementation, for the swift repatriation of patients who live nearer the West Cumberland Hospital, as soon as medically fit for discharge with KPIs in place re access to beds for transfer
- Develop a system to alert when a West Cumbrian patient is in the CI, with processes to “pull” the patient back to WCH asap
- Ongoing monitoring of the improving quality metrics such as HSMR

### Obstetrics

- The provision of a medically led obstetric unit, supported by dedicated anaesthetic cover for category 1 sections and an epidural service. Neonatal unit supported by consultant paediatricians.
- Outreach support across the clinical network to provide antenatal care in WCH, support to the midwife led birthing unit and consideration of elective low risk LSCS at that site

### Paediatrics

- Blue light paediatric admissions with improved medical support to the admissions unit, ward and neonatal services

- Clinical network delivery of the “paediatric day hospital” at WCH to provide assessment of children where admission might not be necessary, out-patient services, on-site support to allow day case paediatric surgery and support for elective low risk LSCSs
- Overall paediatric provision as part of the “coast to coast” existing paediatric clinical network

Other considerations at CIC

- dexta scanning not available at CI
- Single CT scanner
- IR suite capacity competing with cardiology and increase demand from vascular network?

## HEALTH INFORMATICS

Although Health Informatics is not “in scope” for this report, it is the view of the author that this is key to delivering transformational change, and measurement of KPIs to provide assurance and drive up quality.

The *Clinical Digital Maturity Index* published by EHI intelligence gives NCUH NHS Trust a ranking of 140<sup>th</sup> out of 159 Trusts. Whilst this is a crude measure it does reflect on the relative lack of quality information, and the lack of electronic systems such as order comms and e prescribing.

The recent CQC findings of “inadequate” relating to health records suggests that major investment is going to be required. An alternative to patching up the paper based health records, would be to consider scanning of the records “on demand”, with an electronic document management system that would provide advance search capability. Once scanned, the paper record can be destroyed. This then provides a patient record that can then be immediately accessed from any site, by anybody with the correct authorisation.

Essential to providing integrated services between social care, primary care, community care and secondary care is access to all the information held about a person, and for that person to also be able to access appropriate parts of their records.

It is recommended that the Health Informatics strategy is reviewed in light of the regulatory compliance issues and the need for transformational change.

## **Appendix 1 - Specialty level services at WCH**

For each specialty an analysis is needed by HRG code and patient's address to determine the volume of activity that could be provided at WCH. This will then quantify the amount of increased activity at WCH, and the consequent decreased in activity at the CIC.

This then needs to be modelled re staffing and potential capacity to determine the reality of each specialties service re-configuration, and the financial implications. It is clear that it would not be realistic to provide all of the services that are listed, but each should be tested to ensure that the maximum amount of local services can be provided to the benefit of the local population.

Pathways of care need to be agreed for elective and non-elective prior to implementation.

### **Surgery**

All patients being treated in the 6 new theatres will require an anaesthetic assessment and agreed criteria, which is likely to be all ASA 1 and 2, most ASA 3 and some ASA 4 for local anaesthetic and low risk procedures. BMI cut off at 35 or 40? An increased use of risk scoring systems such as p-POSSUM should be considered to assess individual patient risk.

WCH could develop as a centre specialising in regional anaesthetic techniques, facilitating services such as hand surgery etc.

Care is needed in using terms such as low risk. Medium risk could be delivered (both from complexity and co-morbidity perspectives), provided there is appropriate back up as provided by the "higher acuity" support from critical care.

The new hospital provides some fantastic opportunities to improve the range and quality of services. Playing to its strengths of ultra-modern facilities, diagnostic equipment and single rooms with en-suite rooms is essential.

### **ENT**

- Outpatients – full service – are nasendoscopes and decontamination available
- Electives – limited, ? day-case only
- Paeds – limited, day cases from paeds "day hospital"  
    ?tonsils

### **Oral/Max-Fax/Orthodontics**

- Outpatients – full service with OPG X-ray machine
- Electives – majority ?day-case only
- Paeds – majority of cases as day cases

## Eyes

- Outpatients – full service if appropriate kit available
- Electives – cataracts plus other non complex i.e. not VR
- One stop cataract services with the new facilities
- Paeds – majority of cases as day cases e.g. squints

## Urology

- Outpatients – full service
- Electives – flexi scopes, TURBT and TURP
- Paeds – cirr's and un-descended testis

## Breast Surgery

- Outpatients – full follow up service
- New patients if diagnostics available for one stop service
- Electives – lumpectomy, simple mastectomy ?reconstruction
- Part of a Women's surgical unit

## Gynae

- Outpatients – full service including colposcopy
- Electives full benign gynae service, no major cancer surgery
- TOP medical or surgical provided

## General Surgery

- Outpatients – full service including one stop "PR bleed" service
- Electives for simple hernias (laparoscopic or open), lap cholecystectomy, lumps and bumps etc
- No bowel resections
- Paeds – full day-case service e.g. hernias

## Vascular

- Outpatients – full service if vascular lab technology available
- Electives – varicose veins as per NICE guidance – LA

## Ortho

- Outpatients – full service
- # clinic
- Electives – arthroscopy, primary hip and knee
- Paeds – day case procedures
- Semi urgent trauma surgery? e.g. MUAs, plating wrists/ankles. No major long bone # needing nailing

## Pre-op assessment

- Could higher risk elective patients who are going to have their surgery at the CIC receive their pre-op assessment at WCH?



## Medicine

To provide whole days of consultant activity, including support for in- patients, and therefore delivering networked specialty care across the 2 sites

### Cardiology

- Outpatients – full service but kit e.g. pace maker reviews, echo
- No cath lab so even simple pacemakers not possible?
- What would need to be provided to deliver “stress tests”
- Specialist heart failure clinics

### Gastro/endoscopy

- Full outpatient service
- All elective simple endoscopy (no ERCP)
- Two rooms in new build with full JAG accreditation and 2 additional treatment rooms within the hospital
- capacity for future expansion – bowel screening

### Respiratory

- Outpatients – new patients – full lung function tests needed
- Follow up – full service
- Bronchoscopy done at CIC with EBUS

### Renal

- Full outpatient service including one stop clinic with US
- Renal biopsy, access lines for haemo and CAPD, fistula formation at CIC
- Haemo-dialysis of all but the most unstable
- Haemofiltration is an indication for in patient transfer

### Care of the Elderly

- Opportunity to develop a one stop assessment centre with diagnostics such as CT, MR and dexa scanning
- Link this with telehealth support integrating community and social care – IT access to these systems is going to be there?

### End of Life Care

- Linkage between local oncology, chronic pain and community services provides an opportunity for excellence

### Oncology

- new and follow up outpatients with appropriate diagnostic support
- Chemotherapy, an increased range of treatments
- Provision as part of a wider specialist clinical network

### Rheumatology

- new and follow up outpatients

- Disease modifying treatments given in the chemo unit?

#### Endocrinology

- Full outpatient service with community outreach for diabetes
- Provision of MDT foot clinics and linked clinics with eyes and obstetrics

#### Haematology

- Full outpatient service for new and follow up
- What lab back up is needed
- Simple procedures such as bone marrow
- Lines inserted in Carlisle

#### Rehabilitation

- Develop a service for West Cumbria patients at WCH
- Post-acute stroke
- Step down from acute care where rehabilitation is necessary e.g. post critical care

#### Dermatology

- Full outpatient service for new and follow up
- Community outreach

Neurology, Community paediatrics and Sexual health are services provided by CPFT, and service models could be developed to further support integrated care provision.

### **Support**

#### Blood sciences lab

- Current provision is full MLSO on-call (required for obs)
- Potential for hub and spoke model
- Increased use of "point of care" testing
- Significant savings and improved resilience of the CIC MLSO on-call rota

#### Pharmacy

- Hub and spoke model
- Lack of automation – no robot
- E prescribing to be implemented
- Sterile pharmaceutical products from a central location

#### Tele-health

- Could WCH be developed as the tele-health hub
- The new facilities and the nurse practitioner "back of house"

#### AHP support

- Vital resource for sub-acute and rehab functions
- OT involvement at front door has shown benefit in some places in admission avoidance

## Appendix 2 - Documents reviewed

Care Quality Commission – NCUH NHS Trust Quality report	Jul 14
Care Quality Commission – Cumberland Infirmary	Jul 14
Care Quality Commission – West Cumberland Hospital	Jul 14
NCUH NHS Trust – Risk register – risks graded 15 and above	Jul 14
NCUH NHS Trust – “Keogh action plan”	Jun 14
North Cumbria Strategy – “together for a better future”	Jun 14
NCUH NHS Trust – Quality Account	Jun 14
NCUH NHS Trust – Integrated Business Plan 14/15 – 18/19	Jun 14
NCUH NHS Trust – Board Risk Assurance Framework	Mar 14
North Cumbria Health Care System – Clinical Strategies and Service Assessments	Jan 14
NCUH NHS Trust – Refreshing the Clinical Strategy 2014/2015 to 2018/9 - Building a Platform for Improvement	Jun 14
NHS England – NHS Services, 7 Days a Week – Clinical standards	Dec 13
RCOG – Reconfiguration of women’s services in the UK	Dec 13
Future Hospital Commission: Caring for Medical Patients	Sep 13
Cumbria CCG – Clinical Strategies for North Cumbria	?date
NCUH NHS Trust – North Cumbria Clinical Strategy	Mar 11
National Clinical Advisory Team – update on previous review	Mar 11
National Clinical Advisory Team – North Cumbria Review	Sep 10
Cumbria Primary Care Trust – “Closer to Home”	Feb 08
Cumbria Health Review – Overarching Final Report	Jan 07
The North Cumbria Whole Systems Health Review – Towards a financially viable health strategy	Aug 06

## Appendix 3 - Methodology of the Review

A previous visit had been undertaken as part of an informal visit in May 2014. A meeting was held with the majority of the Executive Team, and site visits to both hospitals occurred. Dr PM Upton was subsequently invited to return to the Trust and spend 5 working days on this review.

A substantial amount of materials were provided before the visit which occurred between July 7<sup>th</sup> and July 11<sup>th</sup> 2014. Both hospitals were re-visited and a tour of the new WCH occurred with Les Morgan on 10<sup>th</sup> July. Meetings or phone-calls occurred with the following:-

Dr Debbie Freake, Executive Director of Strategy  
 Damian Gallagher, Director of Human Resources  
 Ann Stringer, Northumbrian Director of Human Resources  
 Helen Ray, Executive Chief Operating Officer  
 Dr Jeremy Rushmer, Executive Medical Director x2  
 Dr Peter Weaving, GP Clinical Director  
 Ramona Duguid , Acting Director of Governance/Company Secretary  
 Annie Lavery regarding patient experience  
 David Rogers, CCG Medical Director

Ruth O'Dowd, Clinical Director - anaesthetics  
Gail Naylor, Executive Director of Nursing  
Les Morgan, WCH Project Director  
Dr Denis Burke, Director Emergency Care and Medicine Business Unit  
Nick McDonaugh, Deputy Director, Emergency Care + Surgical Business Unit  
Julie Hendry, General Manager, Clinical Support and Cancer Services  
Francine Duncan, Pathology Manager  
Dr Johnny Cardwell, Director for Child Health Business Case

In addition during site visits there was a good opportunity to speak to a number of senior nursing staff on both sites

## **Appendix 4 - Dr PM Upton career summary**

Dr Paul Upton is a practicing consultant. He joined the Royal Cornwall Hospitals Trust as a consultant anaesthetist with an interest in critical care in 1995. Between 2002 and 2008 he worked part time clinically, with the remaining half of his time being spent as the Hospital Sub-Dean to the new Peninsula Medical School. He led the development of the year 5 curriculum.

In 2008 he moved to become Assistant Medical Director for Governance and a year later became acting Medical Director. He was then substantively appointed as MD and served a 4 year term. During this time the Trust moved from having 4 weak ratings with Standards for Better Health, and being described as “heading for corporate failure” to being un-conditionally registered with the CQC and progressing to a Board to Board with Monitor.

In his current role as Director of Transformation he has developed his existing interest in Health Informatics. He has led the introduction of e prescribing across all in-patient areas of the Trust. Smart phone access to the Trust's guidelines has just been launched, and a major revision of the capital programmes has prioritised Health Informatics and a replacement programme for the PAS, EPR and many other existing systems is to move to procurement imminently. He is a “finalist” for a 2014 national award from the EHI for Clinical Informatics Leadership.

Paul played a leading role in developing the Clinical Strategy for secondary care provision in Cornwall, particularly working to resolve the issues that existed at West Cornwall Hospital. He developed “an offer” that was subsequently delivered that has provided new facilities and services in the West and an “urgent care centre” that provides a selected blue light service to the local population.

In 2014 he established a health consultancy company – BusinessDoc Ltd

**Centre for Health Research & Practice Development**

**Final Report for the  
Public Consultation on the "Closer to Home" proposals  
for Cumbria Primary Care Trust**

**Dr Bob Carroll & Dr Ruth Balogh**

**April 2008**

## North Cumbria Primary Care Trust 'Closer to Home' Consultation

### Responses from the public and organisations

#### Final Report

#### Contents

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#### Acknowledgements

Thanks are due to Ruth Haigh, Gonzalo Araoz and Steve Balogh for help with the coding of the responses and to Mark Bennett and Nicola Duers of Cumbria PCT for their support.

## 1. Introduction

Cumbria Primary Care Trust has developed a strategy in consultation with key partners to provide health services closer to people's homes in North Cumbria. Proposals on the strategy have been subject to a consultation period of three months during which time the public and organisations have been asked to respond to the proposals through a questionnaire or through other form of feedback including a series of public meetings. A document containing relevant information about the proposals was made available to the public with the questionnaire in pull out form in the centre pages. It was also made available on a dedicated website. The consultation process was subject to scrutiny by the Health and Wellbeing Overview and Scrutiny Committee of Cumbria County Council.

The Centre for Health Research and Practice Development, University of Cumbria was commissioned to undertake the analysis of the responses to the consultation. The questionnaire was devised by the PCT not the University. The questionnaire data took the form of paper-based and web-based responses completed by the respondents. Some questionnaires were completed with the help of, or by, interviewers in GPs' surgeries. These often provided poor data responses and there were many questions not answered compared to the other responses. Personal details were masked in accordance with data protection requirements. The analysis took the form of highlighting and coding the main points in answers to the questions in the questionnaires and in other written responses and categorising these coded responses. Main themes cutting across the categories were then identified.

This report sets out the findings of the analysis of those responses and is divided as follows:

- Total numbers of responses for the questionnaires and other responses and distribution according to post codes and gender, and totals for the four agree/disagree questions.
- General comments on the consultation document. This includes observations on the document, questions and responses.
- Summary of responses from individuals to the specific questions on the questionnaire and from other responses with the categories of responses identified.
- Summary of responses from organisations; each organisation is shown separately.
- Major themes extracted from across all the responses and discussed in more detail.

## 2. Totals

The number of responses received

## Closer to Home Project Cumbria PCT

No. questionnaires from individuals	No. other responses from individuals	No. of responses from organisations	Total responses
676	390	85	1151

60 questionnaires were completed on line, 47 from individuals and 13 from organisations. 6 questionnaires were completed in Polish and translated. Some organisations completed a questionnaire as well as giving another written response. In total 25 organisations completed a questionnaire.

Post code areas of responses from individuals were divided into four main regions and totals of responses shown. West Cumbria includes Workington and South Copeland.

Carlisle & District	West Cumbria	Eden valley	Other	Not Known	total
116	620	185	115	30	1066

### Gender of respondents

Male	Female	Not Known	Total
296	503	267	1066

There was no separate box for male/female so there are a large number in the not known category. Clearly many who gave initials only would have been male.

Totals of responses for the four 'Do you agree' questions were divided into the following categories: agree, agree with reservations, disagree, non committal, no reply. The first line is for individual responses, the second is for organisation responses.

*Q.6. Do you agree that the Cumberland Infirmary Carlisle is the most appropriate place to handle major trauma in north Cumbria?*

	Agree	Agree with	Disagree	Non	No reply	Totals
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## Closer to Home Project Cumbria PCT

		reservations		committal		
Individuals	219	40	270	36	111	676
Organisations	4	6	1	6	25	25
Total	223	46	271	42	119	701

*Q7. Do you agree with our proposed range of intermediate care beds both across the whole of North Cumbria and at each individual hospital?*

	Agree	Agree with reservations	Disagree	Non committal	No reply	Total
Individuals	108	33	146	67	322	676
Organisations	1	3	2	3	3	25
Total	109	36	148	70	338	701

*Q.9. Do you agree with the proposed range of services to be provided in the community hospitals?*

	Agree	Agree with reservations	Disagree	Non committal	No reply	Total
Individuals	25	48	46	47	280	676
Organisations	7	7	1	5	5	25
Total	262	55	47	52	285	701

*Q.10. Do you agree with our preferred option for acute hospital services in North Cumbria? Please explain why.*

	Agree	Agree with	Disagree	Non	No reply	Total
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## Closer to Home Project Cumbria PCT

		reservations		committal		
Individuals	126	68	68	12	440	676
Organisations	10	2	2	4	4	25
Total	136	35	70	16	444	701

There are a number of possible reasons for the very high 'no reply' totals, and include:

- difficulty of answering complex questions which refer to a range of changes.
- respondents not having read the document fully and feeling unable to answer the question.
- questionnaires were completed in the GP's surgery whilst waiting for an appointment and were short of time.
- some people who gave verbal responses to an interviewer in the GP's surgeries terminated the interview before completing all the questions.
- respondents felt that they did not have enough knowledge even after reading the document to answer the question.

### 1. General comments on the consultation document

Although the majority of responses came through the questionnaire, there were also responses in the form of letters and some provided several pages of detailed comments.

Some people and organisations responded in this way because they felt the questionnaire did not provide them with a suitable format for giving their views and comments and some responded with detailed comments and also completed the questionnaire. Some of the responses indicated that the respondent worked in the NHS and had very detailed and specialist knowledge of a certain area, and others indicated that the respondent or the family had experience of being a patient for lengthy treatment in or out of hospital, for example, cases of trauma and palliative care. Some organisations cited very specific interests because of their unique situation, such as Haverigg prison with its need to have escorts for prisoners. Others cited special interests because of their relationship with the PCT, for example, Cumbria County Council and its provision for social care and Eden Valley Hospice for its provision of palliative and end of life care. There were then some very well informed and detailed responses and examples from experience. Many people stated that they appreciated the opportunity to comment.

The Closer to Home consultation document itself was not always well received. For some, and particularly organisations and those who considered the document more carefully, there was not enough detailed information or enough evidence, 'more vision than fact' as one response suggested. Some statements in the document were queried in regard to the evidence on which they were based. One medical practitioner referred to papers in the British Medical Journal as support for his arguments. Respondents often posed questions of their own. It was also stated occasionally that questions were leading, that it was badly written and not user friendly. However, it was also clear from the responses that for many people the amount of information was perhaps enough or even too much to take in to answer the questions, since there was evidence that some people clearly had not read or remembered the information given, and some questions were clearly misunderstood, particularly Q5 about a single point of access. Many people had difficulty in answering the questions in a straight forward way. This was because there were a number of things to consider, for example, Q7 part 3 'intermediate care beds across the whole of Cumbria and in individual hospitals', and Q9 asks to consider a range of services in community hospitals without specifying precisely what will be available at each hospital. This makes it difficult to answer a simple 'yes' or 'no' to the 'do you agree?' questions. Some therefore answered 'yes and no' to the same question and many did not reply to these questions. People sometimes found it difficult to list the advantages without voicing their concerns and there was often a proviso or condition. Answers to a question often included answers to another question particularly when they had particular concerns, such as the downgrading of WCH. Responses were sometimes written in the margins and had to be related to questions by the researchers. All these points made analysis difficult.

### **2. Responses to the questions**

The key categories are presented succinctly for ease in identifying the responses.

#### ***Our vision for the future***

***Q.1. We propose to provide more healthcare services in the community, closer to home.***

***What do you see as the advantages of providing care closer to home?***

1. Access and travel: ease of access and travel, saving time and money for both patients and visitors, easier access has benefit of easing patients' tension, promoting relaxation and recovery.
2. Familiarity and local staff: familiarity with either home or local surroundings and environment and local staff aiding the wellbeing of patients, 'you're not just a number', responsive to local needs, strengthens communities.
3. Facilities: the extension of facilities in the community will benefit everyone and reduce travel.
4. In acute hospitals: shorter waiting times to see doctors/consultants/treatment, less time in hospital settings, reduction of bed blocking, and fewer visits to acute sector lessening the exposure to hospital infections, commitment to a new hospital in West Cumbria.
5. Other: positive environmental impact and reduces carbon footprint, costs less, cost effective, writes off historic debt. Acknowledges geography of Cumbria.

***Do you have any concerns about providing care closer to home?***

The main concerns revolved around facilities, staff, funding and care in the home.

1. WCH: the loss of facilities and downgrading of WCH.
2. Beds: the number of beds and the reduction in the number of beds in acute and community hospitals resulting in shortage, risk of being sent home instead of being treated.
3. Facilities: the need to extend and upgrade facilities in community hospitals, inadequate waiting areas, difficult parking, administration arrangements, access so that walking is possible, services isolated from other services, doubts about whether the necessary changes could be achieved.
4. Staffing: concerns about pressure on staff, staff training, expertise, shortage of staff in both acute and community hospitals and local practices, GPs working hours and facilities.
5. Funding and resources: doubts about whether there would be sufficient funding to cover requirements, must not be seen as cost cutting exercise, costs not given for impact of accessibility of care, domiciliary care more expensive than convalescence

## Closer to Home Project Cumbria PCT

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homes, difficult to gauge the level of resource required, based on economic outcome rather than clinical outcome and quantity rather than quality.

6. Care: communication between organisations, division of responsibility between social services and the PCT, availability of sufficient numbers of carers, 24 hour care, respite and palliative care, some want to be treated in hospital and feel isolated at home, and lack of awareness of support structures, standard and quality of care, discharge from hospital care without adequate care in their homes, about preparedness for the change.
7. Equality between areas, 'post code lottery', and rural and South Copeland issues.
8. Transport and access: extra transportation will be required, availability of other mechanised transport eg lifts, contraction of transport services, easy access to information, services and support.
9. Not taken wider environmental impact into consideration on biodiversity and landscapes of new build.
10. Idealistic, need pilot scheme and own comprehensive study.

***Q.2. We propose that community services be planned locally in each of the four districts in North Cumbria (Allerdale, Carlisle, Copeland and Eden Valley).***

***What do you see as the advantages of local planning for community services?***

Many people seemed to have missed the key concept of 'local planning' as their answers indicated they saw it as local treatment and gave answers accordingly.

1. The majority of answers revolved around knowing and meeting local needs, locally accountable, local voices, a greater sense of ownership over provision, strengthens the community.
2. Easier access to facilities and more appropriate care, benefits to intermediate care, local GPs' involvement.
3. More efficient, cost effective and informed decisions on the basis of local availability of beds and facilities, locally accountable staff work better, more options closer to home, flexibility, opportunity to forge links with between GPs and local communities and parishes, primary and secondary working as partners. Participatory budgeting should be considered as a model.

***Do you have any concerns about planning local services in this way?***

Most of the answers revolved around local committees and their decision making, the provision of local services and funding issues.

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1. Local committees: how they are constituted and who sits on them, local people and professionals and their expertise for this type of work, doubts about effective decision making, local politics, administration over care, the district borders related to patient care, consultation with local people and especially those who find it hard to speak up for themselves, the need to pay attention to demographic profile of the area.
2. Services: local services competing against each other, fragmentation and lack of coordination, not taking an overall view of services, scope and quality of services and care, reductions in beds, role of local health centres, local GPs and staff knowledge and expertise (not enough), no details of what will be provided yet.
3. Areas; isolation, inequality between areas, 'postcode lottery', people on borders of localities, rural areas (Eden) sparse population may not attract funding to provide viable service, South Copeland not catered for adequately, Kirkby Stephen will need larger premises, more liaison with Parish and Town councils, transport links for accessibility. Are the selected local areas the best geography to plan services?
4. Funding: costs and efficiency issues, will there be adequate funding? Robustness of the financial agreements.

### ***Q.3. Do you have any other ideas for how we could plan and deliver local community health services?***

Many of the answers did not really consider 'plan and deliver' in their response.

Most of the answers related to community care, the range of services, involving local people and the local community, and transport. There was a suggestion of using private finance.

1. Community care: more care in people's own homes and in the community, using more community nurses and carers, work with social services. Community based nurses are under pressure and service understaffed so their numbers need increasing before reducing bed numbers.
2. Range of services: extend the range of services in community hospitals and in General Practices, increase consultants in local hospitals, have dedicated teams for chronic and long term illness, support home carers, extend local GPs work hours, improve services in rural areas and South Copeland, replace CUEDOC.
3. Local people and health workers: local health staff and users are key stakeholders and should be involved in planning and delivery, local people and health workers should be consulted and involved in the decision making, reduce layers of local bureaucracy between locality boards and PCT, involve acute services and local representatives in acute services planning, marketing campaign of changes to raise

awareness. Giving people support and skills to get involved is a critical factor. Robust complaints procedure needed.

4. Local community: links with local community organisations and voluntary sector, collaboration with faith sector for spiritual care, local businesses and services, healthcare managers to attend local council meetings, more liaison with Parish/Town Councils.
5. Transport: provide better transport, better ambulance service with paramedics, utilise paramedics more often.
6. Other: develop teaching hospital at WCH to attract staff, greater involvement in the consultation by Consultants and GPs, consider the size of older population and the support by a range of voluntary organisations.

### ***Emergency care***

***Q.4. We propose providing emergency care services based on a three tier model with services available in community settings, hospital based emergency treatment centres and one centre in North Cumbria to handle major trauma.***

***What do you see as the advantages of providing emergency care in this way?***

Most of the responses related to treatment time, travel issues, efficiency, and staff expertise.

1. Treatment time: reduce waiting, quicker treatment, more specialised treatment, appropriate level of care, saves lives, helps the take up of rehabilitation services, decrease in numbers waiting in A&E departments in acute hospitals, A&E in local setting, 24 hour consultant availability in WCH, availability of beds.
2. Travel: reduction in amount of travel, easier access to treatment, closer to home.
3. Efficient: financially beneficial, logical, efficient, less confusion, appropriate referrals and care.
4. Staff and facilities: concentration of staff expertise and appropriate facilities. Ideal for urban areas.

***Do you have any concerns about providing emergency care in this way?***

Most concerns revolved around the major hospitals, travel, the transfer of patients, staff and facilities.

1. Acute hospitals: only having one hospital for major trauma, loss of facilities at W.C.H., the number of beds and bed congestion, 24 hour service, hospital cleanliness and infections.

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2. Travel and transport: difficulties of travel especially to Carlisle from West Cumbria and South Copeland, ambulance response times, transfer times, parking charges. Air transfer preferable in some cases.
3. Transfer of patients: the correct assessment in emergencies, prevalence of specific types of injury in different areas, not enough vehicles, communication between tiers about transfer, the movement of patients, ill patients surviving the journey, ability to transfer to appropriate tier at the right time, availability of beds, delays in accessing specialist services, ambulance service already overstretched.
4. Staff and facilities: inadequate numbers of staff, adequate staff training including paramedics, availability of up to date facilities and equipment, GPs' work hours, initial assessment and diagnosis, reduction of beds in community hospitals, consultation with emergency service staff and their agreement to the proposals.
5. Other: available funding, major disaster at Sellafield, need awareness campaign to avoid confusion by users. Would community hospitals be able to deal with violence in local A&E facilities?

### ***Do you have other ideas for how we could provide emergency care?***

Other ideas related to the categories of acute hospitals, travel and transport, community care.

1. Acute hospitals: having two major hospitals including all facilities available at WCH., provision at Penrith because of its central position and easy access, 24 hour availability, increase bed numbers and include 'fudge factors' related to new build hospital.
2. Travel and transport: better transport facilities, the upgrading of skills and vehicles in the ambulance service, ambulance service in Eden Valley needs improving, link with and funding for the air ambulance, mobile service to rural areas.
3. Community care: extend community care and facilities including GP's surgeries and 24 hour medical input and care, use paramedics, use St. Johns Ambulance, First Responders services, reinforce CUEDOC services, adequate services including emergency care in specific areas such as Millom and Eden Valley.

### ***Q.5. We propose to set up a single point of access to emergency care services.***

#### ***What do you see as the advantages of a single point of access to emergency care services?***

This question was often misunderstood and not seen as referring to telephone access. Responses where this occurred are not included.



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The advantages have been categorised into caller, operator and cost.

1. Caller: easier, quicker, dispels confusion for caller, CUEDOC takes too long.
2. Operator: has overall picture of requirements and availability of treatment centres, able to direct ambulances and make appropriate referrals.
3. Costs: more cost effective.

### ***Do you have any concerns about a single point of access to emergency care services?***

The main concerns fall into the following groups; call centre problems, operators, patients, other.

1. Call centre issues: number of lines available, waiting, slow service, adequacy of 24 hour staffing, automated service, avoid difficulties of NHS Direct, coping with the volume.
2. Operator: the operators who answer the phone and their knowledge and ability to direct callers appropriately, the training of operating staff, ensuring that diagnosis is not offered over the phone, operators' knowledge of districts in Cumbria and their ability to understand local accents.
3. Patients: not suitable for patients with special needs, e.g. oxygen, special treatments, may not be sensitive or specific enough for patient needs, might fail to recognise life threatening emergencies, the availability of treatment, how can deaf people use a single point of access? Elderly and their difficulty of remembering existing emergency numbers. Need for education and raising awareness of change.
4. Other: local service would be better, speak to a GP, need web access also. How does the proposal relate to 999 and NHS Direct? Same as 999 call, duplication of CUEDOC.

### ***Q.6. We propose that major trauma in North Cumbria will be treated at Cumberland Infirmary Carlisle.***

### ***Do you agree that the Cumberland Infirmary Carlisle is the most appropriate place to handle major trauma in north Cumbria?***

### ***Q.6. Do you agree that the Cumberland Infirmary Carlisle is the most appropriate place to handle major trauma in north Cumbria?***

	Agree	Agree with reservations	Disagree	Non committal	No reply	Totals

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Individuals	219	40	270	36	111	676
Organisations	4	6	1	6	25	25
Total	223	46	271	42	119	701

There were a number of reluctant agreements, with comments such as: providing it could not be done at Whitehaven; emergency surgery should still be provided at WCH; need to upgrade services; 24 hour service required; the appearance that there is not much choice in the matter; major trauma needs to be defined; links required with South Cumbrian hospitals, such as Kendal for South Eden valley and Furness for South Copeland.

Sometimes comments were more positive such as, suitable access, staff expertise.

Many comments were made when they made disagreed or non committal responses. The main ones related to travel; the danger to life with serious injuries, the difficulties, parking problems, cost and time of travelling from West Cumbria, South Copeland, rural areas; and to bed spaces and the need for a major trauma at WCH, particularly with the Sellafield nuclear plant located in that area, the use of Furness General Hospital for some in South Copeland, the need to send patients to Newcastle for certain injuries.

### ***Do you have any other ideas for where major trauma could be treated in North Cumbria?***

Most of the replies suggested WCH, but there were a few supporting Penrith because of its central position and location near the motorway, and Cockermouth, Keswick, Kendal, Hexham and other unspecified centres. It was suggested that CIC services should be expanded to save sending to Newcastle, and a new hospital was proposed.

### ***Do you have any other views on emergency care services in North Cumbria?***

Most responses again supported the status quo at WCH. Other views included: utilisation of trained teams and paramedics which travel round the county as needed; more use of air ambulance, flying doctors, ambulance service and paramedics, CUEDOC, local GP's and services in emergencies; where is comprehensive strategy for a major emergency and how does it work alongside a nationwide disaster programme?; the training of staff in dealing with dementia and other mental health problems; consideration of all relevant published evidence and material before going ahead; travel costs to Carlisle for visitors paid for by the PCT.

Concerns were expressed about insufficient funding, beds and staff in acute hospitals, intermediate care beds, training for staff, and the ability of the ambulance service to cope.

***Q7. We propose to provide intermediate care beds in hospitals, including community hospitals, and have set out proposals for a range of bed numbers both in total and at each hospital.***

***What do you see as the advantages of providing intermediate care in hospitals across North Cumbria?***

1. Local access: easier access, less travel for patients and visitors, less stress for patients.
2. Makes sense, cheaper, more effective.
3. Acute assessment for the appropriate patients, freeing beds in acute hospitals, having special beds for elderly, containment of infection.
4. Patients: needed for patients unable to cope at home, appropriate care near home, more personal and less formal, support network for patients and family, involvement of local GPs.
5. Investment in hospitals, jobs in the local community, better use of cottage hospitals.

***Do you have any concerns about providing intermediate care in hospitals across North Cumbria?***

1. WCH, downgrading of WCH and the effects of this.
2. Travel: difficulties for those who do not live near the hospital, and for rural areas.
3. Staffing: 24 hour medical back up needed, number of adequately trained NHS and voluntary staff required and hours to be worked to deliver the service, trained rehabilitation staff, out of hours working for staff and GPs, and problems with GPs' working office hours, standard of care.
4. Beds: number of beds available, and the loss of beds, bed day savings may not be achieved safely.
5. Transfer of patients, and appropriate discharge time which should not be related to number of available beds, links between cottage hospitals and acute services must be strengthened to enable transfer, no evidence that case management of this group reduces morbidity or hospital admissions, hospital infections.
6. Funding issues, including working with and funding by social services, providing resources and facilities. Keswick is in Allerdale for social care, but Eden Valley funds the Cottage hospital.
7. Children are not mentioned in the document, what provision is being made?

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8. Ageing and growing population, will need more beds, care and facilities.
9. Providing services at Keswick, Maryport, Alston and Penrith.

***Q7. Do you agree with our proposed range of intermediate care beds both across the whole of North Cumbria and at each individual hospital?***

	Agree	Agree with reservations	Disagree	Non committal	No reply	Total
Individuals	108	33	146	67	322	676
Organisations	1	3	2	3	3	25
Total	109	36	148	70	338	701

There were a number of non committal responses with comments about the number of beds and whether they were adequate, and the standard of care.

Some of the agree responses expressed reservations about staffing levels, number of beds and costs.

Most of the respondents who disagreed were concerned about the number of beds in acute hospitals generally and the number of intermediate care beds, and the standard of care. Some stated that details regarding the changes were limited.

***Q8. Do you have any other comments on our proposed use of intermediate care beds in North Cumbria?***

Many of the comments related to the number of available beds of all types at CIC, WCH, Community hospitals suggesting that these numbers were inadequate, and a need to upgrade WCH. Using spare beds in care homes was suggested.

Other concerns were about: adequate palliative care; transfer of patients and continuous intermediate care; the need for specialist staff for people with Alzheimer's who are difficult to deal with in a general setting; insufficient care and patients being unable to cope after discharge; coping with an emergency at Sellafield; provision in South Copeland; provision within 25 miles; sufficient funding and adequate staffing.

### ***Community Hospital services***

***Q.9. We propose a menu of health services that could be provided at the community hospitals.***

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***Do you agree with the proposed range of services to be provided in the community hospitals?***

	Agree	Agree with reservations	Disagree	Non committal	No reply	Total
Individuals	255	48	46	47	280	676
Organisations	7	7	1	5	5	25
Total	262	55	47	52	285	701

There were some agree responses with reservations about staffing, funding, standard of care, transfer of patients, reducing waiting times, travel, 24/7 services and GP's hours, and lack of detail in the proposals.

Some respondents who disagreed or were non committal provided comments suggesting that services will suffer, number of beds would be inadequate, the need for or questions about specific services, and insufficient information about the services to make a conclusion.

Many people gave suggestions which were already in the Closer to Home menu, such as podiatry and dentistry, or about services which are currently available at some of the hospitals, for example, x-ray and physiotherapy. This may be because the document did not specify precisely what will be provided at each hospital, and because each hospital currently does not provide the same services. Concerns were expressed about the inequality between areas. Comments include:

1. Suggested services: x-ray, minor surgery, podiatry, audiology, breast care, speech therapy, physiotherapy, ME, diabetic care, alcoholism, palliative care, dialysis, mental health, respite care, stroke care, coronary care, orthotics, maternity, dentistry, radiotherapy, midwifery, allergies, ENT.
2. 24 hour care needed, increase in number of beds, upgrading of facilities, more consultants.
3. Community hospital friends and supporters groups, carers support groups, need for space for Adult Social care Team and Voluntary Sector to promote joint working.
4. Post office, shopping facilities, link up with existing facilities, leisure centres, schools. Co-location of other community services outside of health so they become a community resource.

### **Acute Hospitals**

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***Q.10. We have set out three options for providing acute hospital services in North Cumbria in the future, including a preferred option.***

***Do you agree with our preferred option for acute hospital services in North Cumbria?  
Please explain why.***

	Agree	Agree with reservations	Disagree	Non committal	No reply	Total
Individuals	126	68	68	12	440	676
Organisations	10	2	2	4	4	25
Total	136	35	70	16	444	701

Some respondents who agreed had reservations about staff and facilities, travel distances, links with Newcastle and Hexham. Some pointed out that they would not have agreed if they lived in West Cumbria. South Eden Valley links with Kendal and Lancaster. It was also suggested that new services in community settings should be operating fully before the option is implemented.

The respondents who disagreed commented about the downgrading of facilities at WCH, further impoverishment of the area, accidents in Sellafield, and in West Cumbria and South Copeland. There was support for options 2 and 3.

***Q.11. Do you have other ideas for how we could organise acute services in Cumbria?***

All the responses have occurred elsewhere.

1. WCH, the downgrading of facilities, losing out to CIC, 2 acute hospitals, also one acute at Kendal, strengthen links between acute and community. Some acute facilities in other areas, such as Kendal and Penrith.
2. Care, social services and partnerships.
3. More intensive care beds, development of specialist units.
4. Reduce management to save costs more funding.

***Final Section Notes and Comments.***

### **Hospitals and Health Services**

1. WCH: retain services as now, downgrading will lead to downward spiral of facilities, recruitment of high quality staff and funding; increase the number of beds; loss of expertise, facilities and specialist units to CIC; retain palliative care bed; WCH needs highly qualified

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A&E consultant, and should be a full teaching hospital. When building the new hospital the impact on local communities and local employment needs to be considered.

2. Beds: concern over reduction in beds and need to increase bed numbers at both acute hospitals, community hospitals provision is inadequate.
3. Staff: concerns about staff recruitment and training, staff morale and staff job losses, expectation of discussions with the trade unions about retraining and redeployment of staff, sufficient numbers of health visitors, nurses, midwives to cope with patients at home, suggestion to rotate staff to improve and distribute skills.
4. Specialists; specialist lead in each hospital, stroke specialists at both CIC & WCH, need specialist units and training in toxicity, ME/CFS and other specialisms, develop latest trauma unit and burns and plastic surgeons.
5. Baby unit should be upgraded to intensive care in order to save travel to Newcastle.
6. Children are not catered for in the document, and this needs to be stated. Potential increased provision for children at CIC means a place is needed where parents can stay in hospital with their children.
7. Signs; adequate signposting and information, to be put in all community hospitals, adequate car parking at hospitals.
8. Services being spread too thinly, GPs' out of hours services. Current pilot of night care service in Keswick is working well, but rehabilitation services are under resourced. Concern about Millom area and need for nursing home in Millom. More detail on support services is needed. Questions about the Cost of utilising Riever House.
9. Look at example in Scotland of 'Rural general Hospital' and 'Remote and Rural Medicine' developed by Royal College of Physicians in Edinburgh.

### **Other organisations.**

1. Reorganisation of community hospitals and care from home needs to be carried out with joined services and close working with Social Services, local councils, hospices, etc.
2. Link hospitals with University of Cumbria.
3. The proximity of HMP Haverigg which has 1000 prisoners and staff and a major disturbance there could cause many injuries.

### **Travel, transport and Ambulance service.**

1. Difficulties of travel, congestion on roads, cost and time of travel from West Cumbria and South Copeland.

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2. Hospital transport scheme should be set up to take patients to hospital, and between WCH and CIC. This could carry staff and supplies.
3. Agreement with ambulance service in Barrow for South Copeland residents, ambulance service in Alston is needed because of its location, preferred option will only work well if the ambulance service can deliver best possible service to rural communities. Concerns about funding the ambulance service.
4. Use air ambulance more.

### **General Comments.**

1. People and consultation: need to inform people, consult people, empower people including hard to reach groups, and not treat them as a commodity, needs of older people to be considered, appeal system to receive help in home. The Consultation was poorly handled, information meetings rather than consultation meetings, Councils not engaged. Venues poorly chosen not well advertised and local communities not engaged. TV and local radio should have been used more. The PCT is too large and remote.
2. Closer to Home consultation document: badly written, presentation of information inadequate, lack of detail, lack of evidence and support for statements, not user friendly, publicity poor, NSF and NICE guidelines not considered. Web site very good but not everyone has access to computers or can use them.
3. Changes: proposals do not take into account environmental changes, carbon footprint, travel changes, tourist/holiday population and ageing population. Accusations that the proposals represent change for changes sake just to meet targets and justify existence of Boards. Does not provide evidence of how the proposed changes impact upon local communities, local economy and businesses.

### **Funding and services.**

1. Changes will be expensive, will the funds be available? Problems in funding schemes (social and medical) organisations need to liaise on funding. Changes based on cost cutting rather than health reasons. Shift of cost from NHS to care sector. Impact of multi disciplinary assessments and appeals not considered.
2. Money that is spent on consultation, other initiatives, management (too much) should be spent on services. More money is required for healthcare system, hospitals and research.
3. Inequality between areas, postcode lottery.
4. Funding required for Air Ambulance and Hospice at Home services.
5. Training for First Responders in the new scheme.



### 5. Summary of responses from organisations.

#### **Cumbria Health and Well-being Scrutiny Committee**

The Committee drew attention to the importance of joint work with Cumbria County Council and the urgent need for the development of a joint business and financial plan to support the changes. They also suggest the need for an effective mechanism for ongoing community engagement and to check that alternative services are put in place to allow the changes to proceed safely and effectively. The Committee recommends that the PCT should proceed to plan and deliver changes to healthcare in North Cumbria on the basis of its consultation proposals including the revisions listed in the in a letter from the Clinical Leadership of the Acute hospitals and the PCT, provided that some issues are addressed.

More health care in the community, commissioned in localities through clinical leadership.

3 tier model of emergency care with a single point of access, a major trauma centre in Carlisle and an Emergency Treatment centre in both Acute hospitals.

Stepup/step down care beds on all hospital sites (both acute and community).

Community hospitals on all current sites with modern services to meet patient needs.

Acute hospital services provided from two hospitals, each with its range of services as described in option 1 in the document with revisions referred to above.

The issues which need to be addressed are too long to summarise here, but are contained on pages 7-10 of the Scrutiny Report. They are listed under the headings of (numbers refer to the number of issues):

Care Closer to Home (3); Emergency Care (4); Community services including Intermediate Care (2); Finance and joint planning (5); Care Streams and Client groups (3); West Cumberland Hospital (1); Other Service Considerations (2); The Consultation process (1); Implementation (8).

#### **North Cumbria Acute Hospitals NHS Trust**

The Trust welcomes the collaborative approach by the PCT throughout the development of its proposals and fully endorses the principles in Closer to Home and in particular the vision of the acute hospitals. During the consultation process a number of clinicians have expressed concerns about aspects of the proposals and intensive discussions were held. The outcomes of the debates are available in their in Appendix 2 and summarised on page 7 in their response. The Trust believes these need to be fed into the Closer to Home Proposals. The key issues and outcomes (summarised) are:

Emergency and complex surgery – continue to develop complex surgery service, provide surgical cover and orthopaedic surgery 24/7 at CIC and WCH.

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Trauma services – significant trauma taken to the nearest ETC for stabilisation and initial treatment with senior clinical assessment available, patients needing immediate surgery should be transferred to the most appropriate place, such as, Newcastle.

Comprehensive geriatric assessment – agreement on principles of service development for older people across primary and secondary care.

Palliative care – specialist palliative care beds to be in acute hospitals, appropriate palliative care beds and services could be in community hospitals.

Bed numbers – revised inpatient bed numbers of 415 at CIC and 220 at WCH, the new WCH to be built with the contingency of a 30 bed expansion.

The Trust also completed the questionnaire. It expressed concerns about the lack of detail in the proposals for community services, about the possibility that local commissioning groups could become dominated by particular interests, and about a lack of coordination across the region. The Trust sees its commissioning relationship as being with the PCT and not individual localities. It urges the need for better working relationships between health and social care, and an integrated approach to commissioning across the localities.

There were the following responses from departments in the acute hospitals.

**Family Care Stream Board** welcomes the Closer to Home proposals but state that for the Family Care Stream it may prove a significant challenge in respect of quality, accessibility and sustainability criteria, and will be a particular challenge for the provision for pregnant women and the sick child. Investment in the preventative services delivered by midwives, health visitors and school nurses must be a priority. The Board points out that the balance between accessibility and quality reflects a problem for Paediatric and Obstetrics services and the two criteria tend to compromise each other.

At present the community hospitals play little part in delivering services to pregnant women and ill children so the acute and community services must be configured in a way that allows children and young people appropriate standards of care, and in the case of children as defined by the NSF. This relates to a suitable environment, including access to education and competences of staff and extending the Children's Community Nursing/Hospital at Home service. Local Service planning Groups must understand the unique needs of children and their families and must be held to account in a transparent way. If more children are to be transferred safely between sites, then considerable investment in training ambulance and hospital staff is required. Transfer does not make for good 'continuity of care'. The '48 hour unit' limit needs to be examined. There is also need for greater co-ordination with Cumbria Partnership trust to reduce the number of children admitted to hospitals.

The Board were disappointed that maternity care received little attention in the document and that it was vague over its provision. If the Special Care Baby Unit became nurse led in

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WCH it would not save money and it would have a major impact on obstetric admission in both acute hospitals, and medical staffing and midwifery staffing would need to be examined. Full obstetric services should be considered as part of the 'premium' required to maintain services at the two acute hospitals.

The Board states that the Maternity Service Liaison Committee is a good example of public/professional partnership and suggests that this model should be used by locality teams and specialities to ensure that future plans are developed based on the needs of patients.

### **Obstetric and Gynaecology Dept.**

Comments are included in the Family Care Stream Board's response above.

### **Supervisors of Midwives**

Comments are included in the Family Care Stream Board's response above.

### **NCAH Midwives**

Comments are included in the Family Care Stream Board's response above.

**Consultant in Genitourinary Medicine** states that the document does not include fathers in the parenting process. GU medicine and contraceptive care has clear areas of identified need. These include access to appropriately trained staff for provision of post-coital contraception, access to long term and hormonal contraceptive methods, access to appropriately trained staff for GU medicine and care, rapid turn-around of results of tests, the provision of HIV specialist care which is not mentioned in the document, the need to meet DOH targets particularly the 48 hour targets.

It was also pointed out that there is a need for financial investment, more information on palliative care, forensic medical services, and infertility care.

### **A&E Consultants WCH (2 separate responses)**

These responses state that the document is weak on detail, uses crude data in some instances which must be treated with caution, indicates that the modelling for bed numbers is unexplained whilst having no modelling on the financial cost or clinical risk associated with increase journey times. There are concerns about provision in cardiology, about the management of the frail elderly with complex needs, about the needs of stroke patients, and the provision of Gastroenterology in the proposals. They suggest that there is no evidence that undertaking all major trauma at one centre would be good for patient care and it would be better to retain the status quo. Also orthopaedic emergencies and surgery, including out of hours surgery, should remain at WCH. They state that the document makes little reference to support services and raise a number of questions about 24 hour services.

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**A&E Consultant CIC states** that some of the data in the submission with regard to Emergency Care at Carlisle are incorrect, and some inferences in relation to reports and consultations are contentious and are addressed in relation to Trauma/Emergency medicine.

The response supports concentration of more complex cases at CIC and the idea of a regional network which includes Newcastle and Middlesbrough. CIC has a good reputation for training in general, and a concentration of more complex cases will improve training in this area. It is too difficult to provide the resources required, such as radiology and appropriate staffing, for complex cases on two sites and concentration on one site would lead to better and more cost effective provision of staff and resources.

The response voices the following concerns: assumptions related to the ability and willingness of Primary Care to take on extra work currently in Secondary Care; the transfer of some services currently provided in Acute A&E departments to other settings at the same quality and cost; the ECP service attached to the Ambulance service; the expertise related to minor injuries in Primary care.

### **Elderly Care Consultant WCH**

Most of the points are covered in the following response.

**Clinical Director Elderly Care WCH** welcomes the opportunity to contribute but has some anxieties about the delivery of the proposals. There should be a move away from the emphasis on the amount of money to be saved to one of identifying the best forms of care for older people and suggests the following: rapid assessment and plans for treatment for older people; planning and implementing early supported discharges in certain cases; in-reach community teams with social workers and commissioning of care packages within 24 hours; enhanced old age psychiatry in patient services; 7/7 rehabilitation services and access to imaging to help with diagnosis; training for specialist nurses to take on extended roles. These would require more Geriatricians and adequate resources.

**Consultant Dept. of Medicine for the Elderly CIC** makes the following points; comprehensive geriatric care is central to the management of frail old people and the evidence is that this is most effective in specialised geriatric units; only about 20% of elderly acute admissions are suitable for community hospital care and community hospital care is more expensive; the data presented by Teamwork are flawed and examples are provided; small community hospitals of fewer than 12 beds are uneconomic; there are already community Parkinson's Disease clinics in 9 community hospitals; there is a massive need for training in specialist skills; moving patients earlier in their stay will have implications for the ambulance service.

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**Consultant Ophthalmologist WCH** states that the high proportion of elderly patients in Cumbria has repercussions for ophthalmology services because of age related diseases and multiple pathologies. The document does not appear to recognise these facts and does not mention ophthalmology. It is suggested that the cut in bed numbers at WCH does not take into consideration the reality of ophthalmic medical care. A very detailed case is put for retaining ophthalmic services at both WCH and CIC and for relocation to one site at WCH rather than CIC. It is suggested that there is no evidence to support the idea that it is cheaper to locate to one site than have services at two as at present.

**Clinical Director Ophthalmology (Directorate feedback)** states the case for the relocation of ophthalmic units at CIC and WCH to a single site state of the art 'Centre of Excellence for Ophthalmology' based at Penrith. It is believed that this would provide easier access for a regional centre, including South Cumbria and South West Scotland. It will provide the opportunity for in house education and training for staff with appropriate links to the University of Cumbria for nationally accredited research and education facilities.

**Consultant and Sister Ophthalmology WCH** suggests that the proposals to use Optometrists and GPs with special interests to provide some of the ophthalmic services in the community have major flaws. The case is made to concentrate ophthalmic services on one site at WCH

**Orthopaedic Department** responded with a focus on option 1 of the PCT consultation document. The department believes that that the only safe way to provide the service is with an 24 hour on call orthopaedic surgeon at WCH who would take responsibility for trauma admitted for surgery there the following day and who would also be key to deciding whether the patient should be transferred. If there is anaesthetic and theatre cover at WCH overnight, it would be preferable if these patients were treated at WCH, but if that is not the case then there would be significant increase in pressure on staff and infrastructure at CIC and investment will be required. Some patients will still require transfer to a tertiary referral centre. There is a very detailed description to underpin these views which cover the current configuration of services at WCH and CIC and key questions which needed to be clarified. These included defining complex elective and non elective surgery and out of hours, identifying responsibility for transfer, the number and type of cases for transfer, co-dependencies that may affect service delivery, risks, and resource implications. Further clarification of the document is required on what is meant by 'out of hours', facilities for emergency work out of hours, how other services which are required will be configured, and the continuance of spinal surgery in Cumbria.

**WCH Medical Staff Committee** has produced a clinical case to address the strategic proposals in Closer to Home. They also completed the questionnaire. The response acknowledges the strengths of the proposals but voices concerns over several issues, namely, the lack of detail in the document and failure to mention a number of specialist services, the lack of involvement of key stakeholders (local GP's, Consultants, the public) before the preferred option was announced, equity of access , robustness of financial plans,

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the reduction of beds at WCH which provides 40% of acute care but would have only 30% of beds, the provision of general surgery; the transfer of patients in orthopaedic surgery and trauma cases, and case management of certain acute conditions (e.g. geriatric assessment, stroke) in the community. Modernisation has already been achieved in a number of conditions with the management taking place through outpatients.

**Paediatric and Elderly Care Clinical Pharmacist WCH** is very critical of the Closer to Home proposals and stating that major changes are proposed without providing evidence for these changes and suggesting that it is more about saving money than improving care. He is against the concentration of resources at CIC and the reduction in beds at WCH, and feels this may increase the death rate, and further states that WCH has demonstrated its excellence and innovation. There is no detail on community provision of the specialist services suggested in the menu.

**Palliative Care Department** pointed out that a model of joint working between NHS, Social Services and Voluntary Organisations where workers in each service attended certain meetings in the other organisations had existed in West Cumbria. The response focuses particularly on the need to consider the needs of people with dementia which does not appear to have been considered.

**26 Consultants WCH applaud** the wiping out of historic 'health debt' and the commitment to an acute hospital in West Cumbria and the philosophy of improving patient flow between primary and secondary care. However, they have grave concerns about key components of the strategy including the reductions in beds at WCH, the 'Best Practice efficiency savings' data and methodology, the management of elderly patients with complex needs in the community, movement of all major trauma to Carlisle, the number of hours each day of available emergency services at WCH, and the inadequacy of communication channels between NCAT and the PCT. Closer to Home is not a consensus view with the full involvement of clinicians from primary and secondary care and they cannot support the proposals as they stand.

**Consultant in Rehabilitation Medicine CIC** gives a negative response to the proposals. He states that the proposals regarding neurological disability and rehabilitation are unclear and that it might mean the withdrawal of a unit from an acute hospital. The response supports NRU in both acute hospitals and early supported discharge for neurological disability and a 'post acute unit' for the mobile, intellectually impaired who need a neuropsychological approach and are at currently managed out of the county or cared for by relatives. He argues that to construct a mixed physical disability and behavioural change unit on a single community site would create an expensive and ineffectual unit and be too far from home for the majority. He supports his case through 12 pages of information, 13 concerns about the clarity of the proposals, and proposals about what should be done and how to proceed.

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**Consultant neurologist CIC** makes the case for one major hospital in North Cumbria on the grounds that it is necessary to provide and recruit specialist teams of the highest standards and that Cumbria's population size will not support two major hospitals. An advantage will be that fewer patients will be sent to tertiary centres. WCH must develop as an acute, efficient and effective hospital for general common simple emergencies.

**Stroke and Rehabilitation Therapy Services Staff, CIC** suggest that at present stroke and neurological services are fragmented and inconsistently provided across the county and emphasise that services should be based on closely coordinated multi disciplinary teams which specialise in the care of people with these conditions. A list of the services which should be provided and have appeared in national policy documents is included. It points out the drawbacks of a Closer to Home approach for these services, and proposes a model of a single acute plus community neurological service in North East Cumbria.

**Consultant Dept of Emergency Medicine WCH** does not support the proposal to have one major trauma unit based in Carlisle as the longer journey times for patients from West Cumbria would have an adverse effect on patients and lead to an increase in mortality rates, and certain cases still have to be sent to a tertiary centre in the new proposals.

**Professor, author of NCEPOD Major Trauma Report** stresses the importance of initial care in cases in emergency and major trauma, and the NCEPOD report shows that current initial care is not of high enough quality to allow any increase in journey times. Planning must consider this issue, and also how initial airway management is dealt with in long transportation times. The management of major trauma needs to be considered within a regional context.

**Dermatology Department** suggests the most appropriate model for Dermatology is to have a strong base with three consultants at CIC with provision for many services in WCH. It envisages a strong academic and research base with high quality equipment and care at CIC, and would also support the expansion of local services in an integrated way. There is a detailed case made in this response for these developments.

### ***Other Health Service organisations***

#### **North Cumbria Maternity Services Liaison Committee**

NCMSLC stated that there are general concerns regarding the consultation and the document and more specific ones related to maternity services, which they suggested should be noted for future consultations. NCMSLC had not been involved in pre consultation despite seeking a dialogue and this could have clarified inconsistencies. They had expected more detailed proposals in regard to maternity services particularly midwifery services. It would have liked to have seen a statement about their services similar to the one in the Closer to Home Feasibility Study.



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The committee welcomes the PCT's commitment to maintain consultant led maternity services in WCH and provided evidence from the West Cumbria Community Maternity Survey to show the support from the public. They state that there is an inequity for patients in pain relief between Carlisle and WCH, as epidurals are not available in CIC. The committee state that the midwifery service was understaffed in 2006 and there has been no recruitment to rectify this. MSLC would like to have dialogue about the midwifery and health visitor roles.

NCMSLC would like further clarification in a number of areas, namely, diagnostic services, Special Care Baby Unit, Anaesthetics, 24 hour emergency services, perinatal mental health issues, maternity bed numbers, and models of maternity care. MSLC state that in 'Maternity Matters' (Dept. Of Health, 2007) recommends that it should have a role in service commissioning at strategic and local levels but this is not happening at present, and it has no relationship with the PCT Family Care Stream Board.

### **The Stroke Association.**

The main points made by the Association were that: the recommendations of the National Stroke Strategy should be given serious consideration; the stroke facilities at WCH and CIC need further investment to meet the Strategy; the different diagnostic tests needed for stroke may not be available in community hospitals; longer term rehabilitation requires the skills and expertise of a multidisciplinary team available in specialist units; resources, expertise and equipment must be available for those transferred to community hospitals or discharged.; an individual care plan is required for each patient; coordinated partnership between health social care and other services is required.

The Association wishes to be directly involved in the development of stroke networks and would welcome the opportunity to work with the PCT.

### **Multiple Sclerosis Society Allerdale branch**

The Society sees advantages of Closer to Home in providing temporary intervention, eg saline drip for people with long term disability or acute infections, but concerns were expressed about respite care, working with and lack of communication with Social Services, and the need to expand community services first.

Intermediate care teams working in the community have been successful, but concerns were expressed about existing medical and support services which exist, and the number of beds in each hospital.

The Society pointed out that neurological rehabilitation and rehabilitation does not figure in the PCT's plans for WCH yet the Neurological and the Young Disabled Unit is a Centre of Excellence and supports local teams.

The Society does not support commercial outlets in community hospitals.



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**The League of Friends of Mary Hewetson Hospital** were concerned about the bed numbers and how they were calculated, the elderly population and their needs in rural areas, and the large number of visitors/tourists to Keswick and their need for medical attention and the necessity for the PCT to cope with this in addition to those of the local population.

**The League of Friends of Brampton and District War Memorial Hospital** welcomes the Closer to Home proposals but has concerns about the reduction in the number of community hospital beds, the funding and staffing levels for care at home, and out of hours care in emergencies. It supports the proposed Health Campus for Brampton.

**The Joint League of Friends of the Community Hospitals of North Cumbria** completed the questionnaire. They have concerns about equity between local areas, funding, care in isolated communities, burden on cares, and adaptation of ambulance services. They feel that the experience of charities and voluntary groups such as Age Concern and Hospice At Home should be sought and joint working encouraged. The important role of BASICS teams and First Responders should be recognised and included in emergency service planning. The number of beds should not be reduced in community hospitals and a wide range of services provided including some forms of surgery. Full cooperation of GPs is needed.

**Eden Valley Hospice** noted that End of Life care was not mentioned in the document and would like the opportunity to contribute to palliative healthcare when restructuring is confirmed. Consideration should be given to more integrated working between hospice organisations and acute services. They also state that there is a lack of understanding of palliative care and expressed concerns about the service at CIC. EVH would like to develop in a specialist role in North Cumbria by increasing outwith services and integrating 'hospice at home' provision. Concerns about the provision of social care at present were stated, and that the barriers between health and social care should be removed. They agreed with the preferred option for acute hospitals.

**Hospice at Home West Cumbria** has serious concerns that the voluntary basis of their service is not fully understood by the PCT and that the implications of the proposals for the community workload with its limited local funding is not appreciated. It is felt that certain services (eg, lymphoedema) cannot be sustained without additional NHS funding. They would like more equitable funding (compared to the rest of Cumbria) for the palliative care service and will need extra NHS funding to meet the proposals on community care.

**Hospice at Home Carlisle** feels that the thrust of the proposals is in line with their philosophy and that they will continue to play a role in palliative care in community settings, but that they have financial and human resource implications for them, and therefore they would welcome involvement at an early stage in order to develop their business plans.

**Cumberland Infirmary IBD Patient Panel** praised the IBD service at CIC and is concerned that proposals should not weaken the service. There is no model for the treatment,

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management and support for these conditions based in the community. They would like to discuss these matters with the PCT as part of the consultation, which they have requested before and were disappointed not to have received a reply.

**Cumbria Partnership NHS Foundation Trust** believes the proposals are on the right lines but may not go far enough to address financial and service sustainability issues. They have a number of questions about the feasibility study and the proposals particularly about costs.

The Trust proposes developing other services in community hospitals, mental health team bases, rehabilitative allied professions, disability services. It has clinical partnerships with NHCNHS Trust, ie, dementia, challenging behaviours, drug and alcohol addictions and A&E mental health needs and feels these should have been mentioned in the document and the Trust needs to be reassured that they will continue.

**Save Our Services West Cumbria** recognises the attempt of the proposals to meet the challenges of providing healthcare in North Cumbria. SOS feels that the proposals fail to recognise the centrality of WCH in the provision of healthcare to the community. They are unhappy at the downgrading of WCH and propose that it remains a DGH, increase the number of beds, that no change should be made regarding major trauma, retain emergency surgery, retain elderly medicine beds because of the complexity of medical needs of this group, retain palliative care, adequate services in Haematology, chemical Pathology, Microbiology and Radiology.

**West Cumbria Carers** welcome the concept of Closer to Home, but are concerned that there is a lack of detail in the community based proposals and in particular the proposed health and social care teams. They state that the wording of many of the proposals, such as the use of 'could include', suggests there is a degree of uncertainty about the services. They would like clarification and further information on a number of issues, such as bed numbers, respite care, the delivery of specialist services in community hospitals, health and social care teams, the composition of locality planning teams, the single point of access, rehabilitation services, and staff training.

**North Cumbria Acute Hospital Patient and Public Involvement Forum** completed the Questionnaire but in addition had a long list of concerns and questions. These include concerns about the consultation process and the document, Community and Acute Hospital facilities, the treatment of major trauma, maternity services at WCH, Palliative Care beds.

### **Cumbria PCT Patient and Public Involvement Cumbria Forums**

Cumbria PPI Forums commend the PTC for the work in the proposals and agree in principle with the ethos of Closer to Home. They have concerns over the document and website, and stated that it was not possible to comment constructively on most of the proposals as too much has to be taken on trust. They suggest that locally elected representatives including local councillors, and people with 'no political clout' should be actively involved in planning

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local services. They feel that telemedicine, which would allow a consultant to be available remotely, should be employed, and that a helicopter service and First Responders should be funded. The Forum states that palliative care patients with complex needs require the specialist services at WCH. It has concerns about the source of adequately trained staff in every area and the inconsistency and inequity which may arise, the reductions in the funding of acute and local beds, and bed planning which used 90% occupancy. The forum feels that improved health outcomes must be the priority rather than cost effectiveness

### **Cumbria Patient and Public involvement joint consultative committee**

Although PPI forums have submitted responses independently as above, a joint response has been submitted in order to raise the profile of certain common themes in the responses. Transport issues: will there be enough adequately trained staff and properly equipped vehicles to cope with the demand for movement of patients?; the poor quality of cross county public transport system.

Community services: lack of detail around delivery of community services; problems with the Choose and Book targets not being reached in Community hospitals; the ability of Social Services to deliver a supportive service; the need to plan for rural issues; equity of services across the County; better methods of gathering the views of minority groups.

Bed numbers; concerns about loss of beds and lack of clarity about bed numbers.

Emergency planning; concerns about the emergency and ambulance services being able to cope; consideration of air ambulance in rural transport issues; more information on the 'single point of access'.

GPs commitment: concerns about GP's commitment and involvement in the new proposals.

Process of consultation: the Forums expressed their concerns about; their lack of involvement and input into the proposals, drop in meetings were not well advertised and not in very accessible venues, the document contained insufficient detail to base judgements, and terminology was of concern; website information was good but only available to those with time, ability and facility to access a computer.

**Public Forum for North West Ambulance Service** states that they were not given an opportunity to discuss the proposals prior to the consultation. The document provides little information on the ambulance services and that there is a lack of substance to the future delivery of services by the NWS Trust. Concerns were raised about the location, publicity and timing of public meetings and lack of NWS Trust representatives at those meetings.

There is concern about financial issues for the NWS, what services it has to provide and what part Locality Groups will play in commissioning their services. It was also noted that some PTS vehicles currently on operation will not be suitable for carrying some patients in step up/step down transfers and that the proposals will probably increase the out of hours patient transport needs. There are concerns about the impact on the ambulance services and require more details are required on the role of the NWS Trust.

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It is not clear how many major trauma patients will be transferred but the NWAS Trust feels that protocols should be drawn up and agreed between the Trusts as to the skill levels required by the staff who accompany these patients whilst in transit. Apart from the task of transporting patients in emergency there is no detail about how NWAS will be utilised in the proposals for emergency care.

**Cumbria Action for Health** completed the questionnaire and had particular concerns about the provision of Palliative Care, the reduction of services at WCH, the reduction in bed numbers, increased pressure on carers, community transport, rehabilitation and stroke services.

**Royal College of Nursing** completed the questionnaire and notes that the proposals will require some staff retraining and redeployment and it expects an ongoing discussion with trade unions about these issues.

**Penrith Day Hospice Team** completed the questionnaire and has particular concerns about the provision of staffing, of palliative care and services at Penrith hospital.

**Eden and Keswick Alzheimer's Society** completed the questionnaire, but was disappointed that the document did not recognise the needs for the growing numbers of people with dementia and suggested there was a need for better training of staff to deal with this condition.

**Unison Northern Region** feels that the PCT has not adequately involved the staff associations, and that the proposals for acute and emergency services will lead to a poorer service for West Cumbria. They "insist that before any proposals are implemented the staff side organisations are fully consulted and involved."

**Unions Cumbria PCT** suggests that there is 'no meat on the bone' yet, no specific detail as to how each community hospital will develop and expresses concern that acute services in West Cumbria will be reduced. They state that only certain staff have been consulted and that nurses, AHP's and support staff have not been involved. They would like reassurances that staff currently employed by the Trusts in the NHS will remain and that services will not be divested to the private sector. They wish to see meaningful dialogue between management and the staff side as a matter of urgency.

### ***Community Groups***

**Brampton Community Association** completed the questionnaire and was particularly supportive of the idea of bringing together health and community services under one roof. The closer working relationship would help the Association to reach all the community and promote services and healthy living agendas and lists some 'localisation benefit scenarios.'

**Residents of Rural North East Cumbria** supports greater localisation of health services and suggests using community centres for health information and advice, training courses

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‘Dealing with Illness for the general public’ (which has been initiated elsewhere) and for Health trainers and Health Support Workers. ‘Northumberland Fishnets’ provides an example of PCT support for community health initiatives.

**Whitehaven Methodist Fairtrade Circuit** expressed unease at the Closer to Home proposals, particularly at the loss of facilities departments and beds at WCH.

**The Parish of Whitehaven Parochial Church Council** requires more detail to comment on the advantages of the proposals, and would like to know where the funding and resources are coming from to implement the proposals. Consideration should be given to the significance of the deprivation index of West Cumbria and hence the greater impact of a reduction in services in this region. They feel there are no advantages to providing emergency care in the proposed way to West Cumbria, and there should be two equally resourced hospitals. Palliative care and paediatric services should be retained in WCH. They feel CIC will not be able to cope with the proposed arrangements.

**West Cumbria Strategic Partnership** partially completed the questionnaire. Among its main concerns were the chosen localities. They questioned whether these were the areas which people identified with and were best for planning of services, and whether the PCT had fully considered the impact of change on environmental issues and on the local economy and local businesses and urged the PCT to do so.

**Churches Together in Cumbria** completed the questionnaire.

**Age Concern Carlisle and District** completed the questionnaire.

**West Cumbria Rape Crisis Ltd** completed the questionnaire.

**Age Concern South Lakeland and Barrow** completed the questionnaire and are awaiting with interest for the South Cumbrian proposals.

**Carlisle partnership HCOP Group** completed the questionnaire. They pointed out there was insufficient information to answer some of the questions.

### **South Workington Neighbourhood Management**

The main points made by SWNM were: health services in South Workington were not adequate, eg, lack of clinical services and suiting the needs of the provider rather than the user as they often do at present; access to care at home will require a seamless multi-agency approach and insufficient information is given on how this will be provided; they do not support the loss of any facilities at WCH or the reduction of beds at Workington Community hospital; they support the mainstreaming of air ambulance service, the ‘BASICS’ and ‘First Responders’ schemes; the proposals appear to place an added burden on the Third Sector.

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**Rotary Club of Bassenthwaite** suggests that there is little evidence that sufficient provision and investment will be made including that for social services. Their main concern is over the reduction of services at WCH and its viability as a major acute hospital, and that Option 1 has not been explored enough including patient dis-benefits.

**Cumbria Children's Trust** is concerned on two main counts; that the needs of children are not adequately acknowledged, and how changes to community based specialist nursing services may affect PCT resources. They point out that there was a proposal to cut £2 million from the budget in Cumbria: A Whole A System Review: Feasibility Study. It argues that the PCT should take into account strategies in the Children and Young People's Plan for Cumbria and ensure that they do not compromise services to children, young people and their carers.

**Connexions Cumbria** supports the Cumbria Children's Trust response and adds that lifestyle issues should be linked to the document 'Risk Taking Behaviour Strategy for Young People'. They also point to the greater impact of travel and transport problems on children and young people as they are not independently mobile and may not have access to support.

**People First** (a voice for people with learning difficulties) welcomed the Closer to Home proposals with some comments from individuals. They wanted improved support and breaks for carers.

### ***Councils***

#### **Cumbria County Council**

CCC stated that they are reviewing their social care facilities and beds. They want to be a full partner in planning the appropriate provision and to break down any barriers that exist and take forward proposals on health and social care teams. Concerns expressed include where cost improvements may be achieved, eg, Cumbria Whole System Review: Feasibility Study suggested a £2million budget reduction for community based specialist nursing including health visitors. CCC feel that the document is adult focused and the opportunity exists to reshape services for children and young people and sees the opportunity around the agenda 'Every Child Matters'. CCC has already developed local joint management teams and this provides an opportunity to work with the PCT and Health services in local management teams.

CCC completed the questionnaire. The CCC welcomes the flexibility and responsiveness to local needs, and would like to see the integration of planning for services in community health and social care. Access to services should be equitable and not become a post code lottery.

Emergency Treatment Centres must be staffed and resourced adequately as well as major trauma centres. The needs of West Cumbria must be taken into account bearing in mind

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travel difficulties. The CCC wish to see the expansion and support of air ambulance services. Option 1 is the best option but reassurance is needed that the bed numbers in acute hospitals is adequate.

CCC is seeking to be a full partner in community schemes. There is a need for coordination of the different transport services and for the CCC, the PCT and the Transport Authority to work together.

**Carlisle City Council** completed the questionnaire. Their main concerns were the adequacy of capacity and resource, funding (rural proof funding), and reduction of bed numbers in community hospitals.

**Allerdale Borough Council** gave a detailed response and completed the questionnaire. ABC welcomes the concept but have reservations about the proposals. They wish to see the barriers between primary and secondary broken down and joined-up community care. They are in favour of a bottom-up approach to change. They state there is a lack of clarity, detail and evidence for the proposals in some parts. They are concerned about the dependency on the bid for £80 million of funding and 'no plan B' in the event that it is not secured.

They have concerns about the bed modelling used in both acute and community hospitals and the reduction in bed numbers. They are concerned about the down-grade of WCH, the loss of palliative care at WCH, and about the demographics not being taken into account, the catchment area and deprivation, and visitor numbers at Keswick. ABC point out that CIC does not have a neurosurgery unit and major trauma cases often have to be taken to Newcastle for neurosurgery.

**Copeland Borough Council** was generally disappointed with the consultation document and felt it contained inadequate information to enable a full response.

CBC favours the retention of the specialised stroke unit at WCH, the bed numbers in that unit, the palliative care service unit at WCH with the same bed numbers, the same level of ambulance service, the Young Disabled Unit, the consultant led maternity unit and paediatrics, the retention of major trauma and emergency treatment unit, and support services such as pathology and microbiology.

CBC feel it is necessary to gain the support of local GP's and put in place the necessary support structure before changes take place, and note the impact on social care services. There are concerns about funding and the absence of a 'fall back' position.

**Eden District Council** completed the questionnaire.

**Caldbeck Parish Council** completed the questionnaire and wanted to know whether Caldbeck Surgery and Wigton hospital would need to provide more space and clinics.



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**Ennerdale and Kinniside Parish Council** completed the questionnaire. They were critical of the consultation process and thought that it was poorly handled, the document difficult to obtain, Parish Councils and local communities not engaged and venues were poorly chosen and advertised.

**Lamplugh Parish Council** suggest that the Community Hospitals should not become the 'cinderellas' of the Trust, and query what will happen to the money being saved and how it will be used.

**Papcastle Parish Council** thought there was not information to be able to give reasoned answers. 'Too much vision and not enough fact'. Concern was expressed about the number of beds and the lack of information on social care bed provision, and about facilities at WCH.

**Patterdale Parish Council** objects to the proposed reduction in beds at Penrith hospital and would like to know the figures for occupancy levels.

**Langwathby Parish Council** is concerned about the reduction of bed numbers at Penrith hospital.

**Haile and Wilton Parish Council** is concerned about the loss of facilities and beds and the downgrading of WCH which threaten its viability. The Council has doubts over whether the Closer to Home proposals can be implemented and about the staffing and funding provision.

**Great Strickland Parish Council** is concerned about the distance to the acute hospitals and feels that more services and beds should be available at Penrith Community Hospital.

**Gosforth Parish Council** feels the presentation of data in the document is confusing and some of the terminology needs more detailed definition or examples. It pointed out that people living south of Egremont do not regard themselves as North Cumbrian. Although it accepts that option 1 is the only viable one of those offered it is extremely concerned about the needs of people in West Cumbria and South Copeland, and the downgrading of WCH. A recent journey from South of Whitehaven to Carlisle took 2hours 20minutes, and a traffic accident South of Calderbridge requires a 100 miles detour to get to Carlisle.

They have concerns over removal of Palliative Care and long term rehabilitation to CIC, and about waiting times, administration including links with WCH services and parking at CIC. Also concerns were expressed about cooperation with social services and availability of support services.

The system is dependant on skills of 'first attenders' and resources and training for paramedics and ambulance staff must reflect that.

**St Bees Parish Council** welcome the opportunity to comment on the proposals. However they do have a number of concerns and have raised 33 questions which they would like the PCT to answer, and invite a representative from the PCT to attend a Parish Council meeting



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to answer them. The lack of detail in the proposals make it hard to make judgements on them, and appear to be a cost cutting exercise based on short term objectives. The Council submitted detailed arguments and supporting statements from medical journals.

They are concerned about the reduction of bed numbers in both the acute sector and community hospitals and about the model that it is based on and feel it does not take into account possible disasters noting that it has Sellafield in the area. They have added concerns about critical care beds and believe that the maintenance of ITU/HDUs are essential at both acute hospitals, and about the transfer of patients in major trauma and emergencies. Further concerns were raised about the loss of the Pathology Unit at WCH, and the lack of consultation with the ambulance service and GPs.

**Cockermouth Town Council** is against the reduction of beds and the plans related to Youth Disability Unit and Stroke Unit at WCH but are in favour of increasing the number of beds at Cockermouth Hospital and of step up/step down beds.

**Kirkby Stephen Town Council** completed the questionnaire. The Council is concerned that the geography of Kirkby Stephen is not taken into sufficient consideration, and that people in the area need improved access to facilities and links with South Cumbrian hospitals. It would like clarification on the provision of maternity and midwifery services.

**Millom Town Council** feels that the document is lacking in robust evidence to support much of the business case recommended. Rurality and transport difficulties are a feature of the Millom area and MTC supports the idea that Millom Community Hospital be redesigned and refurbished to provide a 'Hospital Village'. MTC has concerns about service becoming a postcode lottery, the provision of out of hours medical services, providing enough ambulances with trained crews, recruiting community nursing staff in rural areas, about adequate funding for rural communities, and at WCH the future of the stroke unit bed numbers, microbiology, pathology, mental health care, and also confusion about transfer of Millom area patients to hospital (Furness, Lancaster, WCH, CIC).

MTC state that extensive changes will be required for inter agency working with social services, and that services provided by partners (air ambulance, First Responders, BASICS) should be centrally funded and not have to rely on public donations.

**Workington Town Council** is supportive of the principle of Closer to Home, but wants the maximum number of bed numbers retained. It feels that there the need to determine how much of £80 million can be obtained, and is unhappy with trauma patients going to Carlisle from West Cumbria.

### ***Other Organisations***

**Haverigg Prison** welcomes the proposals, but the need for escorts to go with prisoners for medical appointments presents staffing issues. They feel that they need a better healthcare

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facility nearer the prison and that Millom Hospital should be upgraded and offer more services and facilities.

**University of Cumbria, Faculty of Health, Medical Sciences and Social Care** is fully supportive of the aims of Closer to Home. The Faculty is developing its curricula to meet the needs of education and training for the NHS and community care through its full and part time CPD provision, and is reviewing its provision in collaboration with NHS and Social Care providers.

### 6. Major Themes

#### Access, travel and transport

The difficulties of travel in Cumbria were noted in the consultation document and were of major concern in the responses.

The main advantage of receiving treatment closer to home was seen to offer patterns of service that would reduce travel, saving time and money for patients and visitors, resulting in less strain for patients and visitors, and aiding recovery. The increase use of community hospitals was generally welcomed for these reasons.

However, the people of West Cumbria and South Copeland were particularly concerned about extra travelling to Carlisle with the downgrading of WCH and loss of major trauma and several specialist units. The document states that the journey from Whitehaven to Carlisle is 39 miles and takes 68 minutes. Respondents suggested that accidents were not uncommon on that road resulting in the road being blocked for several hours with detours of up to 100 miles being required. Some people pointed out the difficulties on that particular route and the length of travel times they have experienced and these have often been longer than the suggested time, and then encountering parking difficulties at CIC on arrival. Other people who had not always got access to a car stated that public transport by bus and train was not necessarily available at convenient times for appointments or visiting and was time consuming. One person gave the example of the unavailability of public transport for a return journey and resulting in a £70 in taxi fare. Concern was expressed about journey times for emergency treatment by ambulances and that people's lives were being put in danger and that the situation would become worse if major trauma services were only provided at CIC.

People also suggested that there was a need for the provision of better public transport, better coordination and links with County Council and transport providers, more links and funding for the ambulance service and the air ambulance service, and a NHS transport link between CIC and WCH for the public, staff and supplies.

#### Hospitals

##### WCH

There was strong opposition to the downgrading of WCH. This was not just about increase in travel for some people who would have to go to Carlisle. There was concern about a single major trauma unit for Cumbria in Carlisle, and that the loss of facilities, specialist units, beds and expertise was going to cause staff recruitment problems for consultants, doctors and nurses and lead to a further downward spiral for WCH. It was pointed out that it was often difficult to recruit and attract suitably qualified staff to this area. Some people suggested that major trauma and full emergency facilities should be retained because of the closeness

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of Sellafield nuclear plants and its potential for serious accidents and incidents, and for sea and mountain rescues. WCH status and certain units, such as Palliative Care, the Stroke Unit and Young Disabled Unit, and supporting units of Microbiology and Pathology should be retained at WCH. These units were highly praised by some respondents and it was pointed out that they would be a significant loss and that relocation at CIC would cause families a lot of stress. There was a very strong feeling about the Palliative Care Unit with one letter which containing 18 signatures against its possible closure. Likewise there were at least 372 objections to the closure of the Stroke Unit, Ullswater Ward and Younger Disabled Unit. These units were seen as Centres of Excellence and there is a fear that patients will not receive the same level of care in acute or community hospitals elsewhere. People suggested that politics and finance were driving the changes and closures at the expense of the patient.

### **CIC**

Whilst many people agreed that, if there was to be only one major trauma unit, then CIC was the best option to concentrate facilities and expertise, it was pointed out that Carlisle was situated in the far north of the county and was not easy to access for people from West Cumbria and many rural areas at the area bordering South Cumbria. The preference was for two major trauma hospitals and WCH was the only viable second location. Concerns were expressed about emergency and ambulance response and travel times to CIC and the possibility that patients might suffer as a result. There were also major concerns about treatment and the number of beds at CIC. People cited problems and illustrated them with personal examples, such as having to wait in corridors and cancellations because there were no beds available. Public transport and parking problems have been noted above under the heading 'access and travel'. It was noted by medical staff that the CIC did not have a neurosurgery unit and that some patients will still have to go to Newcastle or elsewhere.

### **Furness General Hospital and Kendal Hospital**

Some people in South Copeland could not understand why South Cumbria was not included in the consultation and why FGH was not included. Some people in the area thought FGH should have been included and that emergency treatment would be sought there as it was nearer and more accessible. People in South Eden valley noted that Kendal was nearer than Carlisle and should have acute facilities and be available to them.

### **Community Hospitals**

Whilst many agreed with the concept of increasing the facilities and usage at community hospitals for reasons relating to local access, travel, familiarity, local staff, and benefiting both patients and visitors, there were concerns expressed about staffing, facilities and funding. There would have to be a major upgrading of facilities if extra services were to be provided, and doubts were expressed as to whether the funds would be available and the

plans achieved. The document lists services which are currently provided at each hospital and a list which could be provided. However, there was a lack of detail about the exact nature of the services which could be provided, in particular the specialist units. People were uncertain about what would be available at their local hospital including the number of beds. There were many services suggested, some of which were listed but others include audiology, ME, dialysis, dietetics, disability services. There was concern over whether enough staff of the appropriate levels of skill would be available, such as the provision of consultants and doctors rather than nurses for particular cases. Concern was also expressed about GPs' involvement and whether they had been consulted, their hours of work and about the availability of 24 hour medical care. For some people the issue of inequality between areas and hospitals and a 'post code lottery' was a concern. One person suggested exploring the concept of 'Rural General Hospitals' which was now established in Scotland with specialist training available in a Scottish medical school.

### **Beds**

The number and availability of beds in both acute and community hospitals was one of the biggest concerns. People were unsure how many beds would be available and whether the step up/step down number would be part of the current number or added to it. Many people noted a decrease in the total number of beds in the two acute hospitals and community hospitals. They were against a reduction and thought that more beds would be needed in the future because of the proposed closer to home proposals and the aging population. Although the idea on intermediate care in community hospitals was favoured, and respondents thought it would free up beds in the acute hospitals, it was thought that more beds would be needed. Concern was expressed about the transfer and discharge of patients and the possibility that it could be driven by the number of available beds rather than to appropriate level of care and treatment.

### **Working with other organisations**

Many of the responses acknowledged the need for close links and joined up services between organisations, the most frequently mentioned being social services and voluntary services involved in care for elderly patients. Some individuals and organisations that undertake this work stated that the partnership needed to be improved and better than it had been so far been and others doubted whether this would happen to the extent that is needed. Some people have said they have encountered difficulties dealing with social services and there have been funding issues.

### **Funding**

Some organisations congratulated the PCT on obtaining NHS Northwest funding to remove the 'historic debt'. However some are concerned about the dependency on a £80 million bid and the lack of alternative plans if this does not materialise. There is also concern expressed

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at the proposal in the Cumbria Whole Service Review Feasibility Study to cut £2 million from the community based nursing and health visiting funds. This seems to contradict the proposals for Closer to Home and investment in local community services, work with social care and through health visitors. Whilst some people commented that the Closer to Home proposals would be more efficient and cost effective, there were equally many people who thought that a large investment in community facilities and services would be required to carry out the proposals, that changes would be more costly, such as, community and home health support and care. Many doubted that the PCT would have sufficient funds to carry out the proposals to the required standards. There were accusations of cost cutting at the expense of healthcare, merely to reach targets and cost savings, and of shifting the cost burden to Social Services in some cases. There were concerns that it would lead to inequality between areas, to a 'postcode lottery' with rural areas hit hardest. There were calls for joint funding with other organisations such as Social Care providers, for more funding for already financially stretched Voluntary Organisations involved in providing health services such as Hospice Organisations and First Responders. The ambulance service, air ambulance and transport services also needed more funding because of the nature of the geography in Cumbria. It was pointed out that some of the cost cutting measures to save money did not add up in terms of future demands as they did not take into consideration the ageing population, the tourist and holiday population and type of activities undertaken. Many people indicated that it was important to put in place adequate community services and joint working with organisations before there was any reduction in the acute services. This would be likely to put a strain on finances.

# The Cumbria Local Health Economy Strategic Plan 2014 - 2019

June 2014



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## Foreword

Welcome to this five year plan for the Cumbria Local Health Economy which sets out how health and care organisations across the county will make sure that our population have the best possible chance to live healthy lives but that if they do become ill or have an accident that they consistently receive the high quality services they deserve.

NHS Cumbria Clinical Commissioning Group (CCG) has led on the development of this plan, in line with a national requirement to do so, but has worked collaboratively with all partner NHS bodies and Cumbria County Council. We are also pleased that we have been joined in our discussions by Healthwatch Cumbria.

The development of this plan perhaps carries more significance in Cumbria than in other areas because of the difficulties we have faced in recent years and more so over the past 12 months when we have seen national intervention over quality of care issues. This has been compounded by serious recruitment difficulties and severe financial problems.

However, we have reached a turning point and have recognised that across the health economy that if we sincerely wish to make sure that the care our patients receive is what we would wish for ourselves or our families, we need a step change in our approach to collaborative working.

To drive forward the necessary improvements we have established the Cumbria Health and Care Alliance and as system leaders we are strongly committed to ensuring that we do the right thing for our patients and service users. This means making sure that they can access the right healthcare in the right place when they need it and that any plans we develop are capable of helping us to address the financial problems that we have suffered from for so long.

There are already two substantial programmes of work in the north and south of the county, branded *together for a healthier future* and *better care together* respectively which are ploughing ahead to plan for a better future for health and care services.

At the forefront of our thinking is radically increasing the scale and integration of services provided outside hospitals. This means a much greater focus on providing more care and support in local communities to help people to stay well but when they do become unwell making sure that as much of their care as possible can be provided close to where they live. It also means that services will be much more joined up without organisational barriers.

Another important element of our plan is to make sure that when people do need hospital care, for example, in an emergency, that they can be assured of the best and safest possible services, based on nationally recognised outcomes, so that they have the best chance of a good recovery.

This will mean making decisions, with our health and care professionals and with patients, the public and our key stakeholders on which services should be consolidated on which hospital sites. Most of all we want to improve the health of our local population by collectively using all of the resources available to the NHS and our key partners in local authorities and the third sector to tackle some of the enduring public health challenges we face. It is only by doing this that we can

promote wellbeing and encourage people to live healthier lives on a much bigger than we do now that we can begin to reduce some of the inequalities that exist within and across our communities.

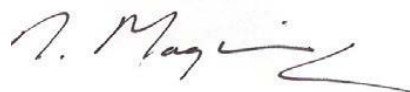
We accept that people may be cynical and say that they have seen strategic plans launched in Cumbria in the past but that not much has changed, as many of the problems are still there. The difference with this five year plan is that with the existence of the Alliance, we have the weight of the local health economy behind it. These organisations are determined that improvements will be made and we describe in the plan the mechanisms we will use, supported by a new clinical and managerial culture.

We have reached a point where we can only and must go forward – our patients deserve no less. If we do not, the responsible regulatory and commissioning organisations outside Cumbria will intervene and we will no longer be in control of our own destiny. We recognise that change is never easy and we would like give a reassurance that we will be mindful at all times of our statutory obligations in relation to patient, public and stakeholder engagement and to those relating to formal public consultation.

We hope that this plan gives confidence about the commitment and determination that exists at the highest levels and throughout our organisations to bring about the transformation in services and care that is needed.



Hugh Reeve  
Clinical Chair  
NHS Cumbria Clinical Commissioning Group



Nigel Maguire  
Chief Officer  
NHS Cumbria Clinical Commissioning Group

# Executive Summary

## 1 Status of this Document

This document sets out the collective five year plan for the Cumbria Local Health Economy. It is both the draft plan for NHS Cumbria Clinical Commissioning Group (CCG), and the collective plan for all the partner NHS organisations working together, including:

- Cumbria Partnership NHS FT
- NHS Cumbria Clinical Commissioning Group
- North Cumbria University Hospitals NHS Trust
- North West Ambulance Service NHS Trust
- University Hospitals of Morecambe Bay NHS FT.

Although obviously not an NHS organisation, Cumbria County Council is a key partner in the delivery of this plan, in terms of the Local Authorities place based leadership role and its responsibilities for Public Health and Social Care.

## 2 Our Vision and Principles

We are here to make a real difference to people's lives. Firstly this is about making a difference by improving the health and wellbeing of individuals and their families. In particular it is about taking serious action to reduce the inequalities in health that exist between different communities across Cumbria. We want to add years to peoples' lives, and quality life to those years.

Making a difference to people's lives also includes improving the day to day experience of patients and those working to deliver better healthcare. Working for the health service in Cumbria should be a privilege and a source of pride. We want this to be true for all our colleagues, as we recognise that quite simply people who are happy in their jobs provide better care.

Our key underpinning principles are:

- Doing the right thing for our patients, service users and populations
- Putting ourselves in your shoes – is this the care we would want for ourselves or our families?
- Access to the right healthcare, in the right place, right when you need it
- The Cumbrian health pound is finite and can only be spent once.

### 3 Our Objectives

To achieve our vision, we have set ourselves some important objectives. Collectively, as a system we are fully committed to:

**Radically increase the scale and integration of out of hospital services, based around Primary Care Communities:**

Primary Care Communities are developing around groups of practice lists in natural communities, and will serve populations of between 15, 000 and 40, 000 depending on local circumstance. At an overarching level, the key transformation for Primary Care Communities will be to move away from episodic, unconnected care, to a seamless system based on joint work around the patient and their family.

**Achieving sustainable, high quality provision, by delivering a programme of Hospital Services Consolidation:**

However successful our population health programmes and Primary Care Communities become, there are times when most of us will need to go to hospital. This should be reserved for those times when we need specialist help, requiring the staff skills, technology, and support services which can only be delivered in hospitals.

At the moment, there are real challenges in ensuring that our hospitals can continue to deliver the expected levels of care, and some major changes may be needed. The international evidence shows that small hospitals can deliver excellent quality of care, particularly if they work as part of broader clinical networks with larger, more specialist hospitals.

Overall, we will need smaller, cheaper, but still better hospitals in the future.

One important feature will be to fully address transport, across emergency ambulance provision, patient transport for planned interventions, and transfers between hospitals using new solutions, particularly to enable Cumbrian patients to access the optimal intervention delivered in tertiary centres outside our county.

**Deliver a modern model of integrated services, ensuring an optimal use of resources for patient pathways across community and hospital services and for cross-cutting priorities across the system:**

There is much more to a modern model of integration than Primary Care Communities. There will need to be a real connection between Primary Care Communities and clinical resources which have traditionally worked only within hospitals. We will need to develop networks so that clinicians with specialist skills, traditionally based in hospitals, can provide support to clinicians working outside of the hospital. The document, 'Future hospital – Caring for medical patients' published by the Royal College of Physicians in September 2013 proposed the creation of medical divisions. This is one element of the specialist support for our Primary Care Communities. A large part of a medical division would be based in the community and would be made up of clinicians, nurses and therapists for all organisations – 'teams without walls'. The 'walls' are both physical

(the 4 walls of the hospital) and organisational. This will bring specialist skills into the community to contribute to the management of increasing acuity and dependency outside of a hospital setting. The basic model is shown below.

## THE CUMBRIA HEALTH AND CARE SYSTEM

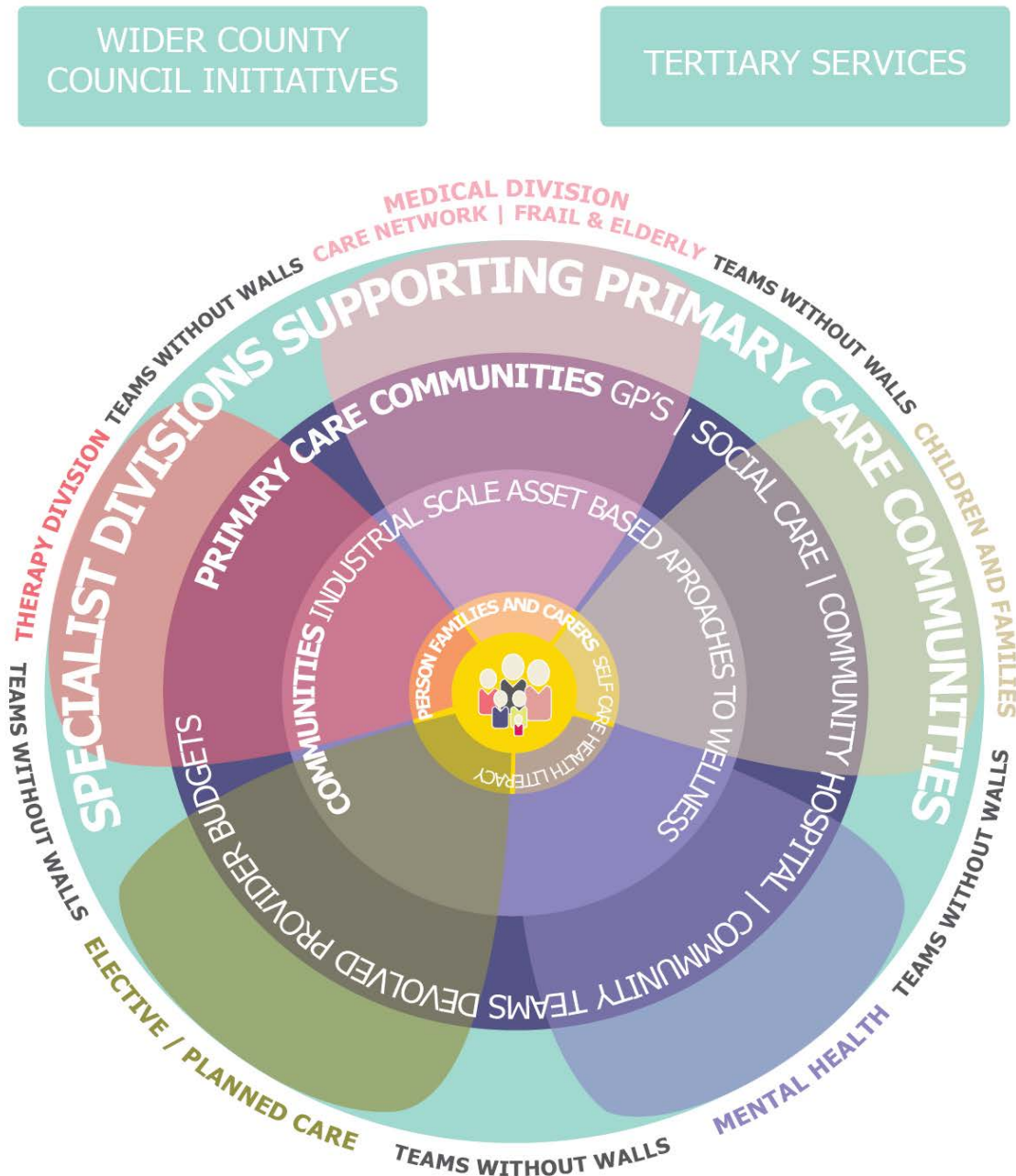


Figure 1 : The Cumbria Health and Care System

Improve population health outcomes, based on a major impact on reducing social isolation, smoking and alcohol misuse, and increasing activity and healthy eating:

We will work together with partners across Cumbria to deliver the Cumbria Wellbeing Strategy, and to refocus our system to promoting population outcomes as a health system, rather than just a healthcare system. This will include removing the constraints which prevent the third sector from taking a greater role, and seeking to achieve a new partnership between statutory and non-statutory services, built on the unique contributions both sectors can make.

## **4 The Challenge for Cumbria**

Delivering our aims and objectives will be difficult. We will need to achieve radical change on a scale previously unseen. In part, this is because of the major challenges the NHS, and the interconnected social care services, are already facing in Cumbria.

Collectively, we need to acknowledge the scale of the problem:

### **The system causes more harm than is acceptable**

A wide range of core standards, including NHS Constitution Commitments, are not reliably delivered in Cumbria. This inevitably compromises patient outcomes.

There has been significant regulatory intervention from the Care Quality Commission (CQC) regarding the quality of a wide range of services. At the time of writing both North Cumbria University Hospitals NHS Trust and University Hospitals of Morecambe Bay NHS FT are in special measures, the highest level of escalation in the NHS.

### **Our system currently spends more money than it is allocated**

Collectively, we need to get the best possible value from our resources, and deliver a credible programme of cost reduction that removes our current over spend (in the order of £40M in 2013/14) and meets the efficiency challenges of the future (in the order of £30M in the next five years), in a period of austerity for the NHS.

### **There has been a loss of public confidence**

Inevitably, the continuous media reporting of the challenges in Cumbria has led to significant public anxiety. Additionally, communities are worried that valued local services will be lost, and that the NHS system will make bad choices just to balance the books.

### **We can't always attract the right staff**

Across Cumbria it continues to be very difficult to attract the right clinical staff, particularly in some specialist areas.

### **Our previous plans weren't successful enough**

Many of these problems have been present in Cumbria, to different degrees, for a long time. Despite some notable successes, we need to accept that we have not collectively planned

successfully to deliver a sustainable system, which delivers the right quality and right outcomes within the available resources.

## 5 What will be Different This Time

Collectively, the senior clinical and managerial figures in the Cumbria system have recognised that there has been a collective failure to fully confront and resolve these challenges in the past. These leaders have committed to working together, in the best interests of the patients, the population, and the system, rather than the interests of individual organisations. This gives us the best possible chance of jointly solving the challenges we face, in the spirit of shared accountability.

This will not be enough. We will need to engender a new clinical and managerial culture. This will need to be based on a credible continuous improvement culture, supported by evidence based tools to support front line practitioners and clinicians to drive service improvement, all of the time, everywhere, forever. For the future, 'just about good enough' will no longer be anywhere near good enough.

This will require a major investment in how we value all of our colleagues, striving to deliver the best care in our system.

We also need to be realistic. If we are not able to meet our challenges locally, the responsible regulatory and commissioning organisations outside Cumbria will intervene, and will impose solutions outside our control. We need to show demonstrable improvement quickly to keep control of our destiny.

## 6 Our Commitment

Collectively, the organisations across Cumbria have made some important joint commitments, so that we can meet the challenges we face:

- We will be much more accountable, and ensure that we consistently and reliably **deliver the standards of care** that are already enjoyed across most of the country, and should be ours of right
- We will **stop spending other people's money**, and will return our local NHS system to sustainable financial balance
- We will embed **continuous service improvement** methods across our system, empowering front line clinicians and practitioners to drive their own improvement in the interests of patients and communities
- We will **work together much more flexibly**, including where necessary changing which organisation delivers services, where it is delivered, and how it is paid for
- We will always put the **interests of patients and the overall system first**, ahead of our own organisations interests and professional interests.



## 7 Getting Back on Track: Long Term Transformation

In the short term we need to take action to stabilise our services, to get back on track, in order to achieve:

- A reduction in the harm caused to people
- Momentum through credible steps towards financial balance
- Developing an open narrative for the public, which reduces anxiety, instils confidence, and encourages participation.

This will involve taking difficult decisions, and will require resilience, creativity, flexibility and a good deal of collaborative working.

In the medium term we will transform the local health and care system. This will be based on delivering our objectives, i.e:

- Developing Primary Care Communities
- Achieving hospital services consolidation
- Delivering an excellent modern Model of Integration
- Improving Mental Health and Learning Disabilities Services
- Building a high quality Children's Health and Care System
- Becoming population health focused.

## 8 What This Will Mean for Our Population

The population health challenge is enormous. We will work with partners to deliver the key priorities set out in the Joint Strategic Needs Assessment (JSNA):

- Improving care to respond to the challenges of an **ageing population**
- Improving the health of **children and young people** and the quality and integration of care services
- Improving **mental wellbeing** and reducing **alcohol misuse**
- Reducing health **inequalities and premature mortality** from cancer and cardiovascular disease.

This will include up scaling population health approaches, to seriously address some of the key determinants of health and causal factors in people avoidably using healthcare services, including social isolation, smoking, alcohol misuse, excess weight and inactivity.

## 9 What This Will Mean for People Who Use Our Services

To deliver our vision we will need to develop a new level of partnership between the local population and the local health and care system. This will include:

- Providing much better information to help people to make good, informed decisions about when and how to access services



- Radically re-orientate our system to provide specialist support for self-management. People want to retain control of their own health and healthcare, we need to reorganise the system to help them to do it.

## **10 What This Will Mean for Our Staff**

Our staff are our greatest strength. Individually and collectively they strive to provide the best quality of care they can for their patients. To support the workforce, we will:

- Enable continuous service improvement, all of the time, everywhere, forever, through the development of the Cumbria Learning and Improvement Collaborative (CLIC)
- Ensure that we have safe, but productive, staffing levels
- Ensure that care is provided in the right place, by the right clinician, based on good team working and multi-disciplinary approaches
- Provide rewarding careers
- We won't simply ask hard working staff to just do more, rather we will work together to maximise the time staff spend on work which really adds value to patients, and reduce the activities that don't.

## **11 What This Will Mean for Organisations**

Organisations in Cumbria will need to change. This will mean much less organisational sovereignty, and a focus on working together for the common good.

To be sustainable, the current configuration of NHS trusts, social care, and commissioning organisations may need to change. Any changes will be designed around promoting integration in the best interests of patients.

## **12 What This Will Mean for Everyone**

Overall, we want to achieve a much high quality system, which delivers really good and much fairer outcomes, within the financial resources we have available. This is summed up by the seven 'No's' developed by the North East Transformation System, as listed below:

- No barriers to health and wellbeing
- No avoidable death, injury or illness
- No avoidable suffering of pain
- No helplessness
- No unnecessary waiting or delays
- No waste
- No inequality.

## **Section 1      Introduction and Context**

### **1      The Purpose of this Plan**

In December 2013 each of NHS England, Monitor, the NHS Trust Development Authority, and the Local Government Association set out joint operational and strategic planning guidance.

This required all NHS trusts, NHS Foundation Trusts and NHS Clinical Commissioning Groups (CCGs) to develop the following:

- A two year operational plan for submission on April 4<sup>th</sup> 2014
- A draft five year strategic plan for submission on April 4<sup>th</sup> 2014
- A final five year strategic plan for submission on June 20<sup>th</sup> 2014.

The guidance required NHS Trusts and CCGs to jointly produce the plans, working as part of a Local Health Economy (LHE).

This document is therefore both the draft plan for:

- NHS Cumbria Clinical Commissioning Group (CCG) as the lead commissioner of healthcare for Cumbria
- The plan for the whole healthcare system.

The plan should be considered alongside the complementary:

- Two year operational plan for NHS Cumbria CCG
- Two year operational and five year strategic plans produced by the local NHS Trusts.

The plan is intended to provide a clear:

- Direction of travel for healthcare in Cumbria
- Clear statement of our collective ambition to
- Set of intentions to enable services to become clinically and financially sustainable
- Outline of engagement, including public and clinical engagement
- Description of how the local organisations work together in governance terms
- Indication of the main interventions we will take forward to deliver our ambitions
- An initial indication of options for some services.

This is not intended as a consultation document, rather it provides a strategic direction of travel. We fully recognise our statutory obligations in relation to public consultation and we are committed to working with the overview and scrutiny committee to ensure these are carried out in line with requirements.

## 2 Introducing the Supporting Documents

We have worked to deliver two major planning programmes to provide much more detail on the planned service models. The products from those programmes should be read alongside this overarching plan, and provide much more detail. The programmes are:

**Better Care Together:** Over the past year NHS Cumbria CCG has worked with Lancashire North CCG, NHS England, and University Hospitals of Morecambe Bay NHS FT to develop a strategic plan for the south Cumbria and north Lancashire area. Latterly this process has broadened out to include participation from all NHS Trusts and providers of Social Care in the area.

This work has resulted in the strategic plan provided at the end of this document.

**Together for a Healthier Future:** More recently, we formed the north Cumbria programme in mid-February, to similarly develop a long term strategic plan for the system. The governance arrangements have been comparable to Better Care Together, but in some ways simplified as there is only one CCG, one NHS England Area Team, one Acute Trust, one Community Services and Mental Health Trust and one upper tier Local Authority involved.

This work is less developed in north Cumbria, and has so far been based on developing a shared narrative for the challenges we face and the service models and service improvement we will need to overcome those challenges.

A second phase of development during July – September 2014 will be undertaken to include a much fuller appraisal of the scenarios and proposals, including activity, workforce and financial modelling.

**Engagement as part of the process:** Both programmes have included extensive clinical, patient, public and stakeholder engagement, as described in both documents.

## 3 The Partner Organisations

### 3.1 The Partner Organisations

In Cumbria, the Local Health Economy (LHE) is comprised (for planning purposes) of:

- Cumbria Partnership NHS FT
- NHS Cumbria Clinical Commissioning Group
- North Cumbria University Hospitals NHS Trust
- University Hospitals of Morecambe Bay NHS FT

As there are major interdependencies between healthcare and social care, Cumbria County Council is a major partner within the LHE, although it is not technically part of the LHE in relation to the national guidance.

### **3.2 Our Partnership: The Cumbria Health and Care Alliance**

Collectively the partners of the Local Health Economy firmly believe that to address our current and future challenges, the whole system will need to work much more collaboratively. This will include a new partnership with the public, patients, and partner organisations.

In 2013 NHS Cumbria CCG brought together the leaders of the Cumbria health and social care organisations, under the banner of the Cumbria Health and Care Alliance, to work collectively with shared commitments.

The Alliance is a commitment to work together, and not a new organisation or any formally constituted arrangements, though we will continue to develop joint governance arrangements including participation and oversight from Trust Non-Executives and Chairs and from Cumbria County Council elected members.

The Alliance development has been led by the CCG Clinical Chair and Chief Officer, with extensive support from the Director of Clinical Innovation, with the full participation of the Chief Executive and Medical Director from each of the NHS Trusts, and the Chief Executive and lead Directors from Cumbria County Council.

### **3.3 The Partnership for Population Health: Cumbria Health and Wellbeing Board**

The Board will play an increasingly important role, not only in providing challenge and assurance of our plan, but in providing leadership and coordinating joint work.

It will be especially important for us to work closely with the Board in relation to:

- Moving to a population health based system
- Enabling the integration of health, social care and the third sector in the best interests of our population and service users.

### **3.4 Formal Democratic Scrutiny: Health Scrutiny Committee**

NHS Cumbria CCG has worked closely with the committee leading up to the submission of the five year plan, and will continue to work with the committee during the subsequent implementation.

It is possible that a number of public consultations maybe needed. NHS Cumbria CCG is committed to ensuring that no major, permanent changes in services occur without the full participation of the public. The CCG will seek to work with the committee to ensure that the NHS and social care partners fulfil this commitment, and will continue to seek guidance from the committee.

## **4 How We Produced This Plan**

In the autumn of 2013 the leaders of the Cumbria health and social care system came together to have a full, frank reflection on the challenges we collectively face. Those leaders, which included the Chief Executive and Medical Director of the local NHS Trusts, the Clinical Chair and Chief

Officer of NHS Cumbria CCG, and the Chief Executive of Cumbria County Council, agreed the joint following work:

- A **single version of the truth**, describing consistently the quality, financial and workforce challenges we collectively need to overcome
- A clear set of **stabilisation** actions, to fix the here and now
- A clear set of **transformation** actions, to meet our high aspirations for the future.

Those leaders agreed to set up the Cumbria Health and Care Alliance, as an important forum for us all to work together. Through the Alliance, we have jointly taken forward our planning work, leading to the production of; first our individual organisations two year operational plans, and now our draft five year strategic plans. This has been supported by:

- The Better Care Together process in south Cumbria and north Lancashire
- Analogous work in north Cumbria, first through the North Cumbria Clinical and Strategic Leaders Group, and latterly through the Together for a Healthier Future Programme Board
- Cross Cumbria specific work streams, for example Children's Services
- Specific service reviews, for example the review of community hospitals and minor injury units, adult mental health services and the planned review of maternity services
- Taking forward key enabling programmes, for example establishing the Cumbria Learning and Improvement Collaborative and joined up clinical informatics
- Specific planning work, for example the development of the Better Care Fund Plan.

Both the appended Together for a Healthier Future and Better Care Together Strategic Plans describe fully how the plans were developed, including clinical, public, patient and stakeholder engagement.

## 5 The Structure of the Local Health Economy

In total, Cumbria is served by 81 GP Practices (and one practice in Bentham which is a member of NHS Cumbria CCG) providing general practice to list sizes from 700 to nearly 25,000. Out of hours primary care is provided by Cumbria Health on Call. Cumbria is primarily served by the following NHS Trusts:

- **Cumbria Partnership NHS FT:** Provides community services (e.g. District Nursing), some specialist physical health services (e.g. Neurology and Diabetes) and community and in-patient mental health and learning disability services. The Trust works across Cumbria, and provides a limited number of specific services to the north Lancashire area.
- **North Cumbria University Hospitals NHS Trust:** Provides a range of secondary care services, and some tertiary services, from Cumberland Infirmary Carlisle and West Cumberland General Hospital in Whitehaven. The Trust primarily serves the Allerdale, Copeland, Carlisle and Eden localities of Cumbria, as well as providing a small volume of patient activity to Scottish residents.
- **University Hospitals of Morecambe Bay NHS FT:** Provides a range of secondary care services, and some tertiary services, from Furness General Hospital in Barrow, and Royal Lancaster Infirmary, and a more limited range of services from Westmorland General

Hospital in Kendal. The Trust primarily serves the Furness and South Lakes localities of Cumbria, as well as the population of NHS Lancashire North CCG.

- **North West Ambulance Service:** Provides patient transport and emergency ambulances to the population of Cumbria, as well as the wider geographical area of Lancashire, Cheshire, Merseyside and Greater Manchester.

Additionally, patients from Cumbria access a wide range of NHS services outside the county, particularly for elective and complex procedures, including some interventions which are not otherwise available in Cumbria. The chart below shows the broad deployment of NHS Cumbria CCG resources financial terms.

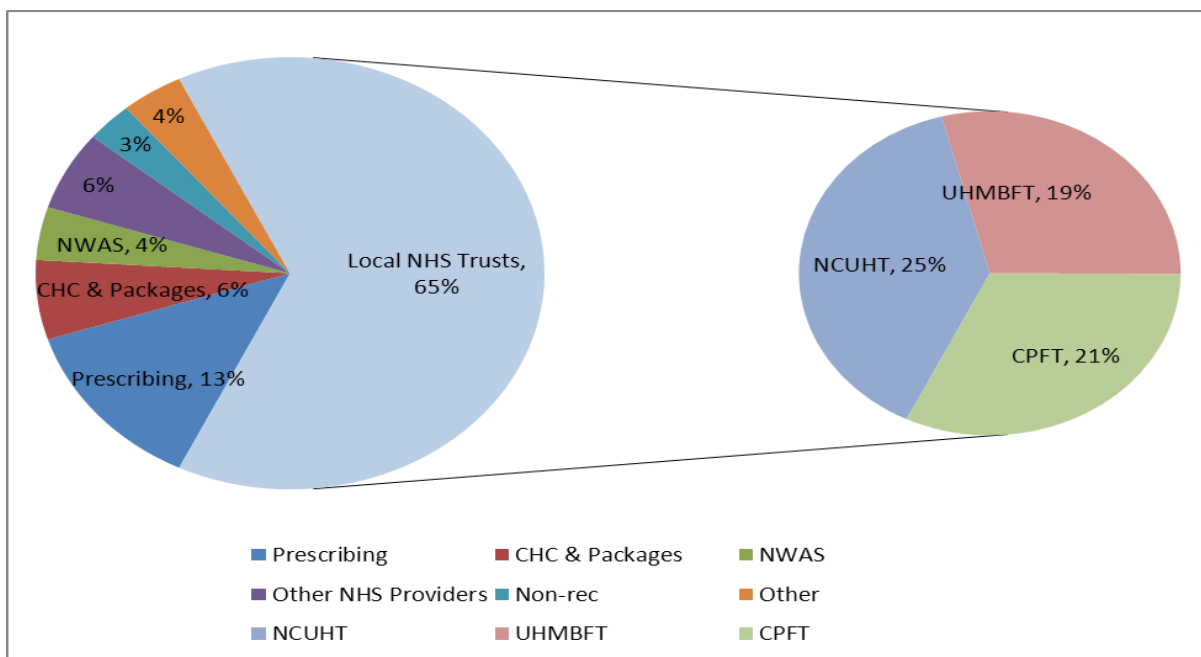


Figure 2 : Deployment of NHS Cumbria CCG resources financial terms

## 6 Geography

Cumbria is England's second largest county, covering over 2,600 square miles. With a population of only half a million people, Cumbria is also England's second least densely populated county. The challenge of providing quality services to isolated clusters of population is unique in the north of England.

Cumbria is geographically isolated, rather than rural. The majority of the population live in towns and large villages. These centres of population are far away from each other, and even further from the nearest cities. The west coast is especially isolated. Barrow, with a population in excess of 70,000 is some 47 miles from the nearest large town of Lancaster, and 100 miles from the regional capitals of Manchester and Leeds (entirely by A roads in the latter case). Whitehaven and Workington, with respective populations of 25,000 each, are some 39 miles and 30 miles from Cumbria's largest urban centre of Carlisle with a population of 75,000, which itself is another 60 miles away from the regional capital of Newcastle.

In part because of our geographical context, and also reflecting our natural communities and District Council boundaries, Cumbria works on a locality model for large parts of healthcare commissioning and delivery.

The localities are a key building block to enable locally responsive services, which recognise the diversity of Cumbria and that one solution does not fit all our communities. Importantly for NHS Cumbria CCG, the localities form the main mechanism for engaging with its member GP practices, for primary care development, and for commissioning community services. The commissioning localities are largely co-terminus with the provider locality for both Cumbria Partnership NHS FT and for Cumbria County Council.



**Figure 3 : Map of NHS Cumbria CCG Commissioning Localities**

## Section 2 The Case for Change

### 1 Our Demographic and Geographic Context

The age distribution of the population of Cumbria is expected to change significantly over the next five years. While the overall population of north Cumbria is forecast to grow by at 0.9%, the number of people aged over 85 is expected to grow by 19%. This is a bigger shift than the national forecast, the total population growth across all ages is 4.3%, and in the over-85 population 18.1%, as shown in figure 4 below.

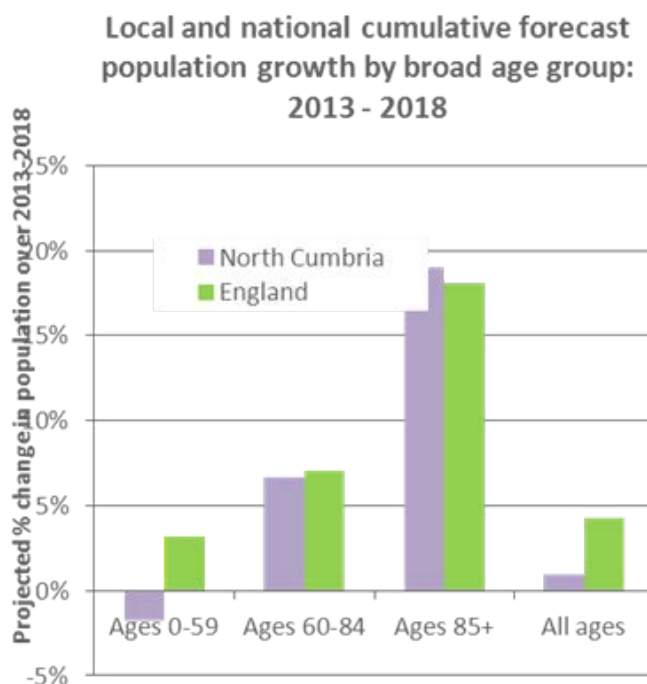


Figure 4: Local and national cumulative forecast population growth

Overall, older people have both more frequent and more complex care needs. As such, an ageing population has a disproportionate effect on the overall demand for health and social care services. For example:

- Currently 28% of people in north Cumbria are aged 60 and over, but 42% of all secondary care activity is provided to this age group
- Another example is dementia, which affects 1.3% of the national population at age 65, but 12.2% of people by age 82.

This means that demand for care services will increase more rapidly than general population growth, as a result of the ageing population.

Cumbria accounts for half the land mass of the whole north west region, spread across 2,600 square miles. The distance between the two main towns of Carlisle and Barrow is the same as from Manchester to Birmingham. Overall we have very low population density. Eden valley has the lowest population density of any Local Authority in England, just 24 people per square km,



compared to Islington with 13,875 people per square km. Our west coast hosts geographically isolated and economically deprived small towns and villages. This presents major challenges for service delivery. We have major differences in health outcomes across the county - people in Barrow spend twice as long in their life suffering ill health than people in South Lakes or the Eden Valley. One of the drivers in variations in outcomes is excess weight, from the Public Health England report in 2014 we have the most obese Local Authority area in England (Copeland) and high levels of type 2 diabetes in both adults.

## 2 Key findings from Engagement Activity

As part of the Better Care Together and Together for a Healthier Future programmes we have undertaken extensive public engagement. For a full description of the engagement, please refer to those documents. The key messages from both programmes were very consistent, and are shown below.

### Better Care Together Summary

- **Travel** – patients should only travel where necessary. Services should be local, although people were willing to travel for the best care available.
- **Access** – often seen as problematic and should be improved. GP access and out of hours care at evenings and weekends seen as insufficient and should be improved.
- **Integration** – services are not sufficiently joined up, whether within health for example acute and mental health services or between health and social care. Care pathways are not joined up and boundaries between different services are hard to understand and navigate. Good discharge management is a particular area that should be improved.
- **Out of Hospital care** – seen as providing effective alternatives to current care, with many people being very satisfied with community alternatives to acute care.
- **Prevention** – personal responsibility for maintaining health seen as important. Young people in particular said they understood and took on such responsibility.
- **Acceptability of change** – many people understood and accepted the need for change. however it was important that change delivers real benefits that are quickly apparent.
- **Risk** – concerns raised around a number of risks, particularly, increases in risk arising from changes to services, travelling longer distances when people are unwell, whether enough staff will be available particularly at weekends and risks from budget reductions.
- **Customer care and communication** – mixed experience with a number of people concerned about lack of caring approach from some clinical staff and the need for more effective communication by administrative staff.

### Together for a Healthier Future Summary

- **Travel:** Travel was a big issue with many comments about the distance people often have to travel for services and how the timings of appointments means they have difficulty in getting there by public transport. There was recognition that it is sometimes necessary if patients need specialist care and in the focus groups in particular there were indications that quality was more important than distance.
- **Access to services:** There were many comments about perceived difficulties in access to GP services and long waits for hospital treatment, as well as operations being cancelled and a

feeling that the administrative arrangements were not always as efficient as they should be.

- **Integration:** There were many comments about the need for more joining up across services, particularly for older people and those with complex health needs. This included strong messages about the need to work more closely with the third sector.
- **Prevention:** The importance of prevention was stressed at the road shows and at the third sector events.
- **Better communication:** Communication across services and with patients needs to be better, with experiences of breakdowns in communication, particularly between GPs and hospitals.
- **Loss of local services from Whitehaven:** There were also comments about services being taken out of Whitehaven and being moved to Carlisle.
- **Patient experience:** While there were many positive comments about local NHS staff, some felt that it was no longer a vocation but just a job and that the personal touch was increasingly missing.

### 3 Outcomes and Inequalities

#### 3.1 Outcomes

As clinical leaders, improving outcomes for our communities is what drives us. We must lead our local health economies to use the challenges we face, financial and otherwise, as a platform to make real and transformational change which will make significant improvement to the quality of care provided to our patients and the outcomes we achieve. All CCGs, together with their NHS England Area Teams are being asked to jointly set levels of ambition against seven overarching outcomes. The seven outcomes are deliberately broad so as to drive improvement for all our local population. These are rooted in the NHS Outcomes Framework.

For measures where NHS Cumbria CCG currently performs below national benchmarks, the CCG has set more challenging levels of ambition, recognising both the increased need and potential for change. All these levels of ambition are underpinned by the initiatives set out in this strategic plan and, while challenging, are realistic ambitions for improving outcomes for our population, as shown in the chart below.

The chart shows:

- The ambition area
- The metric, being the measure we will use to judge if we are successful in meeting the ambition area
- The baseline from 2012/13
- The trajectory for 2018/19
- The comparative position for our 2012/13 baseline position shown as a red, amber, green based on quintiles as explained in the legend.

Figure 5 : NHS Outcomes Framework – Seven Ambitions

Ambition area		Metric	2012 / 13	2018 / 19	Change	RAG
1	Securing additional years of life for the people of England with treatable health conditions.	Potential years of life lost from conditions considered amenable to healthcare	2151	1816	15.6%	
2	Improving the health related quality of life of people with one or more long-term condition	Health related quality of life for people with long-term conditions (measured using the EQ5D tool in the GP Patient Survey).	71.1	76.7	7.9%	
3	Reducing the amount of time people spend avoidably in hospital	Composite Measure on emergency Admissions	2204	2009	8.7%	
4	Increasing older people living independently at home following discharge from hospital.	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	84.3	88.0*	4.4%	
5	Increasing the positive experience of hospital care.	Patient Experience of Inpatient Care (proportion of poor responses)	118.5**	137.0	-15.6%	
6	Increasing the positive experience of care outside hospital, in general practice and in the community.	The proportion of people reporting poor experience of General Practice and Out-of-Hours Services	4.30	4.28	0.5%	
7	Progress towards eliminating avoidable deaths in our hospitals caused by problems in care.	Hospital Deaths Indicator in Development	N/A	N/A	N/A	

**Legend: National Quartiles**

Bottom	
2nd Bottom	
Middle	
2nd Top	
Top	

## 3.2 Population Health and Inequalities

The health of people in Cumbria is varied compared with the England average. Overall, deprivation is lower than average, however there are some high levels of deprivation, with areas of the county falling in the most deprived 10% nationally. Deprivation is particularly severe in the urban areas of Barrow and west Cumbria. 15.4% of children in the county live in poverty below the national average of 21.3%, however in one ward in Copeland the percentage of children living in poverty rises to 49.2%. Although deprivation is most prevalent in Cumbria's urban areas there are also hidden pockets of deprivation in some of the county's most rural communities.

Cumbria's overall performance in a range of health and wellbeing indicators disguises significant inequalities in health outcomes. 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 areas 8.4 years below the national average. Health outcomes in north Cumbria are poorest in Copeland and Carlisle whereas Eden and South Lakes have high levels of health and wellbeing. With the exception of Eden, all districts have problems around alcohol misuse. Poor mental health is also an issue for the county with incidences of neuroses, self-harm and suicide higher than those nationally.

The chart below shows the correlation between deprivation and mortality, and demonstrates the need for us to work much more strongly across the health and care system but also with all our partners to address serious inequalities.

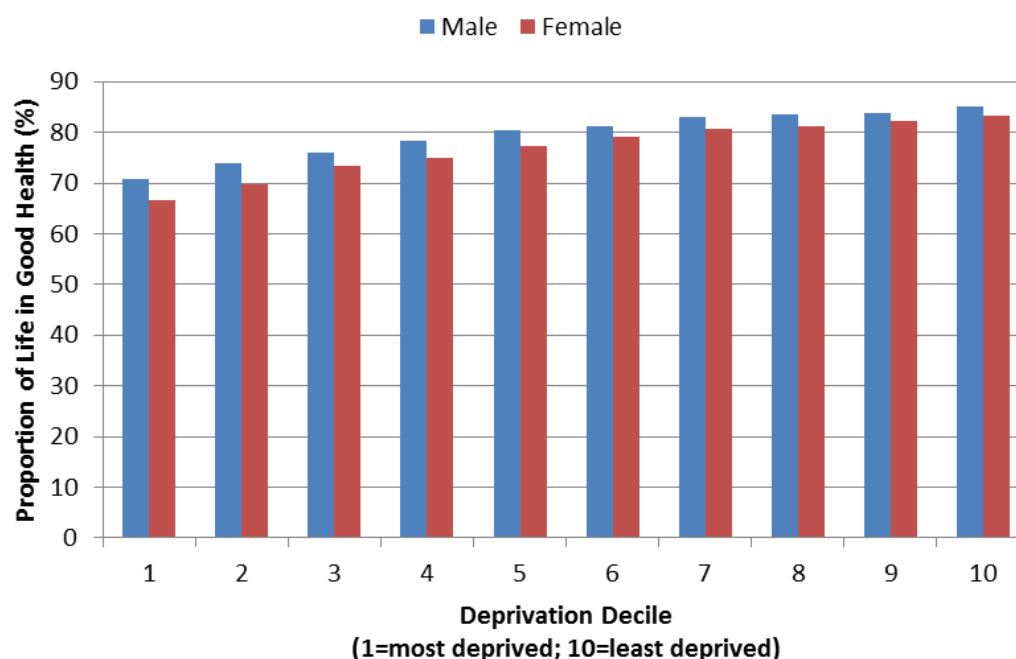


Figure 6 : Correlation between deprivation and mortality in Cumbria

## 4 Performance and Quality: Delivering Standards Reliably

### 4.1 Quality Challenges

During the two year period of 2012/13 – 2013/14, there have been a number of substantial quality challenges in Cumbria, which have resulted in regulatory intervention.

North Cumbria University Hospitals NHS Trust was included in the Mortality Review led by Sir Bruce Keogh, NHS England Medical Director. The review identified a significant number of impediments to the delivery of quality services. In the period following the review the Trust have taken forward many improvements and are now within the expected range for Hospital Related Mortality. The review led to the Trust being placed in special measures.

University Hospitals of Morecambe Bay NHS FT were included in the wave 1 of the new Chief Inspector of Hospitals reviews. Following the review, and the subsequent risk summit, the Trust were placed in special measures.

This means that at the time of writing, both the major Acute Trusts serving Cumbria are in special measures, the highest level of escalation in the NHS.

Additionally, there has been further intervention from the Care Quality Commission and/or NHS England regarding:

- A wide range of interventions across nursing homes in Cumbria
- A series of Quality Surveillance Groups, leading to several Risk Summits, relating to specific NHS trusts and or services across Cumbria.

Finally, at the time of writing the Inquiry in Public primarily relating to maternity services at Furness General Hospital is still in hearing.

A key recurring issue across many of these quality challenges, is the difficulty of recruiting clinicians and practitioners with the necessary skills, and of enabling those clinicians to continuously improve services within a professionally supportive clinical culture.

### 4.2 NHS Constitution Standards

Our system does not reliably deliver the standards associated with the NHS Constitution. The performance of NHS Cumbria CCG and that of our local acute trusts is consistently below the national operational standards on a number of measures from the Expected Rights and Pledges within the NHS Constitution.

NHS Cumbria CCG has failed to achieve the **18 week referral to treatment time** throughout 2013/14 and continues to fail in 2014/15 at May 2014. This is primarily due to North Cumbria University Hospitals NHS Trust (NCUHT) which has failed this standard for over a year. NCUHT is also inconsistent in achievement of the incomplete pathways. University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBT) has improved greatly in achieving RTT standards in 2013/14 but is still on occasion not achieving the admitted standard. In 2014/15 they have identified that a

backlog has built up due to insufficient capacity and they plan to fail the RTT admitted standard during June/July 2014 in order to clear the backlog and get back on track. This has been agreed with commissioners but with requests for assurance that a backlog will not then recur. Cumbria Partnership NHS Foundation Trust (CPFT) regularly underperform on the 18 week non-admitted standard in services commissioned by the CCG. This is in the specialties of neurology and community paediatrics.

In addition NCUHT and CPFT are now not achieving the **diagnostic 6 week wait standard** by a significant amount (15.9% and 18.6% respectively at May 2014), and UHMBT have failed it by a small degree (between 1.1-2%) on occasion in recent months. NCUHT and UHMBT are also failing to achieve the standard for **cancelled operations not rebooked within 28 days**. Together these present a risk to the CCG in terms of the challenge to achieve and consistently maintain the elective pathway standards for the patients of Cumbria into the future, with by far the largest risk currently being NCUHT.

**Cancer waiting times:** The CCG has failed the maximum 62-day wait from referral from a GP to first definitive treatment for all cancers standard for 12 out of the last 13 months and NCUHT has failed this for 11 out of the last 13 months. In January 2014 NCUHT also failed the maximum 31 day targets for surgical, drug and radiotherapy treatment, the first time it has failed all three at the same time, and in April 2014 the 14 day from referral to first OPA standard was not achieved, a standard that NCUHT have achieved for the past 6 months. UHMBT had been achieving the cancer standards for much of 2013/14 but have failed to achieve the 62 day standard in recent months. Again this presents a risk to delivery of optimal cancer care for the Cumbrian community.

**Urgent Care Services:** For a large part of 2013/14 NCUHT has not achieved the four hour waiting time standard for A&E. In February and March 2014 performance improved dramatically with the 95% standard being achieved almost every day, as a result of primarily internal changes to the Trust that have improved patient flow. However, performance since then has been extremely variable and the current Quarter 1 performance at 8/06/2014 is 93.2%. UHMBT have deteriorated in their performance. Having achieved the 95% four hour standard in quarters 2 and 3 of the year, quarter 4 has deteriorated dramatically and they did not achieve the standard. At 8/06/2014 their Quarter 1 performance is 92.2%. In addition they have only achieved the maximum 30 minute ambulance handover for one month in the last 12. Urgent care services therefore continue to be challenged across all of Cumbria and effective, substantial and deliverable urgent care plans will need to be implemented in the next two years to ensure a sustainable system is in place into the future.

**Health Care Acquired Infections:** Although NCUHT perform well against C. Difficile trajectories UHMBT had failed their 2013/14 trajectory by January 2014 and the CCG has also overall failed its trajectory. In addition there have been two MRSA cases for the CCG in 2013/14 as well as one at NCUHT and one in UHMBT. Further work is therefore needed to reduce and prevent health care acquired infection in Cumbria.

### 4.3 Variations in Reliably Delivered Services

We know that there are significant variations in the delivery of services right across the system. For example:

**Primary Care:** Although General Practice across north Cumbria has a high level of Quality Outcome Framework (QOF) attainment, there is very wide variation in the levels of disease registers (case finding) compared to forecast disease prevalence, and in the consistent delivery of interventions. Similarly, there are widely varying utilisation rates of hospital services, though both elective referral and unscheduled care, which are not a correlation of overall morbidity.

**Hospital Care:** We know that hospital mortality as measured through both HSMR and SHMI consistently show higher rates of mortality at West Cumberland Hospital than at Cumberland Infirmary Carlisle, although overall mortality as recorded through these measures has significantly improved in the last year.

**Mental Health Services:** There is a significant variation in access to IAPT services, and services for severe and enduring mental health, across north Cumbria, and significant variation in the interventions service users receive for comparable needs.

#### **4.4 Delivering Care in the Right Place, at the Right Time**

We commissioned the Oak Group to carry out an audit at each of University Hospitals of Morecambe Bay NHS FT, North Cumbria University Hospitals NHS Trust (NCUH) in February-April 2014 and the community hospitals delivered by Cumbria Partnership NHS Foundation Trust (CPFT). This audit was undertaken in order to facilitate improvement of care quality and reduction in delivery costs by identifying patients in the acute setting whose care could be delivered in an alternative setting (non-qualified admissions or bed days). The audit showed that care could be provided in alternative environments for:

- 28% of medical admissions and 61% of continuing days at UHMBFT
- 23% of medical admissions and 62% of continuing days at NCUHT
- A large part of the unqualified provision at both Acute Trusts relates to sub-acute needs, which could potentially be met in community hospitals)
- 18% of admissions and 47% of continuing bed days in community hospitals.

This position is typical across England, and any major change is reliant on developing more effective out of hospital options and an increased use of sub-acute wards.

## **5 Workforce**

Overall, our staff tell us that things need to change. While staff in some specific services show very high levels of professional satisfaction, this is not the norm. Overall, our staff have consistently provided feedback, including through the national staff survey, that shows lower levels of satisfaction and lower levels of confidence in the service delivered than any national benchmark.

Our staff have repeatedly identified ways in which they could be better supported and enabled to drive service improvements. Although there are signs that we are becoming much better at responding to those issues, there is still clearly lots of room for improvement.



Delivering sustainable services is dependent on recruiting, retaining, and developing our workforce. Currently, we have a major over reliance on temporary staff, including on locum consultants, middle grade and junior doctors. This over reliance is potentially a risk to the clinical and financial sustainability of services, and is a clear risk to continuity of service and quality.

**A much fuller description of the workforce challenges is provided in each of the Better Care Together and Together for a Healthier Future Documents.**

## **6 Financial Sustainability**

NHS Cumbria CCG has delivered a planned surplus of £5 million in 2013/14, and plans to maintain this level of surplus over the next 5 years (i.e. it will spend its annual funding allocation in full).

For 2014/15 NHS Cumbria CCG will receive a revenue allocation of £677 million that is 8.5% (circa £57 million) above target funding. Following guidance issued by NHS England, the CCG's financial plan is based upon the minimal allocation uplift over the planning period. Although the CCG allocation formula identifies Cumbria's population need to be greater than that for the predecessor Cumbria PCT, NHS Cumbria CCG's financial allocation is significantly over target owing to a combination of the baseline position inherited from the PCT along with a small fall in Cumbria's overall population at a time when the rest of England's population has increased. However, it is noteworthy that the CCG allocation formula does not make allowance for the cost of delivering healthcare where significant elements of the population are located in geographically remote areas or the impact of rurality.

In Cumbria the NHS system currently spends much more than it is allocated and this deficit presents in the provider sector. In effect, the Cumbria acute trusts, and therefore Cumbria collectively, are reliant upon resources from outside Cumbria to remain solvent, as noted below. Also, given the CCG's current distance from target allocation it would appear unlikely that a change in the allocation formula would provide significant additional resource into the Cumbria health economy to potentially off-set the problem.

- University Hospitals of Morecambe Bay NHS Foundation Trust has a financial risk rating of 1. The Trust has a recurring financial deficit of c£25 million, against an annual income in the region of £260 million.
- North Cumbria University Hospitals NHS Trust has received in excess of £100 million transitional funds over the last five years to "balance the books". The Trust is forecasting a deficit of £26 million in 2013/14, against an annual income in the region of £228 million.

Work has been undertaken in both acute trusts to establish the underlying reasons for the level of deficit, including the extent to which it inherently costs more money to deliver services across small district general hospitals which are geographically isolated from each other. It is noteworthy that both trusts are currently (in common with other healthcare providers in Cumbria) placing significant reliance on premium cost staffing (e.g. locums).

Cumbria Partnership NHS Foundation Trust, following a period of financial health, is now facing difficulty in identifying a deliverable cost improvement programme for 2014/15 and beyond.



Our approach to rebalancing the system therefore will need to be planned and delivered at a credible pace and scale, ultimately delivering a radical, rather than piecemeal, redirection of resources.

**The scale of our financial challenge is more fully described in each of the Better Care Together and Together for a Healthier Future documents.**

## Section 3      Our Vision for Cumbria

### 1      The Vision

The following principles were adopted by NHS Cumbria CCG and endorsed by all the partner organisations of the Cumbria Health and Care Alliance:

#### **NHS Cumbria CCG Vision:**

We are here to make a real difference to people's lives. Firstly this is about making a difference by improving the health and wellbeing of individuals and their families. In particular it is about taking serious action to reduce the inequalities in health that exist between different communities across Cumbria. We want to add years to peoples' lives, and quality life to those years. Making a difference to people's lives also includes improving the day to day experience of patients and those working to deliver better healthcare. Working for the health service in Cumbria should be a privilege and a source of pride. We want this to be true for all our colleagues, as we recognise that quite simply people who are happy in their jobs provide better care. Our key underpinning principles are:

- Doing the right thing for our patients, service users and populations
- Putting ourselves in your shoes – is this the care we would want for ourselves or our families?
- Access to the right healthcare, in the right place, right when you need it
- The Cumbrian health pound is finite and can only be spent once.

Building on those principles, we recognise that health and social care services in Cumbria need to change for the better. There are four reasons for this:

- We know that not all services are as safe as they should be - and furthermore, the people of Cumbria are not all sharing in equal access to the best possible outcomes for their health or their care
- The day-to-day experience of people using services is not as good as it should be – and we don't listen enough to what people are telling us about their experiences
- The ever increasing cost of services as they are currently delivered – even if they were good enough and fair to everyone – is not sustainable and the local NHS and the County Council will be bankrupt if things carry on as they are
- The staff – doctors, nurses, carers, managers, everyone – who work for the NHS and for social care in Cumbria are often frustrated, unhappy, over-stretched and demoralised and there is a crisis in trying to recruit new people to come and work here.

We believe we can change things for the better and we believe we must do it together with all the people who live, work and use services in Cumbria. We think all of the following will be required:

- Individuals and families taking more responsibility for their own health and wellbeing – supported by expertise from many places, which is coordinated by...

- ... Local communities having an integrated and constantly developing approach to all the assets based in their community (including voluntary, professional, commercial and faith based) – supported by expertise from ...
- ... Local health and care integrated teams, working with shared budgets, to serve communities of between 15 and 50 thousand people – supported by ...
- ... Two teams of acute services (north and south) working across the community and in all our hospitals to meet needs that cannot be managed by the local teams – supported by ...
- ... Specialist services, many in Cumbria and some – where necessary – as far afield as Newcastle and Manchester.

To make this work we will need:

- Much more of a 7 day approach to how services work and are accessed
- More skills to eliminate waste, improve everyday processes and manage changes (without drama and heartache)
- Better communication skills, both one-to-one and for communities, between the professionals and the people who use our services
- Better information and clinical informatics systems
- Better alignment of planning and budgets so no perverse incentives block our plans or our progress.

Ultimately, we want everyone using our services to be delighted at the quality of care that they receive, and all of our workforce to be proud of the quality of care they are able to give, with an equal partnership between service users, including their carers, and clinical and practitioner staffs. Additionally, we cannot be successful by continuing to overspend.

As part of our commitment to improving quality and outcomes, we have also agreed to adopt the ***Improving Fairness, Quality and Outcomes: The Seven No's*** framework developed by the North East Transformation System:

- No barriers to health and wellbeing
- No avoidable death, injury or illness
- No avoidable suffering of pain
- No helplessness
- No unnecessary waiting or delays
- No waste
- No inequality.

## 2 Aims and Objectives

Our collective overarching **aims** for the next five years are to:

**Ensure a Sustainable NHS for Future Generations:** By this we mean ensuring a system which is clinically sustainable in terms of the service model, standards, and safe, appropriate levels of staff, and which is also affordable.

**Improve Outcomes:** By this we mean improving the outcomes for individual patients and their families, and population level outcomes.

**Reduce Health Inequalities:** By this we mean narrowing the gap between the populations who enjoy the best outcomes, and those populations who endure the poorest outcomes. A good example is to reduce the difference in life expectancy between communities.

Our collective **objectives** for the next five years are to:

**Radically increase the scale and integration of out of hospital services, based around Primary Care Communities:** Primary Care Communities are developing around groups of practice lists in natural communities, and will serve populations of between 15,000 and 40,000 depending on local circumstance. Primary Care Communities will be to move away from episodic, unconnected care, to a seamless system based around the patients and their families.

**Achieving sustainable, high quality provision, by delivering a programme of Hospital Services Consolidation:** However successful our population health programmes, and Primary Care Communities, become, there are times when most of us will need to go to hospital. This should be reserved for those times when we need specialist help, requiring the staff skills, technology, and support services which can only be delivered in hospitals.

**Deliver a modern model of integrated services, ensuring an optimal use of resources for patient pathways across community and hospital services and for cross cutting priorities across the system:** Building on the integration through Primary Care Communities, we will break down traditional boundaries between the workforce in the community and in hospitals. One example is how we will connect the care for older people in and out of hospital under the leadership of Elderly Care Consultants working in both settings.

**Improve population health outcomes, based on a major impact on reducing social isolation, smoking and alcohol misuse, and increasing activity and healthy eating:** We will work together with partners across Cumbria to deliver the Cumbria Wellbeing Strategy, and to re-focus our system to promoting population outcomes as a health system, rather than just a healthcare system.

### 3 Principles for Success

The following principles for success were agreed by a broad range of clinicians and practitioners. We will achieve better outcomes for the people of Cumbria by building upon the foundations of:

- Putting prevention first
- Being person centred in everything we do
- Rigorously using national and local evidence for our services.

We require pioneering leadership and we intend to:

- Show more respect and better behaviours, both as individuals and organisations, creating a positive and transparent culture for success
- Build the right workforce that learns and trains together, and then works together in collaborative, well-communicating teams
- Create sustainability by building common platforms and continuously improving everything we do.

## **Section 4      Our Initiatives**

### **1      Continuous Collaboration: Cumbria Health and Care Alliance**

The Cumbria Health and Care Alliance is focused on a continued collaboration across the system, based on the optimal models for meeting patient's needs, and seeking to reduce the constraints caused by organisational sovereignty. In seeking to increase our collaboration, it was necessary to adopt some collective principles backed up by a common set of behaviours.

We have agreed the following as important characteristics for our behaviour, and the need for those behaviours to be actively modelled by the clinical and managerial leaders in our system:

- Have a relentless focus on quality
- Seek to integrate and work together
- Actively performance manage, hold ourselves and each other to account
- Be clear what we are trying to achieve, with a small number of important priorities
- Work hard on alignment of vision, with day to day actions in accordance with a shared narrative
- Always involve clinicians, and hold them to account
- Be mindful of tactical opportunities grounded in reality, not just intellect and emotion
- Ensure we make things happen while creating strategy, importance of momentum
- Collectively, have more ambition
- Put patients and the whole system first, and the health of our organisations follow
- Develop solutions which are politically possible, managerially credible, can attract or already enjoy public support, and command clinical and professional respect.

### **2      Continuous Service Improvement: Cumbria Learning and Improvement Collaborative (CLIC)**

#### **2.1      CLIC**

We know that delivering the right configuration of services is important. However, we also know that supporting frontline clinicians, practitioners and managers to continuously improve the services they deliver will have an even greater impact. If we are to be successful, we will need to engender a genuine and continuous cultural and behavioural change across the system, enabled by leadership and by giving all our staff the right improvement tools and techniques.

To achieve this, the Cumbria Health and Care Alliance committed to forming the Cumbria Learning and Improvement Collaborative, CLIC. This is intended to develop into the key shared vehicle for continuously driving service improvement, in all services across Cumbria, forever. We are still working on the final CLIC work plan, but in simple terms CLIC is:

- An umbrella that brings together the collective effort of the CCG, its member practices, the Cumbria Partnership NHS FT, two acute trusts and Cumbria County Council (Adult Social Care, Public Health and Children's Services) on education, training, development,

improvement work – indeed any organised effort to meet the needs of individuals and teams, helping them to achieve their objectives in a better way.

- A kind of snow-plough to help you get where you are going, clearing away barriers of any kind by sharing experiences, skills and innovations and supporting (and improving) all our organisations in doing what needs to be done to achieve the right outcome.
- A club (a partnership) so we all learn together, where no one partner is assumed to have a monopoly on need or solutions and where all talent is being used in a patient and population centred way, not a ‘sovereign organisation’ way.
- An infant. Full of potential but definitely not fully formed. There is as yet no fixed plan or position – indeed no fancy ideas, jargon, models or must do’s at all – just a commitment to find a way (together) to stop just talking about excellence and start the journey towards it, one step at a time. You cannot be right or wrong about what ‘it’ is, as we (together) haven’t yet developed it.

## **2.2 The Workforce Solution**

Through the workforce session facilitated by CLIC we developed an outline five year plan for improving recruitment, retention and development with detailed actions for the next three to six months. The plans, and indeed all the content from the session, can be found at:

<http://www.theclic.org.uk/clic/events/clic/a-workforce-plan-for-cumbria-thinking-out-of-the-box-about-recruitment-retention-and-professional-development>

## **3 Joint Commissioning**

Cumbria County Council and NHS Cumbria CCG are developing ambitious plans to take forward joint commissioning on a much greater scale. This recognises the significant interdependencies between health and social care, and the potential to deliver more efficient, integrated services through joint commissioning.

The creation of the Better Care Fund has provided a powerful catalyst for accelerating those plans. In 2015/16 the Better Care Fund for Cumbria will be c£40M, and will require new and improved governance and joint commissioning arrangements. However, we aspire to pool much greater sums in 2015/16 to grow the Better Care Fund. Those include:

### **Mental Health, Learning Disabilities and Substance Misuse:**

- Establish a revised learning disability pooled fund focused on the most complex packages
- Establish a new mental health pooled fund for April 2015, working closely with Cumbria Partnership NHS FT as the lead provider
- Establish a mental health and learning disabilities joint commissioning team across health and social care, to be in place by October 2014.

### **Continuing Health Care, Nursing and Residential Homes:**

- Aim to establish a joint team to undertake contract management, including performance and quality, by April 2015
- Actively explore establishing a joint service framework for procurement in 2014.

### **Integration to Improve Outcomes for Older People with Frailty:**

- This is the key focus of our Better Care Fund plan for 2014/15 – 15/16, as submitted by the Chair of the Health and Wellbeing Board on April 4<sup>th</sup> 2014
- Further integrate health and social care provision as part of Primary Care Communities.

## **4 Clinical Informatics**

There is strong local agreement across Cumbria health and social care organisations, through the Cumbria Health and Care Alliance, for the continued support to deliver, utilise and maximise opportunities to continue to develop shared clinical informatics system.

This particularly includes:

- Community of Interest Network (COIN) infrastructure and its future state i.e Public Service network (PSN)
- Medical Interoperability Gateway (MIG) development i.e. ability to share detailed GP Cumbria Care record into relevant provider organisations e.g. A&E, Out of Hours, Primary Care Assessment centres and Outpatients
- E-referral and resource management software, (Strata) providing an “air traffic control system” for patient transitions across Cumbria
- Maintain and enhance a single Active Directory for Cumbria, however that may be configured, to facilitate communication and training and access to systems wherever people are based in Cumbria.

These constitute elements of the Common Platform, we are also collectively working to:

- Prioritise development of electronic records over the next two years, which are currently paper based / reliant on faxed information and agree timescales for implementation between the respective Chief Clinical Information officers
- Set out a two year plan to introduce tele-consultations in line with service delivery and improvement plans
- Agree to rationalise and standardise the range of referral forms that are transmitted between any combination of primary, community, mental health and acute services, with the aim of having single Cumbria wide electronic referrals over an agreed timescale.

These developments will provide major gains for the whole system, including:

- Reducing waste through the removal of inefficient paper based systems and through fail safe systems which will prevent the loss of information such as referrals



- Improving clinical decision making, by ensuring that clinicians and practitioners have access to appropriate clinical information, with patient consent
- Improving patient experience, by reducing how often patients have to re-tell their own story, and by maximising the time clinicians and practitioners can add value to the consultation.

## 5 Primary Care and Community Services

### 5.1 Communities and Support for Self-Management

We know that the real bedrock of health and wellbeing is to be found in individuals, families and social connections, and our communities. We will need to find new ways to harness this capacity to enable much more effective health promotion, prevention and self-care, and to move towards a more proactive system preventing rather than managing crisis. Key to this will be developing new relationships between services users and our whole system, including:

- Providing **support for self-management** on a much larger scale, building on our positive experience from roll out of diabetes patient education programmes, particularly DESMOND for type 2 diabetes
- Use of a whole range of health, social care and community assets
- Better use of what is already available in the community
- Greater involvement of the third and voluntary sector, faith communities and so forth including volunteers
- Use of the Neighbourhood Care Independence Programme
- A stronger emphasis on the fact everything needs to put the person at the centre
- Use of assistive technologies including equipment, tele-health and tele-care.

### 5.2 General Practice

General practice forms the bedrock of our primary care community approach. GP practices locally however are struggling to cope with increasing demand, face recruitment pressures and falling incomes. The Centre for Workforce Intelligence (2013) reported a 75% increase in the number of GP consultations in England from 1995-2009. They concluded 'There is insufficient capacity in primary care to meet current and future needs'.

Yet we are about to make major additional demands on the primary and community care system:

- To work collaboratively with each other, with community services, social care and specialists working in the community
- To move from care of the individual to care of a population
- To support a huge shift of care from our acute hospitals into our community based intermediate care tier, sicker patients remaining at home, more support to nursing and residential homes etc.
- To support a huge shift to proactive and up-stream care especially for the frail elderly
- To move from a mainly medical model to a social model of health and wellbeing within communities

- To become experts in admission avoidance
- To lead a major change in the way we manage long term conditions based on care planning and support for self-management
- To provide additional skills in areas such as primary mental health, child health, end of life care and geriatric medicine to support more people safely in the community with the need for fewer admissions and fewer elective referrals.

A core part of our five year plan is therefore how we support general practice to work within primary care communities. The roll out of primary care communities will require a large programme of learning and skills development for primary care both for the 'day job' and in improvement science. A learning community is currently being developed with the support of the Cumbria Learning and Improvement Collaborative (CLIC) to support the first wave of 10 primary care communities being rolled out in 2014/15. The large provider trusts with their infrastructure and critical mass have a key role to play in partnering and supporting primary care in what increasingly will become an 'Alliance' approach to health and care delivery across Cumbria.

This approach to primary care development will be delivered in line with the key recommendations in the Transforming Primary Care document published by the Department of Health in April 2014.

We often refer to primary care when we really mean general practice. However, the role of community pharmacists will also need to continue to develop as part of the model. We know that community pharmacy is not currently used to its full potential, we also know that large numbers of hospital admissions are primarily caused by sub optimal prescribing and medication errors.

### 5.3 The Model for Primary Care and Community Services

We continue to work to develop community services that are responsive to the needs of the Cumbria population. The focus is to create a proactive, joined up out of hospital care system that improves quality and drives efficiency. The model is aligned with national NHS strategy and with the Royal College of Physician's promotion of the principle of joint working across institutional boundaries that would enable healthcare professionals to deliver integrated, personalised care. The basic model is shown below:

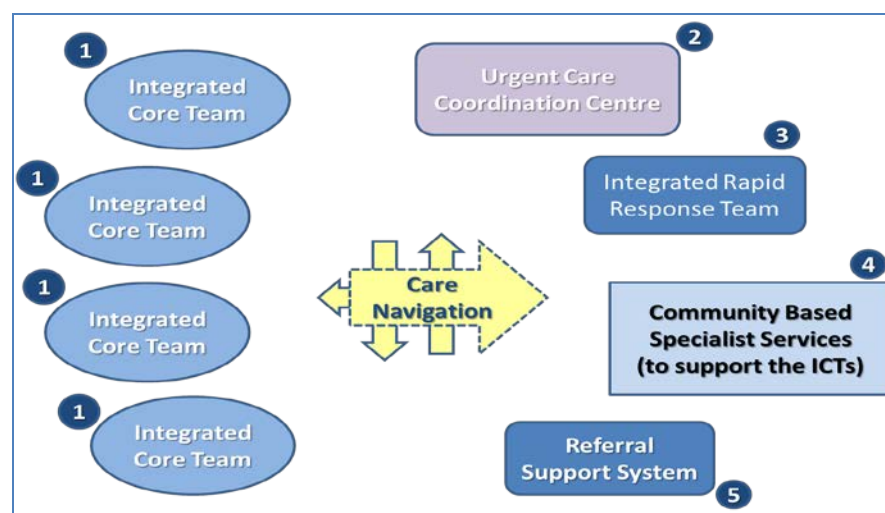


Figure 7 : Model for Primary Care and Community Services

The service model will be delivered in slightly different ways across different parts of Cumbria, reflecting the local context.

Also, our language, in terms of the names we have given to particular functions, is different, particularly between south Cumbria which has worked with our colleagues in Lancashire North CCG and north Cumbria. Overall though, the model in terms of the basic functions and more importantly the outcomes it will deliver is consistent across Cumbria.

The following is an outline description of each of the building blocks for the Out of Hospital model.

**For a fuller description of the model in each of south and north Cumbria please review the Better Care Together and Together for a Healthier Future strategic plans.**

## Element 1 –Primary Care Community Teams

### Definition of Primary Care Communities (PCCs)

Primary Care Communities are a group of care professionals and third sector staff drawn from a range of organisations and professions who collaborate to address the physical, mental and social needs of patients and their carers. They work in partnership with other agencies to also improve the general wellbeing of the population for which the team is responsible.

They are based on GP practice registered populations of between 15,000 and 40,000 that mostly cover more than one GP practice. Teams are configured around natural communities and built upon the workforce in the constituent practices and wider community assets. They are comprised of medical staff, nursing, health care assistant, mental health care, social care, voluntary care, administrative staff and managers working together across organisational boundaries.

Primary Care Community Teams will in particular develop flexible approaches to delivering care making the best use of all the expertise available to them in the following areas:

- Frail elderly care
- Long term condition management
- Services for the housebound
- Urgent/on the day care
- Seven day a week services/care
- Supporting people to maintain their independence ideally in their own home
- Health inequalities; improvements in case finding, disease registers and reduction in unwarranted variations in care.

### The Building Blocks of our Primary Care Communities are:

**A Multi-Disciplinary Team:** There would be 'one team' with a common purpose that included the GPs, responsible for the health of their defined population. There would be a proactive, coherent multidisciplinary approach to care for older people and for those with long term conditions within the PCC focusing on a shift to supported self-care and care planning. District

nurses and practice nurses will work together more productively, maximising the skills across the whole workforce. In some areas the PCC model will help fast track discussions that are already underway around integration of rehabilitation and reablement services.

**Population Based Approach:** The population in each PCC would be risk stratified to identify the risk of non-elective admission, frequent users of services and risk of admission to residential care. The PCC would be the building block for asset based approaches and there would be a tele-health network would connect each PCC to specialists.

**Shared Systems and Data:** The PCC would share information, have a common (or at a minimum interoperable) IT system and real time patient data.

**Leadership and Delegation:** Each PCC would have a leadership team with representation from primary, community, social care, the CCG and third sector and manage at least part of their health and care budget, and would be linked to a programme of education and development – learning how to continuously improve quality, working with other PCCs to share ideas and good practice. Each locality, supporting local PCCs will work very closely with local district/ borough councils to address the health needs of their local populations, maximising the benefit to their populations from joint working and collaboration.

### **Primary Care Communities will deliver the following benefits:**

#### *Primary Care*

- A reduction in unwarranted variation in elective referrals
- An improvement in case finding and disease registers
- Standardised long term condition management including cancers
- Standardised management of the frail elderly, including in residential and nursing homes
- Standardised end of life care
- The delivery of urgent care 8am – 8pm Monday to Fridays and at weekends
- Improved access to, and outcomes from, psychological therapies (IAPT).

#### *Hospital Admissions*

- A reduction in avoidable unscheduled admissions
- A reduction in hospital re-admissions
- A reduction in elective procedures of low clinical value
- An increase in people who die in their place of preference
- A reduction in length of stay for medical patients, and in delayed transfers of care.

## **Element 2 - Urgent care co-ordination centre**

The urgent care co-ordination centre will ensure that patients get to the right place in the system at the earliest opportunity. It will work with the primary care community team and track patient journeys using real time system information.

For professionals it will provide a single point of access to a range of health and social services for patients with an urgent health and/or social care need whilst at home and can provide an alternative to admitting to urgent care services. It will agree the appropriate clinical response

for a patient in accordance with care plans, including discharge plans for patients with complex care needs. The centre will be able to deploy additional community services, for either adults or children. It will also arrange appointments at ambulatory clinics as well as hospital admission.

For professionals, including those in hospitals, the centre will provide a single point of access to a range of health and social care services to help them address the needs of their patient with an urgent need whilst at home. The service will be for patients of all ages with a call option to divert to a children's response where needed. For the patient in hospital the centre will coordinate discharge planning and referring and accessing community and post hospital care across the health and social care system. The urgent care co-ordination centre at Cumberland Infirmary Carlisle (CIC) has started to perform this function.

The role of the co-ordination centre will be to agree the appropriate clinical response for a patient, given the need, the care plan and the knowledge of available local services. The service will have access to care plans for those patients who have been identified as likely to require support to enable continuity of care.

The team will operate using local knowledge and "real time" system capacity data across the health and social care system and ensure that the best package of care or support is delivered to a patient in the most appropriate location, and at the most appropriate time. The centre will be able to deploy community services that support primary care community teams, for either adults or children. For those who need it, the centre can also arrange appointments at ambulatory clinics as well as hospital admission.

A critical enabler is to have a shared IT platform/system in place which displays real time capacity across the system, i.e. in general practice community services, local authority services as well as in the hospital. STRATA is a system being piloted and learning from this early pilot will help identify how best to design the future tools or build on STRATA. If STRATA proves to be effective it can be extended beyond unscheduled care to streamlining referrals, managing appointments, bed management, etc.

The hub or care co-ordination centre will also be able to provide advice to professionals as an alternative to admitting to a care service and will have a vast knowledge base on which to make decisions. This is a critical function of the team and requires skilled staff to be available seven days a week.

The care co-ordination centre at CIC is already beginning to deliver some of these functions successfully, and gives us good local experience to learn from and build on.

### Element 3 - Integrated rapid response and community services

A number of services will be developed, either by PCCs or where appropriate on a larger footprint to specifically target the needs of patients in the community. Examples include:

**Hospital at Home/ integrated rapid response teams:** A multidisciplinary team designed to avoid hospital admission where appropriate and enable hospital discharge before the patient has fully recovered with the necessary out of hospital support. The team makes a rapid

assessment of the patient's medical, nursing and care needs. The team then delivers a package of health and social care ("hospital at home") until the patient no longer requires intensive support and their care continues to be provided through the primary care community team for ongoing recovery and rehabilitation.

There would be a multidisciplinary rapid response function including nurses, occupational therapists, physiotherapists, social workers and home care practitioners (currently called STINT or rehabilitation teams), community hospitals (where appropriate) and pharmacists. People presenting with health and/or social care needs will have access to reablement, rehab services and voluntary sector partners to maximise independence in the first instance. This will include a rapid response function to prevent avoidable admissions and will therefore be available throughout the seven day week. This approach will include access to equipment, assistive technology, adaptations and prevention services. There would be a 'Virtual Ward' including prevention, focusing on those identified as high risk for admission, and reactive for patients who are more acutely ill, for example, those needing IV antibiotics at home. For those with long term needs a care coordinator approach will be in place to ensure people know who to contact if there are changes in their circumstances and to embed a proactive, personalised approach to care and support for themselves and their carers/family.

**North West Ambulance Service (NWS) Pathfinder Programme:** We are working with NWS to deliver the pathfinder programme during the day in addition to the already established out of hours programme. This service gives NWS paramedics the ability to direct patient care needs to local primary and community services if these are better able to meet the patient's needs, rather than taking all patients directly to an A&E service.

## Element 4 - Community specialist services

Specialists would operate across the out of hospital model, providing specialist support for patients, in localities where possible but with good access to hospital based services. They would have an overarching responsibility for the delivery of care and health outcomes for the population in their locality that has diseases covered by their specialities.

In delivering this responsibility specialists would have dedicated time to advise GPs or patients outside a traditional clinic environment. Specialists would have a key role in the education and support of other professionals. Clinical nurse specialists, GPs with a special interest, other community health professionals and social care professionals would have a greater role in the direct delivery of patient care and patient education.

The role of the specialist will evolve and whilst it will still include direct clinical care it will also have a key role in skilling up primary care teams, helping coordinate care across pathways and set standards, pathway leadership and a significant increase in direct same day advice and support to colleagues in the primary care community.

A large number of medical specialities from different organisations could join this medical division for example, acute medicine, geriatrics, rheumatology, neurology, diabetes, endocrinology, respiratory medicine etc. All specialities will still in reach to provide acute care within the hospitals but they will become community based specialities.

Use of technology is a key enabler to this element of the model and opportunities can be learnt from remote healthcare systems and how they use non face to face interaction to diagnose, offer advice and support and maintain follow up care without the patient travelling to hospital. For example, the model includes a clinical support service for nursing homes, providing from the bedside advice on appropriate care, removing the need for residents to be taken to other care facilities unless that best meets their needs.

## Element 5 - Referral support system

This element is a number of activities and approaches that together provide a more effective and efficient system for the pre-operative or pre-acute intervention phase of a patients care pathway. Many of the functions below are already in place. We now need to deliver these more consistently across north Cumbria in a more focused way.

The referral support system will encompass:

- Access to specialist advice and guidance
- Improved access to diagnostic investigations for community based health professionals
- The development of care pathways across specialities including the use of shared decision aids
- Making these pathways clearly available for viewing by all those involved in patient care
- Referral templates
- Peer review of referrals for specialist opinion
- An advice and guidance tool
- Co-consultation in for example outpatient community settings between specialist and members of the primary care community team.

The system will help reduce the need for specialist follow up, including discharge from specialist follow up, but facilitating quick access to specialist review when appropriate. The service will also aim to up-skill community based health professionals' referral skills.

## 6 Community Hospitals and Minor Injury Units

There are nine traditional community hospitals in Cumbria at Alston, Brampton, Cockermouth, Keswick, Maryport, Millom, Penrith, Wigton and Workington. Additionally, there are four step up step down units created in 2010 on the Cumberland Infirmary Carlisle, West Cumberland Hospital, Westmoreland General Hospital and Furness General Hospital sites.

We are committed to a positive future for all of the community hospitals. They provide a vital role in ensuring local access to services and enabling needs to be met in the most appropriate care environment. At an overarching level, the community units should provide 2 clear functions:



- They should be used for step down (after a very short stay in the acute) and step up care, as an integral part of the whole elderly care bed base run by a team of GPs from local practices and elderly care physicians
- They should provide enhanced admission avoidance hubs, acting as 'Frailty units' - one stop assessment centres for the frail elderly (replacing outpatient clinics), focussing on comprehensive geriatric assessment, reablement and rehab, prevention (co-opting third sector and community resource) and admission avoidance such as falls assessments.

Our approach to maximising the contribution of community hospitals will be guided by the following principles:

- The community hospital and SUSHD beds should be combined with the elderly care beds in North Cumbria University Hospitals NHS Trust to form a joint bed base for older people.
- This should be run within a new 'medical divisions', with medical leadership from GPs and elderly care physicians working as one team.
- The norm for Acute Trust admissions should be short stays for older people with rapid transfer out to home ('home first') or one of the community facilities (which may include sub-acute wards in the Acute Trust setting) within the medical division for further assessment and treatment. This is in keeping with the findings from the Oak Group audit.
- There should be day case/ambulatory units within each locality where transfusions and other IV therapies can be *reliably* delivered. The portfolio of these ambulatory treatment centres should be developed in partnership with North Cumbria University Hospitals NHS Trust to deliver whatever treatments currently delivered in the acute trusts that can safely and feasibly be done in the community.
- Each of the minor injury units will either become a part of the Primary Care Community, offering local extended access to community services, or will be aligned to the Type 1 Accident and Emergency Units as part of the joint medical division working to shared governance and standards.

## 7 Hospital Consolidation

As listed in our objectives, a key focus for the delivery of our plans is to ensure high quality, sustainable, hospital services for the future. Delivering this challenge is a difficult task. It will require creativity, invention, and courage from the clinical community and local population.

Our overall aim is to ensure:

- Access to the highest quality urgent and emergency care (connected to Primary Care Communities and A Modern Model of Integrated Care)
- A step-change in the productivity of elective care
- Specialised services concentrated in centres of excellence (working with our commissioning partners in NHS England).



To meet these aims, our local hospital services will need to:

- Be able to reliably deliver the NHS Constitution Standards
- Maintain quality orientated services, which adhere to recognised standards or are based on clinically agreed variations to those standards in patients best interests
- Be sustainable through the support of a skilled, qualified and continuously improving workforce
- Be delivered in the appropriate estate and infrastructure.
- Be delivered efficiently within the resources, which will inevitably mean at lower cost than today.

Through both the Better Care Together and Together for a Healthier Future programmes we have considered a range of scenarios to meet these aims. These scenarios are summarised below. We fully recognise our statutory obligations in relation to public consultation and we are committed to working with the overview and scrutiny committee to ensure these are carried out in line with requirements.

## **7.1 South Cumbria**

**For a fuller description of our plans for hospital consolidation in south Cumbria and as relevant north Lancashire, please refer to the Better Care Together strategic plans.**

The Better Care Together programme had an extensive process for determining hospital options. This started with 132 options which were reduced to a shortlist of six following application of agreed qualifying criteria and 'stakes in the ground' (supported by the Monitor Commissioner Requested Services process).

The six options are outlined in the figure 8. All contain the out of hospital model, and A&E and consultant led maternity services at both RLI and FGH. The differentiation centres on where elective day case surgery takes place.

#	Out of Hospital Model	Urgent care	Women's and children's	Planned care in-patient	Day surgery – GA / LA list
A	5 elements of the Out of Hospital model deployed in each locality	<ul style="list-style-type: none"> <li>FGH Type 1 A&amp;E &amp; dependent services (current service)</li> <li>RLI Type 1 A&amp;E &amp; dependent services (current service)</li> <li>WGH Minor Injuries Unit (current service)</li> </ul>	<ul style="list-style-type: none"> <li>Maternity services with obstetric facilities at FGH</li> <li>Maternity services with obstetric facilities at RLI</li> <li>MLU at WGH</li> </ul>	Consolidate onto RLI and FGH	Consolidate onto RLI and FGH
B	As above, in option A	As above, in option A	As above, in option A	As above, in option A	Day surgery delivered on all sites (WGH, FGH, RLI)
C					Consolidate all day surgery onto RLI
D					Consolidate onto WGH
E					Consolidate onto RLI / WGH
F					Consolidate onto FGH/ WGH

Figure 8: Hospital options in south Cumbria

The outcome of the evaluation process was that option A is the preferred option.

We will continue to refine the preferred option through the Better Care Together process, and through further engagement and formal consultation where appropriate.

## 7.2 North Cumbria

**For a fuller description of our plans for hospital consolidation in north Cumbria, please refer to Together for a Healthier Future the North Cumbria Strategic Plan 2014 – 19.**

We have not developed options for the required change. Rather, we have developed scenarios across a continuum of change, which will be continually reviewed. We will move along the continuum as senior clinicians judge necessary to secure quality, clinical and financial sustainability. All changes will need to be supported by strong evidence and will take into consideration the views of patients, the public and our key stakeholders. We fully recognise our statutory obligations in relation to public consultation and we are committed to working with the overview and scrutiny committee to ensure these are carried out in line with requirements.

Level of Consolidation		
Low	Medium	High
Continuous improvement to meet current and new standards	Reconfiguration of most unsustainable / highest risk services	Planned reconfiguration of whole service model to provide consolidated clinical capacity to adhere to standards and drive quality and efficiency
Continuous review of workforce models and safe staffing	Reconfiguration of elective services informed by public and patient engagement	Increased use of emergency transport
Continuous review of clinical risk and outcomes	Continuous review of all other services	

Figure 9 : Continuum of consolidation

In relation to medium to high consolidation, the following may be necessary:

### Elective Care

- To significantly increase the total number of elective in-patient episodes at West Cumberland Hospital. This will support the delivery of the 18 week referral to treatment standard, reduce cancelled operations, and improve outcomes.
- To develop Cumberland Infirmary Carlisle to deliver higher risk elective procedures, but with a reduction in the total number of in-patient elective procedures at the site. This will ensure the right clinical capacity and capability to improve outcomes for more complex / higher risk patients and procedures.
- Outpatient appointments and procedures, day cases and diagnostics will continue at both sites to ensure access.

### Unscheduled care

- The population of west Cumbria will continue to need to be able to access accident and emergency services at West Cumberland Hospital, and to access the continued provision of lower risk medical interventions and admissions
- In order to reliably meet the needs of patients across north Cumbria, over time, higher risk / complexity patients will need to be admitted to Cumberland Infirmary Carlisle, in some cases following stabilisation at West Cumberland Hospital
- This would mean the consolidation of some urgent care and acute medicine at the Cumberland Infirmary Carlisle site.

## 7.3 Maternity Services

Both the Better Care Together and Together for a Healthier Future programmes have considered a range of scenarios for the sustainable provision of maternity services. Additionally, we have held joint clinical workshops with the two Strategic Clinical Networks serving north and south Cumbria

and the clinicians working in our maternity services at both North Cumbria University Hospitals NHS Trust and University Hospitals of Morecambe Bay NHS FT to develop and share solutions.

We are currently working with NHS England to agree an independent review of the future configuration of maternity services, where possible supported by the relevant Royal Colleges. This will significantly inform how we take maternity services forward in the medium to long term.

## **8 Mental Health**

### **8.1 Mental Health Strategy**

Partner organisations across Cumbria are working to produce a comprehensive Adult Mental Health Strategy for October 2014, which will provide a fuller direction of travel for those services. An independent review of adult mental health services jointly commissioned by the CCG and local authority and delivered by Cumbria Partnership NHS FT working jointly with Cumbria County Council carried out by the Centre for Mental Health has further identified the service areas we need to improve. Two key commitments in the emerging strategy are:

#### **We will develop:**

- A comprehensive primary care treatment service as part of the development of Primary Healthcare Communities
- Integrated delivery between health and social care.

#### **We will improve:**

- Patient and Public engagement and experience
- The performance of our local recovery & rehabilitation services
- The performance of our NSF target services, particularly in access times
- The relationships with other services and agencies
- The consistency of service standards
- Our approach to improving the physical health of people with mental illnesses
- The relationship between resources and needs.

### **8.2 Access**

We have a very high access rates to Improving Access to Psychological Therapies (IAPT) for patients with anxiety disorders, although waiting times can be far too long. Over time some of the First Step service will need to become fully embedded as a part of the Primary Care Community.

We know that access to services with severe and enduring mental health problems is less good. We will deliver a much improved access model, including clear exit planning for patients to return to primary care, and clear and easy re-entry to secondary care services. Similarly, we will need to make major improvements in the flow between home treatment and in-patient services.

We will develop a single point of access into specialist mental health services, providing:

- Assessment and Formulation
- Engagement
- Crisis Resolution at home and in inpatient settings
- Signposting
- Home treatment
- Brief interventions.

### **8.3 Psychiatric Liaison**

There is substantial evidence that providing effective psychiatric liaison at scale delivers major benefits to quality and financial sustainability. Effective liaison enables Acute Trusts to meet the physical health needs of patients with mental health co-morbidities, including cognitive impairment in older people, much more effectively. Liaison also significantly reduces the utilisation of physical health urgent care services, particularly accident and emergency, by people with substance misuse, self-harm, and personality disorder, by enabling their needs to be met in a much more planned way.

We will further develop plans to significantly increase the provision of liaison services working in and out of the Cumberland Infirmary Carlisle and West Cumberland Hospital sites in north Cumbria, and Furness General Hospital and Royal Lancaster Infirmary for south Cumbrian patients. This will include resolving arising issues in providing a 'cross border' service for patients from Cumbria accessing services at Royal Lancaster Infirmary, to ensure consistent patient pathways are delivered reliably and efficiently.

### **8.4 Community Mental Health Services – Psychosis and Non-Psychosis Teams**

Community mental health service (P&NP) teams will provide therapeutic interventions and Care Co-ordination services including:

- Dedicated Cognitive Behavioural Therapy (CBT), pharmacotherapy and care co-ordination response focused on supporting the recovery of people experiencing severe mood and anxiety complaints
- Dedicated Psycho Social Interventions, pharmacotherapy and care co-ordination response focused on supporting the recovery of people experiencing distressing psychotic complaints
- Rehabilitation/recovery functions, including employment, day care and leisure services aimed at supporting people to experience purpose, inclusion and meaning
- Dedicated dementia and frailty service for older adults
- Crisis resolution and home treatment services.

Additional dedicated expertise for specific presentations to support P&NP Teams will include:

- Personality Disorders
- Dual diagnosis (drug and alcohol)
- Eating Disorders

- First episode psychosis (early intervention)
- People with Learning Disabilities who have mental health problems
- Neurological Mental Health
- Autism and ADHD (see Learning Disabilities & Autism Strategy for further information).

## **8.5 Recovery and Inclusion Resources**

Integral to the delivery of services will be the pooling together of recovery and social inclusion resources to support effective care co-ordination and promote mental and physical wellbeing.

At present significant resources are tied up in traditional rehabilitation services that are predominantly inpatient based. In order to deliver a comprehensive recovery service that emphasises rehabilitation in community settings it is planned that existing resources tied up in rehabilitation wards will be directed into more appropriate community based resources linked to individual service user needs.

It is fundamental to the principle of a person-centred approach to ensure the service user is seen as a person and not an illness. To facilitate this, the P&NP teams need to ensure they can support users to access a range of community-based services that will support them to remain engaged in activities of daily living and find meaning, purpose and connection in their lives. It will be the task of the care co-ordinator to support the service user in engagement with mainstream services, i.e. employment, housing, education and leisure. The recovery/inclusion resources will act as a 'pick and mix' menu of resources that can be drawn upon by the care co-ordinator and/or service user to ensure they remain engaged and socially included.

## **8.6 In-patient Services**

Mental Health services should be organised on 'least restrictive' principles, whereby service users received treatment and care in an environment as close to the persons own home and the community as possible. Currently, we think that there are major opportunities to improve home treatment, thereby reducing the number of avoidable unscheduled admissions and also reducing the time patients spend in hospital.

As we improve the effectiveness of our primary care, access and recovery focused mental health services we will also consider the optimal way to configure in-patient services. Initially, we consider that a consolidation of in-patient care across less sites to be a principle that can be applied successfully in both the north and south of Cumbria. We will explore this further with service users, carers and service providers, including of the re-investment back into alternative local services that will be necessary to realise the benefits for patients and their families.

In north Cumbria this would potentially mean consolidating acute mental health inpatient services at the Carleton Clinic site in Carlisle. In south Cumbria this would potentially mean consolidating acute mental health inpatient services at the Dane Garth site in Barrow. Such changes would be subject to much fuller engagement with patients, public and stakeholders, and would require formal consultation.

## 8.7 Transition

Transition from children's to adult services has for many years not been done as well as it should. It was highlighted in "Closing the Gap" and we plan to work with Children's commissioners and CPFT to develop and programme of work to implement national directives and best practice. It has been agreed that as part of the "Earn back" for 2013/14 that CPFT will undertake this work.

## 9 Children's Services

### 9.1 Developing a strategy for children and young people

Working in partnership, we are developing a Child Health Strategy 2014 -2019: *Building Health with Children and Young People*. The vision underpinning the strategy is that the children and families of Cumbria should expect support to be healthy through:

- Fair access to a range of support and services to prevent ill health, provide early intervention and when required have ready access to safe, sustainable high quality health services that are designed around their needs to achieve the best possible outcomes
- Integrated services delivered as close to home as possible, provided by a team of healthcare professionals working together in partnership with children, their families and other agencies.

### 9.2 Key objectives

The key objectives of the strategy are:

- To support children and young people to be healthy and safe by working with partners to strengthen prevention and early help
- To standardise quality and provide better health outcomes providing more focused and integrated services, including children with long term conditions and complex needs
- To develop and implement services to reduce unnecessary hospital attendance and admission
- To develop the whole system pathway to promote emotional resilience and good mental health
- To develop whole system patient feedback across services for children and young people
- To produce a workforce development plan that addresses the needs of the whole workforce
- To develop ways to effectively monitor and support continuous improvement.

Working in partnership with the wide range of agencies involved in the health, care and safety of children and young people, we are developing a model that will deliver the strategy outlined above.

The model will address the needs of all children including those who are acutely ill and the ongoing needs of children and young people with more complex needs and/or who are particularly vulnerable.



The services will be provided by integrated medical and nursing teams working across community and secondary care. The emphasis will be on supporting children and families in the home environment, with a renewed focus on assessment rather than admission. A smaller number of children will be admitted to hospital.

The basic service model is shown below:

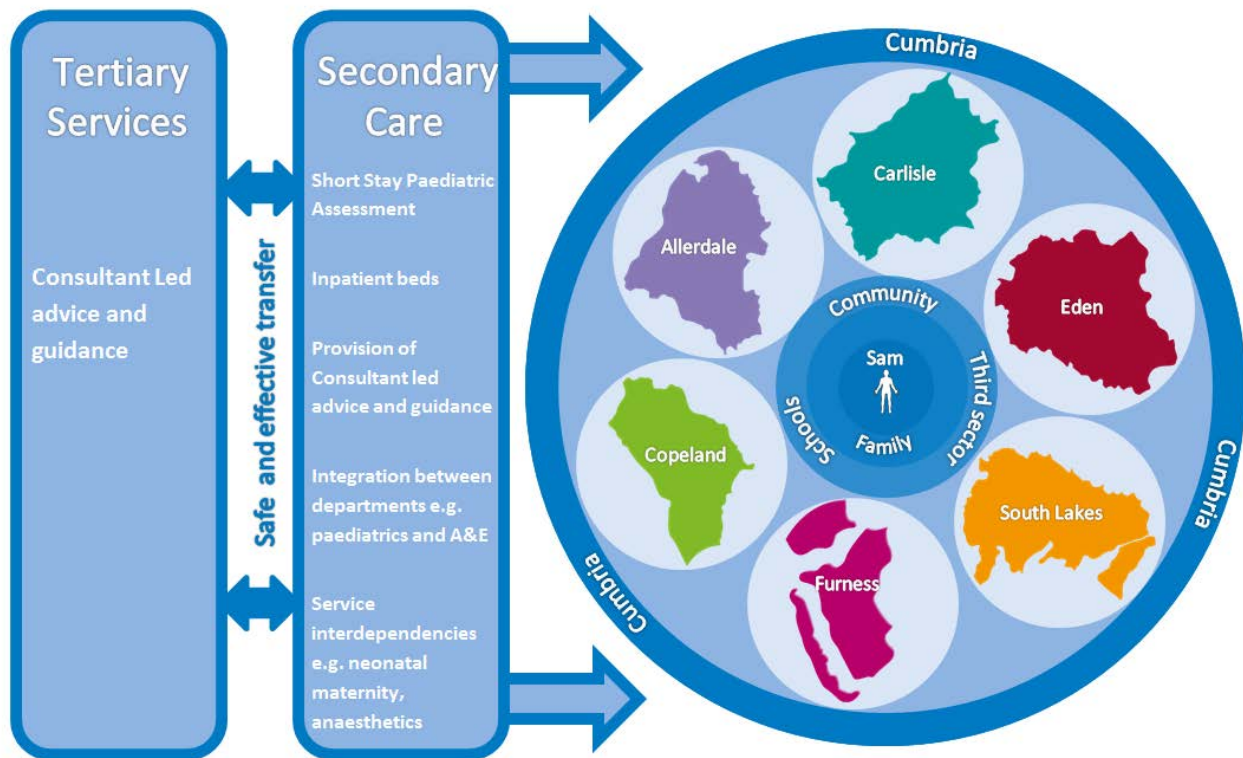


Figure 10: Children's Services model

### 9.3 Prevention and early help

The importance of prevention and early help is a key priority and we are working together as commissioners and providers to support and deliver the prevention agenda and healthy child programme. We will continue to strengthen the partnership with Cumbria County Council children's services to promote early help and the use of Common Assessment Framework (CAF) approach.

Safeguarding practice across the health economy will continue to improve within the Local Safeguarding Children's Board (LSCB) partnership by embedding good practice and developing a culture of learning and continuous improvement.

### 9.4 Primary care

Primary care will be central to meeting the needs of all children and young people and there is a need to have appropriate skills in place to enable this to happen. An advice and guidance service,



established pathways of care, common assessment tool and outreach consultant presence will support primary care.

## **9.5     Unscheduled care**

Children will access the same unscheduled care services as adults, including GPs, GP out-of-hours services, minor injuries and A&E. The specific requirements of the model in relation to children are detailed in *Standards for care of Children and Young People in emergency care settings* and cover the following areas: service design, environment, management of the sick or injured child, staffing and training, safeguarding in emergency care settings, mental health and alcohol substance misuse and major incidents involving children and young people.

When children are acutely ill and require services beyond primary care, GPs will contact a single point of access, where the decision will be made to ensure they receive their treatment in the right place first time. Access will be to an integrated children's nursing team and/or short stay paediatric assessment (SSPA) service for children who require observation and treatment. The SSPA unit operating times will be defined through more detailed analysis of the patient flows. Those children needing care for longer than the short stay unit is in operation should be transferred to an inpatient unit depending on acuity of illness. Assessment and treatment of children and young people with mental health problems will be integral to the model.

## **9.6     Children with complex needs**

Child Health Integration Centres will be based in the localities and will be fully linked to primary care, secondary care and the full health team. The centres will provide a focus for health professionals and partners to work together to ensure the right skills are in the right environment to provide high quality integrated services for children with a wide range of needs. This will include children with more complex needs such as children with disabilities and long term conditions, Children who are looked after and children with mental health problems. The centres will use single assessment, evidence based pathways and will develop the lead professional role to enhance quality services. Complex needs will be planned in partnership.

## **9.7     Integrated children's nursing**

The integrated children's nursing function will develop so that it can both support children with long term needs as well as working with children who are acutely ill to avoid hospital admission or facilitate early discharge.

## **9.8     Child and adolescent mental health services**

Work is underway to develop and implement a comprehensive multi agency framework for emotional health and wellbeing for children and young people. Within the overall model we will work with partners to reduce unnecessary hospital admissions for deliberate and non-deliberate self-harm. The transformation of tier three CAMHS will continue improving the quality of service, response to urgent and non-urgent need and supporting the whole system including supporting and training others.

## **9.9 Transition**

There is also a need to develop services appropriate to the needs of young people as distinct from younger children and also to improve the transitions from adolescent to adult services. This is a theme that will run through the development of the model.

## **10 Population Health**

We will work in partnership, though the leadership and accountability of the Health and Wellbeing Board, to move towards a health promoting system refocused on population health. This will include a focus on delivering the Cumbria Health and Wellbeing Strategy, which set out the importance of each of the following:

- Build a health and social care system based on good intelligence
- Use all available resources
- Involve our communities and the voluntary sector
- Recognise inequalities in all work programmes
- Ensure children get the best start in life
- Prioritise lifestyle improvement, particularly around obesity
- Integrated services and partnership working
- Promote mental and emotional wellbeing
- Good mental health is more than just the absence of mental illness.
- Mental health and physical health problems often coexist
- Improve services and contain mental health related costs
- Increasing numbers of people will live to a greater age with a number of long term conditions
- Support communities to remain independent
- Many more will suffer from dementia
- Build capacity through partnership working.

Importantly, our of Primary Care Communities will have much greater responsibility for their population, including working with partners such as District Councils, the third sector and others to address the wider determinants of health.

## **11 Patient Experience and Safety**

### **11.1 Learning When Things Go Wrong**

NHS Cumbria CCG has established robust systems for driving service quality from a commissioning perspective, led by the CCG Medical Director and Lead Nurse for Quality and Safety. We have developed strong dashboards, working collaboratively with local NHS Trusts and NHS England, and though our Governing Body Quality and Outcome Assurance Committee have strong governance for triangulating information and identifying underlying and interconnected trends. Working with each Trust, we are actively encouraging increased reporting of adverse events, particularly serious incidents, and are promoting a culture of continuous learning enabled by an improved approved to root cause analysis and meta-analysis.

## **11.2 Patient Experience**

We have established a cross system group leading the work on improved capture and use of patient recorded experience and outcomes, including the family and friends test. This is reviewed by the NHS Cumbria CCG lay Governing Body lead for patient engagement, and along with very hard work at the front line in provider Trusts has driven a significant improvement in participation rates and the net promoter score in the family and friends test.

We have established a programme to introduce the iWantGreatCare patient experience system across a number of providers, including working with our GP Practices to use the system. iWantGreatCare is not the only system available, the important thing is that across all our providers we are capable of producing timely, well organised and presented data on patient experience.

## **11.3 Safeguarding**

Our collective approach to safeguarding children is outlined in section 8.5.1. Additionally, we have strengthened our collective arrangements for adult safeguarding, as coordinated by Cumbria County Council and the NHS Cumbria CCG Quality and Safeguarding team. We will continue to embed safeguarding as a core part of all our staff roles.

# **12 Working with NHS England**

## **12.1 General Practice**

NHS Cumbria CCG will continue to have place a great focus on supporting the development of Primary Care as the key building block to successfully delivering our out of hospital model.

The CCG has provisionally expressed interest in formalising the role the CCG will play with NHS England. The outcome of that expression of interest will not be known until later in 2014.

## **12.2 Specialised Commissioning**

Specialised commissioning services are subject to a national review by NHS England and are outside the scope of both the Better Care Together and Together for a Healthier Future strategies. There may be changes arising from the review which will impact on those strategies. We will continue to work with NHS England to ensure that the Cumbria population has appropriate access to high quality specialist services.

A key consideration is the delivery of cancer services. Radiotherapy is currently delivered only in Preston or Carlisle and many patients in south and west Cumbria (especially in the Furness area) are unable to access the service within the 45 minute standard set by NHS England on the advice of the National Radiotherapy Advisory Group. Access within 45 minutes is known to impact on access and uptake.

The former Cumbria PCT was in positive discussions with North Lancashire PCT, UHMBT and Lancashire Care Trust to develop a business case to deliver radiotherapy at Westmorland General Hospital in Kendal. This decision is now on hold with NHS England pending a national review.

The Better Care Together partners support the campaign to provide radiotherapy at Kendal and would strongly urge NHS England to prioritise the resources necessary to establish a sustainable centre at Westmorland General which will ensure all our residents can access high quality care within national standards and which can be a beacon of excellence for cancer care in the wider sub region.

In north Cumbria we will work with NHS England to secure radiotherapy services at Carlisle, including the investment in new Linear Accelerator. We will also work with NHS England to secure the long term, high quality, local provision of clinical oncology in north Cumbria through a well governed clinical network with a specialist Trust delivering services in our local hospitals. Our collective ambition is to achieve a clinically sustainable services, which adhering to recognised standards and delivering excellent outcomes.

It is likely that further developments involving specialist providers delivering more services in our local hospitals may also be beneficial across a number of specialisms.

## **Section 5 Finance, Activity and Outcome Trajectories**

### **1 Outline Financial Strategy**

**We will be constantly refining this financial strategy to enable the delivery of the Better Care Together and for a Healthier Future programmes. This outline financial plan has essentially been developed on an ‘as is’ basis, and will be iterated to fully support our transformational changes over time.**

#### **1.1 Principles**

Over the period 2014/15 – 2018/19 our financial strategy is based on:

- Ensuring the whole system moves towards and then sustains financial balance over a credible time period
- Achieving an optimal deployment of resources to enable the most effective and efficient models of clinical care
- Provides the financial resources to enables the delivery of sustainable services for the population
- Facilitates a planned reduction in the reliance on distress funding by local NHS Trusts.

To achieve this will require the delivery of the service models described in this strategy, and in the more detailed plan for north Cumbria, Together for a Healthier Future, and the Morecambe Bay geographical area, Better Care Together. This will include an increased investment in the out of hospital model, and a reduced reliance on the hospital sector although it should be acknowledged further detailed assessment is require to develop more detailed costings below the “headline” figures. In addition, the CCG considers that potentially alternative contracting models to those currently used in the NHS may be appropriate to manage system risk more effectively and incentivise both commissioners and providers to ensure financial sustainability is maintained.

Where beneficial to the whole system, we will explore the potential benefits of local pricing modification within the context of affordability and the available resource envelope in Cumbria.

#### **1.2 NHS Cumbria Clinical Commissioning Group Allocation**

The financial strategy is predicated on the national planning assumptions for CCG allocations and commissioning responsibilities. Any significant changes to either of those assumptions will clearly impact on the financial strategy. It is noteworthy that the current allocation formula does not reflect the impact of rurality and remoteness, and hence the impact on access and cost of service provision that is a very significant for Cumbria.

#### **1.3 Acute Trusts**

In 2014/15 the investment in both North Cumbria University Hospitals NHS Trust and University Hospitals of Morecambe Bay NHS FT includes significant non-recurring resources, for example to support the Trusts in delivering the 18 week referral to treatment standards and it is assumed

therefore that these requirements will be reduced in 2015/16 (i.e. Investment and activity levels, overall, will be similar to 2013/14).

From 2016/17 onwards, the planned investment is based around an increase in activity, driven by demographic pressures, which is greater than the planned tariff deflator reduction. This means that the Trusts will have marginally increasing income, within which to meet increased demand and inflationary pressures (ie based upon the current model of services). A similar approach has also been used in assessing activity and costs outside Cumbria. This will be reviewed each year, particularly in light of the significant changes to activity that we aspire to deliver through our developing clinical models.

#### **1.4 Cumbria Partnership NHS FT**

The investment in the Trust will be on a 'flat cash' basis, meaning that the commissioner will provide an additional investment to address increased demand from demographic growth equal to the planned tariff deflator. This is part of our commitment to increase the investment in community services, and to ensure parity of esteem for mental health and learning disability services, in each financial year the investment in the Trust will be held constant. This is prior to any further potential deployment of investment resources to address the impact of the strategic change and transformation of "out of hospital services" through our developing clinical models.

#### **1.5 Continuing Health Care and Packages of Care**

The total cost of continuing healthcare and packages of care is forecast to increase by c13% by 2018/19 from the planned 2015/16 level. This reflects the trend for cost growth currently experienced less the efficiency savings we can deliver for example through more effective procurement. It is assumed that the impact of legacy CHC provisions from PCT's are fully covered through the arrangements made in 2014/15 by NHS England.

#### **1.6 Prescribing**

The forecast prescribing cost is based upon net underlying growth experienced for Cumbria over the preceding years, and the marked increase in prescribing costs shown in the most recent indicators, but also reflecting the fact the Cumbria is already identified as a relative efficient level of prescribing spend. This includes a 1.7% growth in 2015/16 from the 2014/15 baseline, and growth in all subsequent years rising to 2.5% in 2018/19 from the forecast 2017/18 investment reflecting both demographic pressures and that the scope for efficiency is diminished over time.

#### **1.7 New Investments**

NHS Cumbria CCG plans to make a £4M investment in predominantly community based services in 2014/15. Those investments will continue on a recurring basis, subject to evaluation, though the Better Care Fund in 2015/16. The CCG plans to make additional investments in 2016/17 of £0.6M, rising up to £4M by 2018/19. This resource, alongside the opportunities through the Better Care Fund of at least £4M recurring, provides our some planned investment in the service models required by this strategy along with funds to manage other known pressures such as re-establishing NHS111 as an effective service. The CCG will additionally seek further cost

improvement opportunities in both its commissioning of services and against its running cost allowance, to generate additional resources to offset any unforeseen cost pressures, and to mitigate the risks of the broader financial assumptions outlined above.

## 2 Outline Activity Plan

The table below shows our overarching activity planning assumptions for all providers at aggregate level across 2014/15 – 2018/19

	% Change year on year				
	14/15	15/16	16/17	17/18	18/19
<b>ALL PROVIDERS</b>					
Elective Admissions - Ordinary Admissions	2.14%	-1.82%	-1.85%	-1.90%	-1.94%
Total Elective Admissions - Day Cases (FFCEs)	2.82%	0.63%	0.63%	0.62%	0.62%
<b>Total Elective FFCEs</b>	<b>2.67%</b>	<b>0.10%</b>	<b>0.10%</b>	<b>0.09%</b>	<b>0.09%</b>
GP Written Referrals (G&A)	-0.76%	0.56%	0.42%	0.54%	0.64%
Other referrals (G&A)	-0.52%	0.00%	0.00%	0.00%	0.00%
<b>Total Referrals</b>	<b>-0.69%</b>	<b>0.40%</b>	<b>0.30%</b>	<b>0.39%</b>	<b>0.46%</b>
<b>Non-elective FFCEs</b>	<b>-1.24%</b>	<b>-0.84%</b>	<b>-1.42%</b>	<b>-1.75%</b>	<b>-1.90%</b>
<b>All First Outpatient Attendances</b>	<b>-0.24%</b>	<b>0.38%</b>	<b>0.29%</b>	<b>0.37%</b>	<b>0.44%</b>
First Outpatient Attendances - following GP Referral	-0.10%	0.57%	0.43%	0.55%	0.65%
<b>All Subsequent Outpatient Attendances (G&amp;A)</b>	<b>-1.65%</b>	<b>-0.18%</b>	<b>-0.14%</b>	<b>-0.18%</b>	<b>-0.21%</b>
<b>A&amp;E Attendances - All types</b>	<b>0.00%</b>	<b>0.00%</b>	<b>0.00%</b>	<b>0.00%</b>	<b>0.00%</b>

Figure 11 : Activity planning assumptions

### 2.1 Trajectory Assumptions

The activity Trajectories for 2014/15 – 2018/19 have been based on a number of assumptions. Most importantly, the assumptions **do not** take account of the activity changes that will result from the implementation of the Better Care Together and Together for a Healthier Future strategic plans. Rather, they have been prepared on an 'as is' basis, and include service changes already at the implementation stage. As such, the assumptions will need to be revisited and will be subject to ongoing iteration.

The **current** assumptions include:

- The impact of Demographic Growth on demand
- Activity required to achieve sustainable 18wk RTT positions
- Growth in Referrals; coding and counting changes
- The impact of planned some Service Developments and Avoidable Admissions reductions, but not our overall transformational actions
- The ongoing increase in day case rates
- The Reduction in outpatient follow-up appointments.

## 2.2 2013/14 Baselines & 2014/15 Trajectories

2013/14 baselines have been based on month 8 forecast outturn MAR figures. In 14/15 an adjustment has been made to account for a data quality issue at NCUH, specifically, in 13/14, NCUH has included specialist activity within NHS Cumbria CCG figures, the Trust intend to correct this from 14/15 onwards and therefore the 14/15 activity reflects a significant reduction in activity to reflect this. Even taking this into account, there is still a significant difference in the volume of Elective Day case admissions in the MAR figures compared to the contract values (MAR is about 3500 admissions higher than the contract baseline), this is likely to be a coding issue between Day Case and outpatients that has been corrected within the contract figures, however, this is still to be investigated by the Trust and CCG.

Detailed assumptions were applied in the 14/15 contracts and the 14/15 activity plans align directly with the forecast change in activity in the contract plans. It should be noted that MAR baselines are not directly comparable to contract baselines due to differences in definitions.

## 2.3 2015/16 – 2018/19 Trajectories

For 2015/16 onwards, slightly broader assumptions were applied as below.

CPFT & Out of county providers – Activity remains static over the 4 years as service developments in other parts of the system cancel out the impact of demographic growth.

NCUHT & UHMBT – the following assumptions have been applied from 15/16 onwards:

- The impact of **demographic growth** – estimated by a local activity model – although this has not been applied to non-GP referrals.
- **Service developments** in Elective reducing the impact of demographic growth
- A shift from Elective Ordinary to **Day Case** activity
- A **reduction in Outpatient Follow up** attendances to keep the total number of outpatient attendances static.
- Reductions in the rate of **Avoidable admissions** in line with plans based on the implementation of the Any Town Interventions. It is expected that these interventions will reduce Avoidable emergency admissions by 12% over the 5 years.
- Stabilisation and reduction in all **other non-elective admissions** through the implementation of the Any Town interventions and other transformation programme interventions over the next 5 years. It is expected that these interventions will reduce all other emergency admissions by 1% plus the impact of demographic growth at each provider.

It is also expected that there will be a shift from Day Case Activity to Outpatients (as Outpatients with Procedure). However, this shift has not yet been quantified but is likely to be significant over the five years.



### 3 NHS Outcomes Framework

Our current performance in relation to the NHS Outcomes Framework is shown in Section 3, The Case for Change earlier in this document.

Measuring and publishing information on health outcomes helps drive improvements to the quality of care people receive. The White Paper: Liberating the NHS outlined the Coalition Government's intention to shift the NHS from a focus on process targets to a focus on measuring health outcomes. Indicators in the NHS Outcomes Framework are grouped around five domains, which set out the high-level national outcomes that the NHS should be aiming to improve. The domains focus on improving health and reducing health inequalities, namely by:

- Preventing people from dying prematurely (Domain 1)
- Enhancing quality of life for people with long-term conditions (Domain 2)
- Helping people to recover from episodes of ill health or following injury (Domain 3)
- Ensuring that people have a positive experience of care (Domain 4)
- Treating and caring for people in a safe environment and protecting them from avoidable harm (Domain 5).

The NHS Outcomes Framework, alongside the Adult Social Care and Public Health outcomes frameworks, sits at the heart of the health and care system.

NHS Cumbria CCG has worse outcomes than national benchmarks in several of the key outcome framework indicators, including premature mortality from Cardiovascular Disease (CVD), respiratory disease and Cancer, unplanned hospital admissions for ambulatory care sensitive (ACS) conditions, for asthma, diabetes and epilepsy in under 19s and for acute conditions that should not usually require a hospital admission. Therefore the levels of ambition for improvement in these outcomes over the next five years is higher than for those where Cumbrian patients are currently achieving better outcomes than national benchmarks.

## Section 6 Our Delivery Arrangements

### 1 Governance for Implementation

We know that good implementation is much more important than a good plan. We have previously fallen short in successfully delivering our plans. To ensure that we are successful this time, we will work together in a well governed, structured way to collectively agree service changes and to collectively manage the system risks and maximise the system benefits, including:

- Continuing the **Cumbria Health and Care Alliance** providing Chief Executive and Medical Director overarching leadership to support an integrated system across all of the county
- Continuing the **Together for a Healthier Future Programme Board** as the main driver of senior cross organisational leadership to ensure delivery
- Continuing the **Better Care Together Programme Board** as the main driver of senior cross organisational leadership to ensure delivery
- Ensuring there is an ongoing programme of **patient, public and stakeholder engagement** so that their views inform any proposed changes and future developments.

### 2 Roles and Responsibilities

The Cumbria Health and Care Alliance will provide the overarching point of strategic leadership for the whole Cumbria system, holding the ring on how we take forward our plans and solving problems together as they emerge. The Alliance will also ensure that consistent principles are applied in both the Better Care Together and Together for a Healthier Future programmes.

The two Programme Boards will form the formal governance for the delivery of the Better Care Together and Together for a Healthier Future programmes, ensuring that the programmes are delivered effectively and that appropriate actions are taken if implementation begins to fall behind plan.

Within each of the programmes, there are clear responsibilities as we move beyond detailed planning. This will mean two distinct elements to each programme, commissioning the new system of care, and providing the new system of care. We will develop robust arrangements to respond to both these elements, and critically to ensure that they continue to be connected as we all work collaboratively to ensure we deliver our collective ambitions for the population.

### 3 Further Work

This strategic plan provides an overarching statement of our direction at a particular point in time. We will undertake much more detailed work, particularly during July – September 2014, to further develop our service models.

We also recognise that as we move towards more defined proposals, we will fully respond to our duties to undertake appropriate engagement and where appropriate public consultation.

**ENDS**



together for a healthier future.

**North Cumbria Strategy  
2014 - 2019**

**June 2014**

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## **VOLUME 3: Supporting Documentation**

### **(NOT INCLUDED IN THIS VERSION)**

The technical detail to be developed July – September

## **VOLUME 4: Public Facing Documents**

### **(NOT INCLUDED IN THIS VERSION)**

The Plain English Version of the Strategy

The Consultation Document (To be developed if needed July – September)

# VOLUME 1: THE SUMMARY

## A FOREWORD

Welcome to the outline strategy for health and care services for north Cumbria, which sets out our thinking about what we need to do to make sure that local people receive the best and safest possible services into the future.

This follows extensive engagement with patients, the public and our key partner organisations and, importantly, with doctors, nurses and other health and care professionals working across the system.

The comments we have received have been invaluable in helping us to shape this outline strategy and while there is much more to do in working through the detail, we feel that this sets out a framework to help us meet the challenges we face.

Allerdale, Copeland, Carlisle and Eden are all wonderful places to live, work and to visit and local health and care services play a vital role in ensuring the overall wellbeing and prosperity of the area.

These services are highly valued by local communities. We know from the feedback we receive from patients that most people, most of the time, have a positive experience of health and care services, receiving the high quality of care that as system leaders we aspire to provide. However, we also know that we have some serious problems that must be addressed. Our system does not reliably deliver the right quality of care which means that some patients do not receive the care they might expect. We can't always attract the right staff which puts additional pressures on our ability to sustain services and our system costs more money than it is allocated. And we know that as the local population becomes older, there will be a greater need for some services.

Such challenges mean that we need to make positive changes to how services are delivered so that we can make sure; that all patients have a good experience of using our services, that our services are as safe and as effective as they can be, based on nationally recognised outcomes, and that we reduce costs.

To achieve this there is a huge commitment to working in a more joined up way to meet the needs of patients so that they can experience seamless care without organisational boundaries getting in the way.

We fully recognise how important it is to our local population to receive as many services as close to home as possible and this outline strategy explains the steps we will take to ensure more effective and accessible community services which reduce the need for patients to go into hospital. This means more responsive services in communities which are much more convenient for local people and which will result in less travelling, which we know is a very big issue for our population.

However, when people need hospital services, these need to be the best and safest possible and for this to be achieved we need to consolidate some of these services. This will ensure that when people need emergency care they go to a hospital that has all of the specialist services that they need to give them the best chance of a good recovery. It will also ensure that when they need a planned operation this can go ahead on the date they have been given and that it is not cancelled because an emergency case has taken precedence, which we know has caused frustration to our patients in the past.

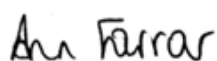
During the development of this outline strategy our work has also included focusing on some specific service areas such as mental health, maternity and children's services and how these can be improved.

But most of all we want our population to be healthy which means providing more support to enable individuals and families to manage their own wellbeing to reduce their risks of becoming unwell or developing long term conditions. When they do become ill we want faster diagnosis and treatment and for them to be active participants in determining the care that they receive.

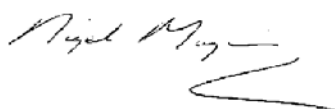
Change is never easy and we recognise that this plan is only a starting point and we have much more work ahead of us if we are to achieve our aspirations for the health and care system in north Cumbria. As our work progresses, we look forward to a continuing conversation with patients, the public and our partner organisations and similarly with all of our health and care professionals to ensure they are properly engaged and empowered to develop new ways of working.

Finally, we would like to offer a reassurance that while change is needed, we fully recognise our statutory obligations in relation to public consultation.


As system leaders, we commend this strategy to you and hope that you will work with us in the months and years ahead to make sure that the people of north Cumbria receive the health and care services they deserve.



**Ann Farrar**  
Chief Executive  
North Cumbria University Hospitals  
NHS Trust



**Nigel Maguire**  
Chief Officer  
NHS Cumbria CCG



**Claire Molloy**  
Chief Executive  
Cumbria Partnership NHS FT

## B EXECUTIVE SUMMARY

### 1 Principles for Success

The following principles for success were agreed by a broad range of clinicians and practitioners. We will achieve better outcomes for the people of Cumbria by building upon the foundations of:

- Putting prevention first
- Being person centred in everything we do
- Rigorously using national and local evidence for our services.

We require pioneering leadership and we intend to:

- Show more respect and better behaviours, both as individuals and organisations, creating a positive and transparent culture for success
- Build the right workforce that learns and trains together, and then works together in collaborative, well-communicating teams
- Create sustainability by building common platforms and continuously improving everything we do.

### 2 Introduction

This document provides a summary of Together for a Healthier Future, the strategic plan for health and care services across the north Cumbria area. The strategic plan was jointly developed by the NHS and upper tier local authority partner organisations serving the north Cumbria area, as part of the collective planning work undertaken as a distressed health economy in the first half of 2014.

### 3 The Case for Change

NHS England, the NHS Trust Development Authority, and Monitor have identified Cumbria as one of eleven challenged health economies across England. This reflects the seriousness of the quality, financial, and sustainability challenges in the local system. We recognise those challenges, and collectively, the leaders of the north Cumbria system have stated that:

**The system has unacceptable gaps in quality;** a wide range of core standards, including NHS Constitution Commitments, are not reliably delivered. There has also been regulatory intervention regarding the quality of services, for example in children's safeguarding. North Cumbria University Hospitals NHS Trust (NCUHT) is currently in special measures, the highest level of NHS escalation, and in 2014 Monitor required enforcement action to be taken by Cumbria Partnership NHS FT (CPFT).

**Our system currently spends more money than it is allocated;**

- In 2014/15 the total forecast spend for services commissioned was c£550m in north Cumbria, the system is only funded to c£520M, a c£30M deficit.



- This is predominantly associated with the planned deficit at North Cumbria University Hospitals NHS Trust of £26.3M. Analysis undertaken by PwC suggests that c£11.8M of the Trust deficit is structural, i.e. the additional costs of delivering services from two relatively small and geographically dispersed hospitals.
- Cumbria Partnership NHS FT are forecasting a deficit of £6.6M in 2014/15 (of which c£4M is attributable to north Cumbria), with an estimated structural deficit of £1.6M.
- Without action, the current deficit in the NHS in north Cumbria will grow to c£87M by 2019. This is driven by the increased cost to deliver services exceeding the increased allocation to NHS Cumbria CCG to commission services, and by the rise in demand.

**We need to change to meet future demand;** the rise in demand is largely driven by demography. The overall population of north Cumbria is forecast to grow by a modest 0.9% by 2019, however the number of people aged over 85 is expected to grow by 19%.

**There has been a loss of public confidence;** our public engagement shows high levels of awareness of the challenges facing the NHS with many people referring to financial and recruitment difficulties. There was also a sense of loyalty to the local NHS with many people, particularly at the road shows, talking positively about their own experiences of GP, community and hospital services. It is clear that while there are many instances of positive experience, there are also some where the care people received was not what they would have expected, for example:

- Access to GP and hospital appointments and cancellations
- The difficulties of travelling and public transport, the cost of buses and taxis, but with a clear recognition that travelling is sometimes necessary if patients need specialist care, and that quality can be more important than distance
- Frustration about car parking at Whitehaven and Carlisle hospitals
- The need for services to be more joined up particularly for older people and those with complex health needs.

**We can't always attract the right staff;** across north Cumbria it continues to be very difficult to attract the right clinical staff, particularly in some specialist areas. In 2013/14 the percentage of the total workforce cost spent on short term staff was 11.3% for North Cumbria University Hospitals NHS Trust and 8.9% for Cumbria Partnership NHS FT, significantly higher than national benchmarks. Local insights show an increasing difficulty to recruit to general practice, with a large number of the current workforce reaching retirement age in the next five years.

**We don't always provide care in the right environment at the right time;** the audit of medical admissions carried out by the Oak Group showed that care could be provided in alternative environments for:

- 23% of medical admissions and 62% of continuing days at NCUHT (much of which relates to sub-acute needs, which could potentially be met in community hospitals)
- 18% of admissions and 47% of continuing bed days in community hospitals.

This position is typical across England, major change is reliant on out of hospital options.

We know that we also do not have the right level of capacity to reliably deliver all of the national standards, particularly the 18 week referral to treatment standard.

## 4 How We Developed Our Plan

In February 2014 the North Cumbria Programme Board was formed. Its purpose is to give overarching programme leadership to the development of a strategy for the north Cumbria health and social care system which:

- Reduces harm through high quality, clinically sustainable services
- Is financially sustainable
- Is founded on patient, public, practitioner and clinical engagement.

The Programme Board agreed that the strategy would need to focus on a dynamic out of hospital model capable of enabling the reconfiguration of in hospital provision and securing care closer to home where possible. To support the development of the strategy, the Programme Board mandated each of the following pieces of work, enabling us to begin to describe a clear direction of travel for the north Cumbria system, as outlined in this summary.

**Care Design Groups;** a broad range of clinicians, social care and third sector practitioners have developed solutions for each of Out of Hospital services, Hospital Services, Mental Health and Maternity through facilitated care design group sessions.

**Clinical Principles;** through the Cumbria Learning and Improvement Collaborative (CLIC) over 100 clinicians took part in full day workshops to construct the guiding principles for developing and delivering our strategic plans across Cumbria.

**Hospital Admissions Audit;** we commissioned an international organisation called the Oak Group to review a sample of urgent care admissions to identify if care could be provided in alternative environments.

**Maternity Strategic Clinical Networks (SCNs);** we held a joint full day workshop with the North East and North West SCNs with clinicians from across Cumbria to develop solutions for the sustainable delivery of maternity services.

**Modelling and Analysis;** supported by PricewaterhouseCoopers, we have begun to model potential solutions in terms of activity, workforce, and financial implications, at a headline level.

**Public and stakeholder engagement;** over 1,000 members of the public or their representatives have taken part in public engagement activities, including 13 roadshows held in public venues and delivered in partnership with Healthwatch Cumbria, 20 independent focus groups targeted at five specific service areas, two large events for the third sector facilitated by Cumbria CVS and 11 meetings with representatives from county, district and parish councils, including the Health Scrutiny Committee.

**Single Version of the Truth;** we commissioned PricewaterhouseCoopers to develop a single version of the truth to provide a baseline assessment of our sustainability challenge.

**Stakeholder Engagement;** a wide range of meetings have been held with district and parish councils, third sector organisations and Cumbria Health Scrutiny Committee.

## 5 The Future Model of Care

### 5.1 An Integrated System

We will work collaboratively, to ensure our system delivers seamless care without organisational boundaries and to solve the challenges we face, putting the interests of the patient and the whole system ahead of individual organisational and professional group interest. To do this, we will develop much stronger systems of shared governance and delivery arrangements, ensuring that taking forward parts of the service models will not have unforeseen or avoidable negative consequences across other services. The North Cumbria Programme Board will support this way of working, as will the established Cumbria Health and Care Alliance, formed in 2013 to enable cross system problem solving and to promote integration.

### 5.2 The Out of Hospital Model

The out of hospital model is designed to enable integration across community hospitals, and joined up working between services traditionally delivered in the community and in hospitals. For the model to be successful, there will need to be a programme of development and support to enable general practice to continue to successfully form the foundation of the system. The out of hospital model is comprised of five elements:

- **Primary Care Communities** are a group of care professionals and third sector staff working in partnership to improve the wellbeing of the population. They are built up from GP practice registers and will cover populations of between 15,000 and 40,000, configured around natural communities.
- **The urgent care co-ordination centre** will ensure that patients get to the right place in the system at the earliest opportunity. It will work with the primary care community team and track patient journeys using real time system information, and support effective hospital discharge.
- **Integrated rapid response services** will include a multi-disciplinary team designed to avoid hospital admission where appropriate and support early discharge.
- **Community specialist services** will operate across the out of hospital model, providing specialist support for patients, in localities where possible but with good access to hospital based services. This will include dedicated time to advise GPs and patients outside a traditional clinic environment, and providing a key role in training and education for other professionals.
- **Referral support system** will enable appropriate referral and patient choice in accessing elective interventions, including access to specialist advice and guidance, improved access to diagnostic in the community the development of care pathways across specialities including shared decision aids.

## **5.3 Improving the Sustainable Delivery of Hospital Care**

We are committed to a successful future for both Cumberland Infirmary Carlisle and West Cumberland Hospital. Those hospitals are very highly valued by our communities, and provide local access to vital clinical services. There are real challenges in delivering quality care in our hospitals, however, and in order to secure consistently delivered high quality care, with a clinically and financially sustainable workforce, the service model needs to change.

We have not developed options for the required change. Rather, we have developed scenarios across a continuum of change, which will be continually reviewed. We will move along the continuum as senior clinicians judge necessary to secure quality, clinical and financial sustainability. All changes will need to be supported by strong evidence and will take into consideration the views of patients, the public and our key stakeholders. We fully recognise our statutory obligations in relation to public consultation and we are committed to working with the overview and scrutiny committee to ensure these are carried out in line with requirements.

### **5.3.1 Elective Care**

There are clear advantages in consolidating the provision of elective services, including reducing duplication, improving efficiency, and ultimately improving patient outcomes. We have the opportunity to maximise the benefits from the redeveloped West Cumberland Hospital to deliver an elective centre of excellence for low risk, high volume procedures. Recognising the interdependencies with critical care on both sites, our direction of travel over time is therefore:

- To significantly increase the total number of elective in-patient episodes at West Cumberland Hospital. This will support the delivery of the 18 week referral to treatment standard, reduce cancelled operations, and improve outcomes.
- To develop Cumberland Infirmary Carlisle to deliver higher risk elective procedures, but with a reduction in the total number of in-patient elective procedures at the site. This will ensure the right clinical capacity and capability to improve outcomes for more complex / higher risk patients and procedures.
- To continue to provide outpatient appointments and procedures, day cases and diagnostics will continue at both sites to ensure access.

### **5.3.2 Unscheduled care**

High quality unscheduled care, on a seven day a week basis, can only be reliably delivered by ensuring the right clinical capacity and capability can be provided on a sustainable basis. This will require changes to our current service model, primarily through an increased consolidation of higher risk / complexity unscheduled care at Cumberland Infirmary Carlisle.

The population of west Cumbria will continue to need to be able to access accident and emergency services at West Cumberland Hospital, and to access the continued provision of lower risk medical interventions and admissions. In order to reliably meet the needs of those patients though, over time, higher risk / complexity patients will need to be admitted to Cumberland Infirmary Carlisle, in some cases following stabilisation at West Cumberland Hospital.

As outlined above, our current planning is based on a continuum. We will carefully gather and consider the evidence, including operational risks, to support any moves along the continuum. Potentially, this could include a further consolidation of all acute medicine at Cumberland Infirmary Carlisle, or the closure to medical admissions at West Cumberland Hospital late at night. However, such a consolidation would require public consultation, extensive planning and risk assessment, including the difficult challenge around emergency transport and the safe conveyance of patients.

### **5.3.3 Maternity Services**

Following the consideration of a much longer list of options, we have identified three options for maternity services across north Cumbria. These are:

- A co-located Consultant led maternity unit and a midwifery led maternity unit, at both West Cumberland Hospital and Cumberland Infirmary Carlisle
- One co-located Consultant led maternity unit and midwifery led maternity unit at West Cumberland Hospital
- One Consultant led maternity unit, co-located with a midwifery led maternity unit at Cumberland Infirmary Carlisle and a midwifery led unit in Allerdale.

In each of these three options the birthing unit at Penrith will continue. The continuation of a Consultant led service in West Cumberland Hospital is only possible with a change to the rest of the service offer at the hospital, particularly in relation to the sustainable provision of anaesthetics. There are important inter-dependencies with the configuration of urgent care described in section 3.2.2.

## **5.4 Clinical Networks**

Increasingly our local services will need to form networks other providers, including:

- Some services will be delivered by Tertiary Centres 'in reaching' to Cumberland Infirmary Carlisle, potentially including large parts of cancer pathways
- Some small specialties cannot be sustainably delivered in north Cumbria or delivered through in-reach, and where necessary there will be an increase in patients travelling to Tertiary Centres
- Mental health services will need to explore options for joint clinical development, including across pathways which are difficult to provide fully in Cumbria
- Specialist community services, for example the Neurology service.

## **5.5 Community Hospitals and Minor Injury Units**

From our public engagement we know how valued the community hospitals across north Cumbria are to local communities. We are committed to a positive future for all the community hospitals in north Cumbria. They provide a vital role in ensuring local access to services and enabling needs to be met in the most appropriate care environment. Our community hospitals will need to continue to adapt, including:

- Minor injury units will be more clearly differentiated between those that are an extension of Primary Care and Community Services, and those which need to be part of an urgent care network working with the acute trust type 1 accident and emergency units
- Community hospitals will be delivered as part of an urgent care network, with shared governance and delivery across acute and community hospital elderly care beds
- Each site needs to move to optimal bed numbers based on a staffing ratio of 1 qualified nurse to 8 patients per shift
- A change in the role for some community hospitals, providing hybrid joint unit for health and social care accommodation and as wellness hubs
- All community hospitals to provide a wellness hub, including ambulatory care, outpatients, social care and third sector resources to support wellbeing and independent living.

## **5.6 Children's Services**

Working in partnership, we are developing a Child Health Strategy 2014-2019 called Building Health with Children and Young People. The vision underpinning the strategy is that the children and families of Cumbria should expect support to be healthy through:

- Fair access to a range of support and services to prevent ill health, provide early intervention and when required have ready access to safe, sustainable high quality health services that are designed around their needs to achieve the best possible outcomes
- Integrated services delivered as close to home as possible, provided by a team of healthcare professionals working together in partnership with children, their families and other agencies.

## **5.7 Mental Health Services**

Partner organisations across Cumbria are working to produce a comprehensive Adult Mental Health Strategy for October 2014, which will provide a fuller direction of travel for those services. An independent review of adult mental health services, jointly commissioned by the CCG and local authority and delivered by Cumbria Partnership NHS FT working jointly with Cumbria County Council, carried out by the Centre for Mental Health has further identified the service areas we need to improve. From the review, and our earlier work, we will:

- Address access to services, including CRISIS and Home Treatment
- Improve the functioning of Community Mental Health Teams
- Move to a greater focus on a recovery model, including maximising opportunities to work with the third sector
- As we improve the effectiveness of our primary care, access and recovery focused mental health services we will also consider the optimal way to configure in-patient services.

## **6 Delivering the Strategy**

We know that good implementation is much more important than a good plan. We have previously fallen short in successfully delivering our plans. There is a huge commitment to ensure that we are successful this time. We will work together in a well governed, structured way to

collectively agree service changes and to collectively manage the system risks and maximise the system benefits, including:

- Continuing the Cumbria Health and Care Alliance, providing overarching leadership to support an integrated system across all of the county
- Continuing the North Cumbria Programme Board, which will provide senior cross organisational leadership to ensure delivery
- Ensuring there is an ongoing programme of patient, public and stakeholder engagement so that their views inform any proposed changes and future developments.

Our next steps will include:

- Formalising a strong clinical advisory group, comprised of senior clinicians from across the organisations, to assess progress and guide decision making
- Exploring options to identify a high performing local system that can work with us to provide challenge, support and guidance, and to also seek an objective, external source of expertise to help us to stay focused on delivery
- Developing fuller, more detailed and robust implementation plans, including detailed modelling of activity and finance, during July - October
- Instituting a shared programme office function, to keep track of delivery and to enable escalation and the right skills to support implementation across organisational boundaries
- Enabling organisational development through Cumbria Learning and Improvement Collaborative (CLIC) to support front line clinicians and managers to deliver the change.

A really important step for us is to determine the overall system financial model, and how that supports the financial position of each partner. This will include quantifying more precisely the problem we are trying to solve in financial terms, and how the problem will be solved across a mixture of routine cost improvements, savings from service consolidation, and savings from a transformation of the whole system.

# VOLUME 2 THE STRATEGIC PLAN

## A THE CASE FOR CHANGE

### 1 Our Overall Demographic and Geographical Context

- We are the oldest population in the North West and ageing at a faster rate. Within 20 years our age dependency ratio (ratio of retired to working age) will be twice that of Greater Manchester.
- Our over-85s are rising at 5% a year, and dementia cases at 4% per year. We face a massive challenge of frailty and multimorbidity.
- We are a county spread across 2600 miles (all of Cumbria) – half the landmass of the North West but a tiny percent of the population.
- Our west coast hosts geographically isolated and economically deprived small towns and villages. This presents major challenges for service delivery.
- Other areas are sparsely populated with the Eden Valley having just 24 people per square km, compared to Islington in north London with 13,875 people per square km.
- We have the most obese locality in England (Copeland) and high levels of type 2 diabetes in both adults and children.
- Recruitment of nurses and medical staff is increasingly challenging for all providers.
- We have major differences in health outcomes across the county – people in parts of Allerdale spend twice as long in their life suffering ill health than people in the Eden Valley.

The age distribution of the population of north Cumbria is expected to change significantly over the next five years. While the overall population of north Cumbria is forecast to grow by 0.9%, the number of people aged over 85 is expected to grow by 19%. This is a bigger shift than the national forecast, the total population growth across all ages is 4.3%, and in the over-85 population 18.1%, as shown in figure 1 below.

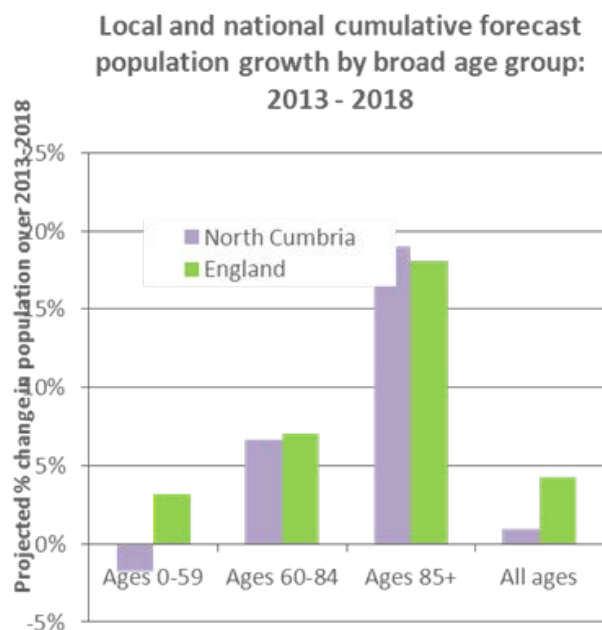


Figure 1 : Local and national cumulative forecast population growth



Overall, older people have both more frequent and more complex care needs. As such, an ageing population has a disproportionate effect on the overall demand for health and social care services. For example, currently 28% of people in north Cumbria are aged 60 and over, but 42% of all secondary care activity is provided to this age group. Another example is dementia, which affects 1.3% of the national population at age 65, but 12.2% of people by age 82. This means that demand for care services will increase more rapidly than general population growth, as a result of the ageing population.

## 2 Key findings from Engagement Activity

A comprehensive report is available detailing the feedback from the engagement activity. This includes an overview of key messages from the 13 public road shows, the two events for the third sector, the 20 independent focus groups and the 12 meetings involving county, district and parish councils. It also has attachments with more detailed feedback from Healthwatch Cumbria which was commissioned to deliver the road shows, Cumbria CVS which was commissioned to facilitate the events for the third sector and TNS which was commissioned to carry out 20 focus groups.

While this activity embraced people with different interests and from different geographical areas, there were some consistent themes which are outlined below. There were high levels of awareness of the challenges facing the NHS with many people referring to financial and recruitment difficulties. There was also a sense of loyalty to the local NHS with many people, particularly at the road shows, talking positively about their own experiences of GP, community and hospital services. However, looking across all of the feedback it is clear that while there are many instances of positive experience, there are also some where people feel that the care they have received has not been what they would have expected.

In meetings with the councils and the third sector it was clear that they wanted to be more involved in working with the NHS.

There is much detail to work through, particularly in relation to the findings of the focus groups which explored five different service areas but some of the emerging themes are as follows:

**Access to services:** There were many comments about access to GP services with people talking about the frustration of having to ring the practice at 8am for same day or urgent appointments and not being able to see the same GP so they felt there was a lack of continuity. People talked about long waits for hospital treatment and there were many comments about appointments and operations being cancelled and a feeling that the administrative arrangements were not always as efficient as they should be.

**Travel:** Travel was a big issue with many comments about the distance people often have to travel for services and how the timings of appointments means they have difficulty in getting there by public transport. It was felt that sometimes this can result in further disadvantage for some communities and can increase health inequalities. There were also comments about the lack of public transport, the cost of buses and taxis and there were strong comments about the difficulty in parking at Carlisle and Whitehaven hospitals. Although travelling was a big issue there was recognition that it is sometimes necessary if patients need specialist care and in the focus groups in particular there were indications that quality was more important than distance.

**Better integration:** There were many comments about the need for more joining up across services, particularly for older people and those with complex health needs. This included strong messages about the need to work more closely with the third sector.

**Better communication:** There were also comments about better communications across services and with patients, with experiences of breakdowns in communication, particularly between GPs and hospitals.

**Loss of local services from Whitehaven:** There were also comments about services being taken out of Whitehaven and being moved to Carlisle with concerns about what services would be available on the redeveloped hospital site.

**Patient experience:** While there were many positive comments about local NHS staff, some felt that it was no longer a vocation but just a job and that the personal touch was increasingly missing. There were also comments that sometimes the basic incidentals not being there such as toys and water coolers in GP practice waiting areas and extra pillows in hospitals for patients.

**Importance of prevention:** The importance of prevention was stressed at the road shows and at the third sector events, which included messages about the role that the sector can play in all of this.

## **3 Outcomes and Inequalities**

### **3.1 Outcomes**

As clinical leaders, improving outcomes for our communities is what drives us. We must lead our local health economies to use the challenges we face, financial and otherwise, as a platform to make real and transformational change which will make significant improvement to the quality of care provided to our patients and the outcomes we achieve. All CCGs, together with their NHS England Area Teams are being asked to jointly set levels of ambition against seven overarching outcomes. The seven outcomes are deliberately broad so as to drive improvement for all our local population. These are rooted in the NHS Outcomes Framework.

For measures where NHS Cumbria CCG currently performs below national benchmarks, the CCG has set more challenging levels of ambition, recognising both the increased need and potential for change. All these levels of ambition are underpinned by the initiatives set out in this strategic plan and, while challenging, are realistic ambitions for improving outcomes for our population, as shown in the chart below.

Figure 2 : NHS Outcomes Framework – Seven Ambitions

Ambition area		Metric	2012 / 13	2018 / 19	Change	RAG
1	Securing additional years of life for the people of England with treatable health conditions.	Potential years of life lost from conditions considered amenable to healthcare	2151	1816	15.6%	
2	Improving the health related quality of life of people with one or more long-term condition	Health related quality of life for people with long-term conditions (measured using the EQ5D tool in the GP Patient Survey).	71.1	76.7	7.9%	
3	Reducing the amount of time people spend avoidably in hospital	Composite Measure on emergency Admissions	2204	2009	8.7%	
4	Increasing older people living independently at home following discharge from hospital.	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	84.3	88.0	4.4%	
5	Increasing the positive experience of hospital care.	Patient Experience of Inpatient Care (proportion of poor responses)	118.5	137.0	-15.6%	
6	Increasing the positive experience of care outside hospital, in general practice and in the community.	The proportion of people reporting poor experience of General Practice and Out-of-Hours Services	4.30	4.28	0.5%	
7	Progress towards eliminating avoidable deaths in our hospitals caused by problems in care.	Hospital Deaths Indicator in Development	N/A	N/A	N/A	

**Legend: National Quartiles**

Bottom	
2nd Bottom	
Middle	
2nd Top	
Top	

### 3.2 Population Health and Inequalities

The health of people in Cumbria is varied compared with the England average. Overall, deprivation is lower than average, however there are some high levels of deprivation, with areas of the county falling in the most deprived 10% nationally. Deprivation is particularly severe in the urban areas of Barrow and west Cumbria. 15.4% of children in the county live in poverty below the national average of 21.3%, however in one ward in Copeland the percentage of children living in poverty rises to 49.2%. Although deprivation is most prevalent in Cumbria's urban areas there are also hidden pockets of deprivation in some of the county's most rural communities.

Cumbria's overall performance in a range of health and wellbeing indicators disguises significant inequalities in health outcomes. 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 areas 8.4 years below the national average. Health outcomes in north Cumbria are poorest in Copeland and Carlisle whereas Eden has high levels of health and wellbeing. With the exception of Eden, all districts have problems around alcohol misuse. Poor mental health is also an issue for the county with incidences of neuroses, self-harm and suicide higher than those nationally.

The chart below shows the correlation between deprivation and mortality, and demonstrates the need for us to work much more strongly across the health and care system but also with all our partners to address serious inequalities.

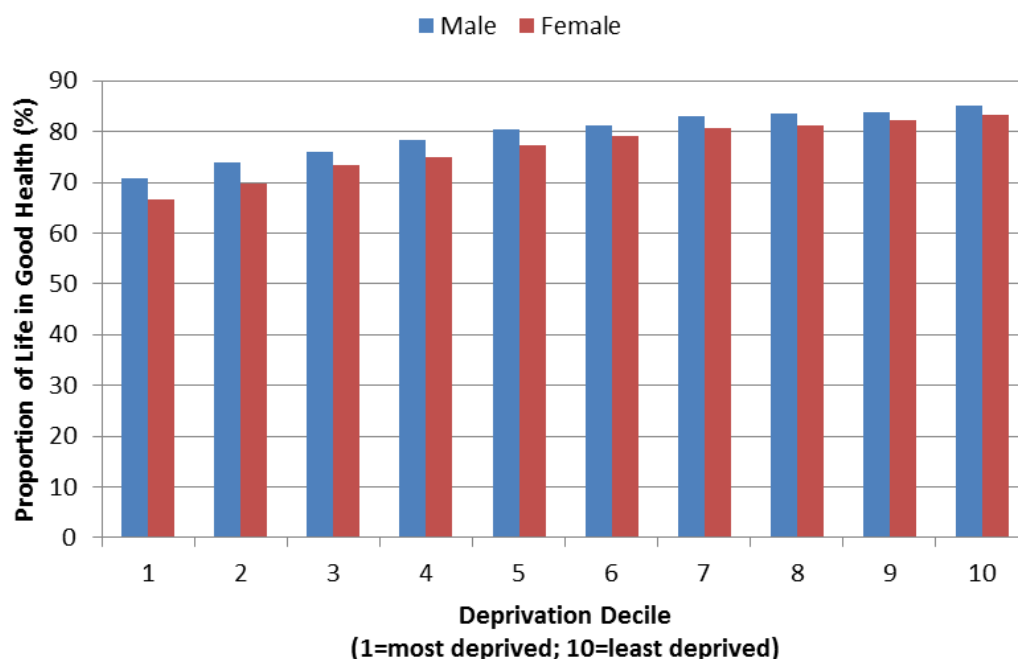


Figure 3 : Correlation between deprivation and mortality

## 4 Performance and Quality: Delivering Standards Reliably

### 4.1 NHS Constitution Standards

Our system does not reliably deliver the standards associated with the NHS Constitution. The performance of the north Cumbria health community is consistently below the national operational standards on a number of measures from the Expected Rights and Pledges within the NHS Constitution.

**Cancer waiting times:** NCUHT has failed the maximum 62-day wait standard for referral from a GP to first definitive treatment for all cancers for 11 out of the last 13 months (April 2013 to April 2014). In January 2014 NCUHT also failed the maximum 31 day targets for surgical, drug and radiotherapy treatment, the first time it has failed all three at the same time, and in April 2014 the 14 day from referral to first OPA standard was not achieved, a standard that NCUHT had achieved for the previous six months. Again this presents a risk to delivery of optimal cancer care for the north Cumbrian community.

NCUHT has failed to achieve the **18 week referral to treatment time** throughout 2013/14 and continues to fail in 2014/15 at May 2014. NCUHT is also inconsistent in achievement of the incomplete pathways. Cumbria Partnership NHS Foundation Trust (CPFT) regularly underperform on the 18 week non-admitted standard in services commissioned by the CCG. This is in the specialties of neurology and community paediatrics. Figure 4 shows the performance against the 18 week referral to treatment standard during 2013/14 at North Cumbria University Hospitals NHS Trust. The standard has not been delivered in any of the last 12 months, and performance has actually worsened during the time period. Our system has not been able to deliver the required level of capacity during this time, particularly in some specialties.

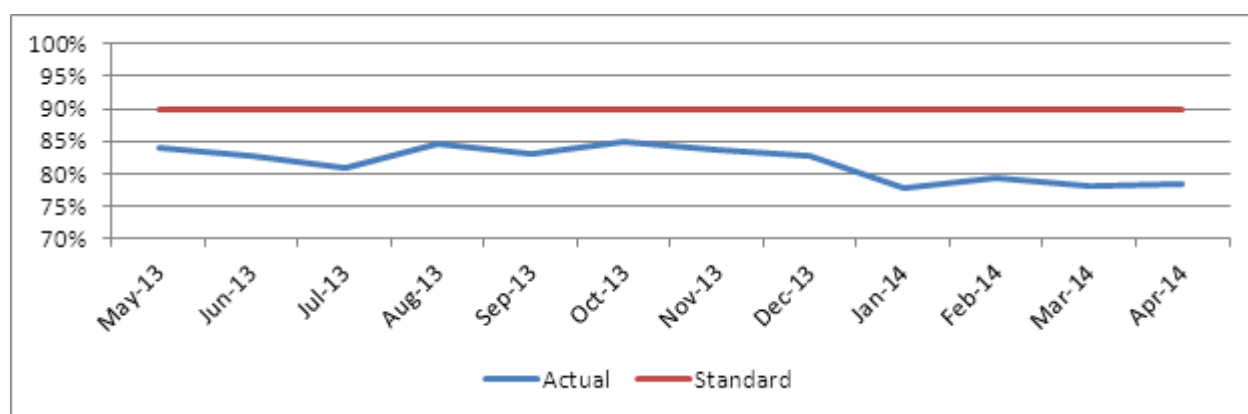


Figure 4 : Referral to Treatment 18 Weeks Admitted

In addition NCUHT and CPFT are now also not achieving the **diagnostic 6 week wait standard** by a significant amount - 16.0% overall (15.9% for CCG commissioned services only) and 18.6% respectively at May 2014. NCUHT is also failing to achieve the standard for **cancelled operations not rebooked within 28 days**. Together these present a risk to north Cumbria in terms of the challenge to achieve the elective pathway standards for patients into the future.

**Urgent Care Services:** The standard is a responsibility of the whole system, and provides a good indication of the reliability and effectiveness of the whole urgent care system. For a large part of 2013/14 NCUHT has not achieved the four hour waiting time standard for A&E. In February and March 2014 performance improved dramatically with the 95% standard being achieved almost every day, as a result primarily of internal changes to the Trust that improved patient flow. However, performance since then has been extremely variable and the current Quarter 1 performance at 8/06/2014 is 93.2%. In addition, whereas previously NCUHT have performed well on ambulance delays their performance on this standard has deteriorated in recent months with 89 >30 minute delays in May 2014. Urgent care services therefore continue to be challenged across north Cumbria and effective, substantial and deliverable urgent care plans will need to be implemented in the next two years to ensure a sustainable system is in place into the future.

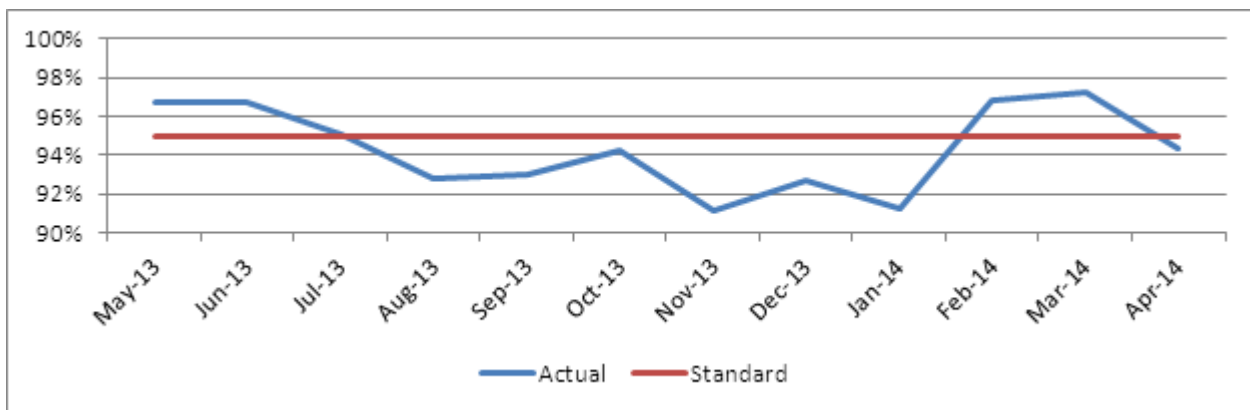


Figure 5 : Accident and Emergency Standard

This level of underperformance is a clear driver for change. Our current approach to performance management has not delivered sustained gains across all the standards.

## 4.2 Variations in Reliably Delivered Services

We know that there are significant variations in the delivery of services right across the system. For example:

**Primary Care:** Although general practice across north Cumbria has a high level of Quality Outcome Framework (QOF) attainment, there is very wide variation in the levels of disease registers (case finding) compared to forecast disease prevalence, and in the consistent delivery of interventions. Similarly, there are widely varying utilisation rates of hospital services, though both elective referral and unscheduled care, which are not a correlation of overall morbidity.

**Hospital Care:** We know that hospital mortality as measured through both HSMR and SHMI consistently show higher rates of mortality at West Cumberland Hospital than at Cumberland Infirmary Carlisle, although overall mortality as recorded through these measures has significantly improved in the last year.

**Mental Health Services:** There is a significant variation in access to Improving Access to Psychological Therapies (IAPT) services, and services for severe and enduring mental health, across

north Cumbria, and significant variation in the interventions service users receive for comparable needs.

### **4.3 Delivering Care in the Right Place, at the Right Time**

We commissioned the Oak Group to carry out an audit at North Cumbria University Hospitals NHS Trust (NCUHT) in February-April 2014 and the community hospitals delivered by Cumbria Partnership NHS Foundation Trust (CPFT). This audit was undertaken in order to facilitate improvement of care quality and reduction in delivery costs by identifying patients in the acute setting whose care could be delivered in an alternative setting (non-qualified admissions or bed days).

The audit looked at 166 admissions to NCUHT across a range of demographic groups, admission types and specialties and are assumed to be representative of non-elective admissions. The audit also looked at 101 patients admitted to community inpatient units at Penrith Hospital and Wigton Hospital. Reviews were undertaken on both admissions and continuing days of stay. The audit showed that care could be provided in alternative environments for:

- 23% of medical admissions and 62% of continuing days at NCUHT (much of which relates to sub-acute needs, which could potentially be met in community hospitals)
- 18% of admissions and 47% of continuing bed days in community hospitals.

This position is typical across England, and any major change is reliant on developing more effective out of hospital options and an increased use of sub-acute wards.

Potentially, this means that through the right investment in primary care and community services, and by ensuring the right pathways during each hospital episode, we could significantly free up capacity in the hospital system, and deliver much better patient experience, clinical outcomes and clinical safety. This would be through use of reablement in peoples own homes to ensure they reach their potential, and recognising that coming out of hospital is not the end of the journey, we need to provide effective care to people in their own home.

For this to be effective, we will need to invest in community services at the maximum possible scale, within the constraints of the financial resources and indeed actual workforce available.

Some of that capacity could be redirected to ensuring that we reliably meet standards in delivering high quality elective services, including the 18 week referral to treatment and cancer waiting time standards. This needs to be viewed in the context of using the hospital capacity we do have much more efficiently.

## **5 Workforce**

### **5.1 Feedback from our Staff**

Overall, our staff tell us that things need to change. While staff in some specific services show very high levels of professional satisfaction, this is not the norm. Overall, our staff have consistently

provided feedback, including through the national staff survey, that shows lower levels of satisfaction and lower levels of confidence in the service delivered than any national benchmark.

Our staff have repeatedly identified ways in which they could be better supported and enabled to drive service improvements. Although there are signs that we are becoming much better at responding to those issues, there is still clearly lots of room for improvement.

## 5.2 The Workforce of the Future

We also recognise that the clinical skills and shape of the workforce needed in the future will be different to the skills needed today. In part, we will need some changes to the national training models and the number of trained staff, in some areas the level of shortage nationally means that it will continue to be a challenge to recruit the right skills in all specialities and disciplines.

Some of the important principle changes we can make locally include:

- Integrated roles without unproductive professional demarcations, using professional skills for the maximum benefit of patients
- More effective working with the third sector and supporting volunteers and natural community support functions
- Change in working behaviours – more proactive roles with a stronger health and wellbeing promoting function
- Stronger emphasis on reablement and empowering patients to be more involved in their care and support means the function of staff is to empower patients
- Reducing, avoiding and delaying the need for statutory services so when need the skills and capacity are really needed they are available quickly.

## 5.3 Reliance on Temporary Staff

Delivering sustainable services is dependent on recruiting, retaining, and developing our workforce. Currently, we have a major over reliance on temporary staff, including on locum consultants, middle grade and junior doctors. The chart below shows the total expenditure on temporary staff in each of North Cumbria University Hospitals NHS Trust and Cumbria Partnership NHS FT, with a combined figure for the north Cumbria system.

	NCUHT	CPFT	Total
<b>Substantive Spend (£m)</b>	£139.9	£94.7	£234.6
<b>Temporary Workforce Spend (£m)</b>	£17.8	£9.3	£27.1
<b>% of total Staff Spend</b>	11.3%	8.9%	10.4%

Figure 6 : Actual Spend on Temporary Staff

There are clear opportunities to reduce spend on temporary staff. By moving to a good practice of 4.5% of staff spend being on temporary staff, the north Cumbria health economy could save just over £9.5m. More importantly, reducing the reliance on temporary staff would deliver improved continuity of care and overall quality. This will only be achievable in some services by changing the service model, as the current ways of working are not attractive to potential staff.



## 6 Financial Sustainability

In 2014/15 the total forecast spend for services commissioned was c£550m in north Cumbria, whereas the system is only funded to c£520M, giving a deficit of c£30M.

This is predominantly associated with the planned deficit at North Cumbria University Hospitals NHS Trust of £26.3M. Analysis undertaken by PricewaterhouseCoopers suggests that c£11.8M of the North Cumbria University Hospitals NHS Trust deficit is structural, i.e. the additional costs of delivering services from two relatively small and geographically dispersed hospitals. Cumbria Partnership NHS FT are forecasting a deficit in 2014/15 of £6.6M (of which c£4M is attributable to north Cumbria), with the Trust's estimate of the structural deficit of £1.6M.

Without action, the current deficit in the NHS in north Cumbria will grow to c£87M by 2019, as shown in figure 7 below.

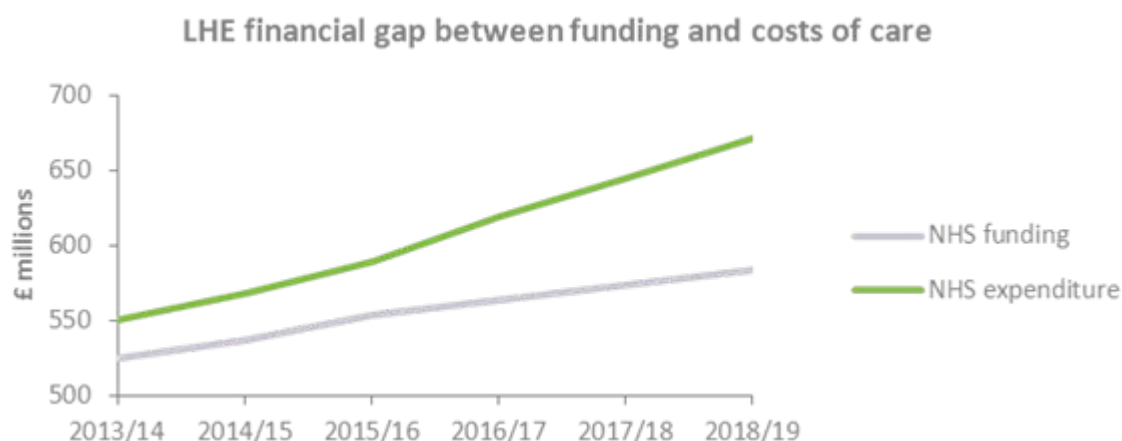
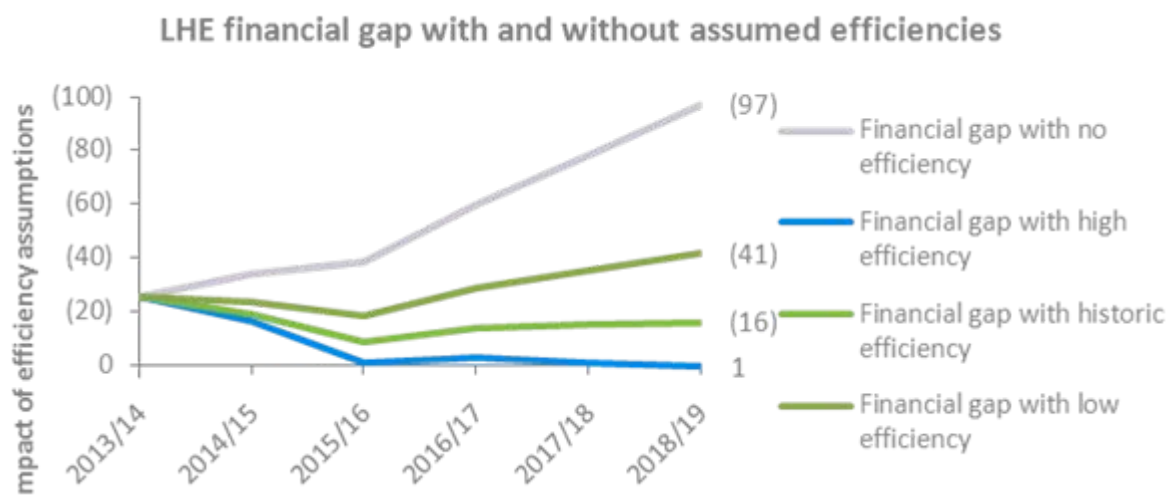


Figure 7 : LHE financial gap between funding and costs of care

This is driven by the increased cost to deliver services exceeding the increased allocation to NHS Cumbria CCG to commission services, and by the rise in demand. In order to reverse our growing deficit, and to achieve financial balance in the future, significant cost improvements will need to be delivered. Figure 8 below shows arithmetical scenarios projecting the potential deficit based on different levels of efficiency.



**Figure 8 : LHE financial gap with and without assumed efficiencies**

In order to deliver a balanced system, all provider organisations need to deliver a continued efficiency gain or 4.5% over each year. Cumulatively, this is a very high level of efficiency, and can only be delivered through transformational change across the whole system.

Our approach to rebalancing the system therefore will need to be planned and delivered at a credible pace and scale, ultimately delivering a radical, rather than piecemeal, redirection of resources.

## **B HOW WE DEVELOPED OUR PLANS**

### **1 Programme Board**

In February 2014 the North Cumbria Programme Board was formed. Its purpose is to give overarching programme leadership to the development of a strategy for the north Cumbria health and social care system which:

- Reduces harm through high quality, clinically sustainable services
- Is financially sustainable
- Is founded on patient, public, practitioner and clinical engagement.

Membership of the board is as follows:

- Cumbria County Council: Director of Health and Care and Assistant Director Adult Social Care
- Cumbria Partnership NHS FT: Chief Executive and Director of Service Improvement
- Healthwatch Cumbria: Chief Executive<sup>1</sup>
- NHS Cumbria CCG: Chief Officer, Medical Director and Clinical Chair
- NHS England CNTW Area Team: Director and Medical Director
- North Cumbria University Hospitals NHS Trust: Chief Executive and Medical Director
- North West Ambulance Service NHS Trust.

The Board is supported by a Planning Group, a Communications and Engagement Group, and a Programme Coordinator and Programme Communications Lead.

### **2 Public Engagement**

An extensive programme of engagement activity to seek feedback to inform the five year plan was launched by the North Cumbria Programme Board on 9 April and ran until mid-June 2014.

During that time more than 1,000 people were engaged in discussions through 13 roadshows in towns and villages, two large meetings for third sector representatives, 20 independent focus groups and 12 meetings with councillors and officers from county, district and parish councils, some of which were also attended by the public.

The roadshows were commissioned from Healthwatch Cumbria and took place at Workington, Silloth, Cockermouth, Wigton, Maryport, Keswick, Whitehaven, Cleator Moor, Brampton, Carlisle, Penrith, Alston and Kirkby Stephen. They were held mainly in busy public venues such as markets and public and supermarket car parks. A highly visible Healthwatch stand was used at all outdoor events and there was a Together for a Healthier Future banner. Representatives from Healthwatch and from local NHS organisations were present at each of the roadshows.

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<sup>1</sup> Healthwatch Cumbria is recognised as a valuable partner in the setting of the North Cumbria Strategy. Their role, in this context, is not to act as a representative of the people but to provide oversight and ensure that a robust and credible engagement and consultation process takes place with the public.

The conversations included a discussion about the challenges facing the health economy which need to be addressed, the development of the five year plan and its focus on more services closer to where people live, more joined up services and ensuring safe and sustainable hospital services. People were asked against that background about what improvements they would like to see to health and care services, what had been good about any care they had received and what could have been better. They were also asked if they had any thoughts about what more could be done to help people to stay healthy and about which health and care services were most important to them.

Comments were logged on individual forms and people were asked if they wished to share their name, address, date of birth, whether they were disabled and their ethnic origin. Some people indicated that they preferred to remain anonymous and this was respected.

The number of forms varied depending on the venue and ranged from 13 at Kirkby Stephen to 71 at Carlisle. Overall, 525 forms were completed but many more people were involved in the conversations as single forms were completed for couples and friends and family members out shopping together.

Cumbria CVS was commissioned to facilitate two events, one at Penrith and the other at Workington, for third sector representatives. The events were promoted through the Cumbria Action for Health Network which has over 400 third sector organisations on its distribution list. These were attended by almost 100 people, of whom 80 were representatives of frontline third sector organisations.

Each event was opened by a senior representative of NHS Cumbria CCG who gave a presentation to set the scene and discussions facilitated by Cumbria CVS colleagues followed. Participants could choose whether to join a general group, or groups focusing on the needs of older people and children and young people.

Taylor Nelson Sofres (TNS), a world leader in market research, which was already providing substantial support to the Better Care Together programme across North Lancashire and South Cumbria was commissioned to carry out 20 focus groups.

There were five service areas: maternity, children's services, unplanned care, planned care and services for older and vulnerable people. A focus group on each of the service areas took place in each of the four localities; Allerdale, Copeland, Eden and Carlisle. A total of 167 people participated in the groups and were recruited because of their experience in those service areas.

When the engagement activity was launched the Programme Board wrote to Cumbria County Council, the four district councils and to the Cumbria Association of Local Councils for onward cascading to parish councils to offer to meet with them to discuss the development of the five year plan. As a result there were meetings with the county council local committees at Carlisle and Eden, with district councils at Allerdale, Copeland and Carlisle and with Alston, Bolton and Allhallows parish councils. This was in addition to the discussions that took place at two meetings with Cumbria Health and Scrutiny Committee and two meetings with the chair and lead members of that committee.

Alongside all of this activity there was ongoing media coverage to promote the public roadshows and the development of the five year plan. This included several newspaper articles and interviews on local radio and TV.

### 3 Clinical and Practitioner Engagement

Clinicians have been at heart of developing this strategic plan across the system. This is additional to all the existing clinical forums we already have in place, and built on the work undertaken for example by the North Cumbria Clinical Leads Groups, the Urgent Care Working Group and each of the CCG localities. By way of summary this has included:

**Clinical Principles:** Through the Cumbria Learning and Improvement Collaborative over 100 clinicians took part in full day workshops to construct the guiding principles for developing and delivering our strategic plans across Cumbria.

**Hospital Care Design Group:** Again over 60 clinicians, social care and third sector practitioners, helped us to develop the continuum for the organisation of the delivery of hospital services.

**Maternity:** A wide range of midwives, consultant obstetricians, paediatricians, anaesthetists and general practitioners considered all the potential options for the delivery of sustainable maternity services through facilitated Care Design Group sessions.

**Mental Health:** Senior clinical leaders from Cumbria Partnership NHS FT and NHS Cumbria CCG reviewed the existing work on adult mental health services and re-affirmed the key priorities.

**Out of Hospital Care Design Group:** Over 60 of clinicians, social care and third sector practitioners have developed solutions for each of out of hospital services.

**Primary Care Communities:** Colleagues from across general practice, community services and Adult Social Care refined the Primary Care Communities model through a facilitated session with the former National Clinical Director for General Practice.

**Recruitment and Workforce Development:** On 22nd May 2014, 51 representatives from across the Cumbria health and care system met together to create a solution to the workforce challenge and build a plan for its implementation. This workshop produced a very clear vision of a single collaborative effort (including a technical hub) to respond to the workforce needs of the Cumbria Health and Care Alliance.

Detailed write ups from each of the above engagement sessions are available and will be included in Volume 3, the Supporting Documents, of this Strategic Plan.

## **4 Single Version of the Truth**

Each organisation had a particular perspective on the challenges we face, including a different understanding of the quality, workforce, and financial deficits in our system. Collectively, we all needed to have a shared understanding of the different issues facing the economy as a whole, and to work from the same baseline position. To support this, we commissioned PricewaterhouseCoopers to produce a single version of the truth document.

The single version of the truth collated and analysed lots of different sets, including on the workforce, demography and service demand, financial and indicators of clinical quality. It also includes a review of our previous plans.

PricewaterhouseCoopers were able to bring added value to the single version of the truth as they could be objective and more importantly bring benchmarked evidence from other health economies across the country.

Overall, the single version of the truth is intended to:

- Quantify the scale of our challenge from our 2013/14 baseline position (e.g. the financial gap)
- Forecast the scale of the challenge by 2018/19
- Quantify how much of the gap our current plans would deliver, and the size of the remaining gap our transformation plans therefore need to deliver
- Identify some opportunities for closing the gap, e.g. a reduction in the reliance on temporary staff.

## **5 Modelling the Future**

We need to understand the benefits that could be delivered from each of the service model scenarios we have considered. PricewaterhouseCoopers have supported us in modelling those scenarios, to understand the broad range of the scale of benefits, and the investments that would be needed to deliver them.

As we progress to firmer plans by the early autumn, we will continue to much more robustly model those scenarios.

## **C THE SERVICE MODEL**

We have developed the service models described in this section in order to respond to the key issues outlined in the case for change, and to meet our ambitions to deliver highest quality, sustainable services reliably and fairly delivering good outcomes.

In the next stage of our work we will model in details the clinical, workforce, and financial benefits of those models, and the investments and other changes we will need to make to enable them to happen. As such, the service models are primarily based on clinical and stakeholder engagement, and will need some refinement and we move towards more detailed planning and implementation.

### **1 Recruiting, Retaining and Developing Our Workforce**

#### **1.1 Continuous Service Improvement**

We know that delivering the right configuration of services is important. However, we also know that supporting frontline clinicians, practitioners and managers to continuously improve the services they deliver will have an even greater impact. If we are to be successful, we will need to engender a genuine and continuous cultural and behavioural change across the system, enabled by leadership and by giving all our staff the right improvement tools and techniques.

To achieve this, the Cumbria Health and Care Alliance committed to forming the Cumbria Learning and Improvement Collaborative, CLIC. This is intended to develop into the key shared vehicle for continuously driving service improvement, in all services across Cumbria, forever. We are still working on the final CLIC work plan, but in simple terms CLIC is:

- An umbrella that brings together the collective effort of the CCG, its member practices, the Cumbria Partnership NHS FT, two acute trusts and Cumbria County Council (Adult Social Care, Public Health and Children's Services) on education, training, development, improvement work – indeed any organised effort to meet the needs of individuals and teams, helping them to achieve their objectives in a better way.
- A kind of snow-plough to help you get where you are going, clearing away barriers of any kind by sharing experiences, skills and innovations and supporting (and improving) all our organisations in doing what needs to be done to achieve the right outcome.
- A club (a partnership) so we all learn together, where no one partner is assumed to have a monopoly on need or solutions and where all talent is being used in a patient and population centred way, not a 'sovereign organisation' way.
- An infant. Full of potential but definitely not fully formed. There is as yet no fixed plan or position – indeed no fancy ideas, jargon, models or must do's at all – just a commitment to find a way (together) to stop just talking about excellence and start the journey towards it, one step at a time. You cannot be right or wrong about what 'it' is, as we (together) haven't yet developed it.

## **1.2 The Cumbria Health and Care Workforce Solution – three to six month actions**

Through the workforce session facilitated by CLIC we developed an outline five year plan for improving recruitment, retention and development with detailed actions for the next three to six months. The plans, and indeed all the content from the session, can be found at:

<http://www.theclic.org.uk/clic/events/clic/a-workforce-plan-for-cumbria-thinking-out-of-the-box-about-recruitment-retention-and-professional-development>

## **2 Out of Hospital Services**

### **2.1 Communities and Support for Self-Management**

We know that the real bedrock of health and wellbeing is to be found in individuals, families and social connections, and our communities. We will need to find new ways to harness this capacity to enable much more effective health promotion, prevention and self-care, and to move towards a more proactive system preventing rather than managing crisis. Key to this will be developing new relationships between services users and our whole system, including:

- Providing **support for self-management** on a much larger scale, building on our positive experience from roll out of diabetes patient education programmes, particularly DESMOND for type 2 diabetes
- Use of a whole range of health, social care and community assets
- Better use of what is already available in the community
- Greater involvement of the third and voluntary sector, faith communities and so forth including volunteers
- Use of the Neighbourhood Care Independence Programme
- A stronger emphasis on the fact everything needs to put the person at the centre
- Use of assistive technologies including equipment, tele-health and tele-care.

### **2.2 General Practice**

General practice forms the bedrock of our primary care community approach. GP practices locally however are struggling to cope with increasing demand, face recruitment pressures and falling incomes. The Centre for Workforce Intelligence (2013) reported a 75% increase in the number of GP consultations in England from 1995-2009. They concluded 'There is insufficient capacity in primary care to meet current and future needs'.

Yet we are about to make major additional demands on the primary and community care system:

- To move from care of the individual to care of a population
- To work collaboratively with each other, with community services, social care and specialists working in the community



- To support a huge shift of care from our acute hospitals into our community based intermediate care tier, sicker patients remaining at home, more support to nursing and residential homes etc.
- To support a huge shift to proactive and up-stream care especially for the frail elderly
- To move from a mainly medical model to a social model of health and wellbeing within communities
- To become experts in admission avoidance
- To lead a major change in the way we manage long term conditions based on care planning and support for self-management
- To provide additional skills in areas such as primary mental health, child health, end of life care and geriatric medicine to support more people safely in the community with the need for fewer admissions and fewer elective referrals.

A core part of our five year plan is therefore how we support general practice to work within primary care communities. The roll out of primary care communities will require a large programme of learning and skills development for primary care both for the 'day job' and in improvement science. A learning community is currently being developed with the support of the Cumbria Learning and Improvement Collaborative (CLIC) to support the first wave of 10 primary care communities being rolled out in 2014/15. The large provider trusts with their infrastructure and critical mass have a key role to play in partnering and supporting primary care in what increasingly will become an 'Alliance' approach to health and care delivery across Cumbria.

This approach to primary care development will be delivered in line with the key recommendations in the Transforming Primary Care document published by the Department of Health in April 2014.

We often refer to primary care when we really mean general practice. However, the role of community pharmacists will also need to continue to develop as part of the model. We know that community pharmacy is not currently used to its full potential, we also know that large numbers of hospital admissions are primarily caused by sub optimal prescribing and medication errors.

## **2.3 The Model for Primary Care and Community Services**

We continue to work to develop community services that are responsive to the needs of the north Cumbria population. The focus is to create a proactive, joined up out of hospital care system that improves quality and drives efficiency. The model is aligned with national NHS strategy and with the Royal College of Physician's promotion of the principle of joint working across institutional boundaries that would enable healthcare professionals to deliver integrated, personalised care.

**The Out of Hospital model is comprised of five elements, descriptions of which follow:**

## Element 1 –Primary Care Community Teams

### Definition of Primary Care Communities (PCCs)

Primary Care Communities are a group of care professionals and third sector staff drawn from a range of organisations and professions who collaborate to address the physical, mental and social needs of patients and their carers. They work in partnership with other agencies to also improve the general wellbeing of the population for which the team is responsible.

They are based on GP practice registered populations of between 15,000 and 40,000 that mostly cover more than one GP practice. Teams are configured around natural communities and built upon the workforce in the constituent practices and wider community assets. They are comprised of medical staff, nursing, health care assistant, mental health care, social care, voluntary care, administrative staff and managers working together across organisational boundaries.

Primary Care Community Teams will in particular develop flexible approaches to delivering care making the best use of all the expertise available to them in the following areas:

- Frail elderly care
- Long term condition management
- Services for the housebound
- Urgent/on the day care
- Seven day a week services/care
- Supporting people to maintain their independence ideally in their own home
- Health inequalities; improvements in case finding, disease registers and reduction in unwarranted variations in care.

### The Building Blocks of our Primary Care Communities are:

**A Multi-Disciplinary Team:** There would be 'one team' with a common purpose that included the GPs, responsible for the health of their defined population. There would be a proactive, coherent multidisciplinary approach to care for older people and for those with long term conditions within the PCC focusing on a shift to supported self-care and care planning. District nurses and practice nurses will work together more productively, maximising the skills across the whole workforce. In some areas the PCC model will help fast track discussions that are already underway around integration of rehabilitation and reablement services.

**Population Based Approach:** The population in each PCC would be risk stratified to identify the risk of non-elective admission, frequent users of services and risk of admission to residential care. The PCC would be the building block for asset based approaches and there would be a tele-health network would connect each PCC to specialists.

**Shared Systems and Data:** The PCC would share information, have a common (or at a minimum interoperable) IT system and real time patient data.

**Leadership and Delegation:** Each PCC would have a leadership team with representation from

primary, community, social care, the CCG and third sector and manage at least part of their health and care budget, and would be linked to a programme of education and development – learning how to continuously improve quality, working with other PCCs to share ideas and good practice. Each locality, supporting local PCCs will work very closely with local district/ borough councils to address the health needs of their local populations, maximising the benefit to their populations from joint working and collaboration.

**Primary Care Communities will deliver the following benefits:**

*Primary Care*

- A reduction in unwarranted variation in elective referrals
- An improvement in case finding and disease registers
- Standardised long term condition management including cancers
- Standardised management of the frail elderly, including in residential and nursing homes
- Standardised end of life care
- The delivery of urgent care 8am – 8pm Monday to Fridays and at weekends
- Improved access to, and outcomes from, psychological therapies (IAPT).

*Hospital Admissions*

- A reduction in avoidable unscheduled admissions
- A reduction in hospital re-admissions
- A reduction in elective procedures of low clinical value
- An increase in people who die in their place of preference
- A reduction in length of stay for medical patients, and in delayed transfers of care.

## Element 2 - Urgent care co-ordination centre

The urgent care co-ordination centre will ensure that patients get to the right place in the system at the earliest opportunity. It will work with the primary care community team and track patient journeys using real time system information.

For professionals it will provide a single point of access to a range of health and social services for patients with an urgent health and/or social care need whilst at home and can provide an alternative to admitting to urgent care services. It will agree the appropriate clinical response for a patient in accordance with care plans, including discharge plans for patients with complex care needs. The centre will be able to deploy additional community services, for either adults or children. It will also arrange appointments at ambulatory clinics as well as hospital admission.

For professionals, including those in hospitals, the centre will provide a single point of access to a range of health and social care services to help them address the needs of their patient with an urgent need whilst at home. The service will be for patients of all ages with a call option to divert to a children's response where needed. For the patient in hospital the centre will coordinate discharge planning and referring and accessing community and post hospital care across the health and social care system. The urgent care co-ordination centre at Cumberland Infirmary Carlisle (CIC) has started to perform this function.

The role of the co-ordination centre will be to agree the appropriate clinical response for a

patient, given the need, the care plan and the knowledge of available local services. The service will have access to care plans for those patients who have been identified as likely to require support to enable continuity of care.

The team will operate using local knowledge and “real time” system capacity data across the health and social care system and ensure that the best package of care or support is delivered to a patient in the most appropriate location, and at the most appropriate time. The centre will be able to deploy community services that support primary care community teams, for either adults or children. For those who need it, the centre can also arrange appointments at ambulatory clinics as well as hospital admission.

A critical enabler is to have a shared IT platform/system in place which displays real time capacity across the system, i.e. in general practice community services, local authority services as well as in the hospital. STRATA is a system being piloted and learning from this early pilot will help identify how best to design the future tools or build on STRATA. If STRATA proves to be effective it can be extended beyond unscheduled care to streamlining referrals, managing appointments, bed management, etc.

The hub or care co-ordination centre will also be able to provide advice to professionals as an alternative to admitting to a care service and will have a vast knowledge base on which to make decisions. This is a critical function of the team and requires skilled staff to be available seven days a week.

The care co-ordination centre at CIC is already beginning to deliver some of these functions successfully, and gives us good local experience to learn from and build on.

### Element 3 - Integrated rapid response and community services

A number of services will be developed, either by PCCs or where appropriate on a larger footprint to specifically target the needs of patients in the community. Examples include:

**Hospital at Home/ integrated rapid response teams:** A multidisciplinary team designed to avoid hospital admission where appropriate and enable hospital discharge before the patient has fully recovered with the necessary out of hospital support. The team makes a rapid assessment of the patient’s medical, nursing and care needs. The team then delivers a package of health and social care (“hospital at home”) until the patient no longer requires intensive support and their care continues to be provided through the primary care community team for ongoing recovery and rehabilitation.

There would be a multidisciplinary rapid response function including nurses, occupational therapists, physiotherapists, social workers and home care practitioners (currently called STINT or rehabilitation teams), community hospitals (where appropriate) and pharmacists. People presenting with health and/or social care needs will have access to reablement, rehab services and voluntary sector partners to maximise independence in the first instance. This will include a rapid response function to prevent avoidable admissions and will therefore be available throughout the seven day week. This approach will include access to equipment, assistive

technology, adaptations and prevention services. There would be a 'Virtual Ward' including prevention, focusing on those identified as high risk for admission, and reactive for patients who are more acutely ill, for example, those needing IV antibiotics at home. For those with long term needs a care coordinator approach will be in place to ensure people know who to contact if there are changes in their circumstances and to embed a proactive, personalised approach to care and support for themselves and their carers/family.

**North West Ambulance Service (NWAS) Pathfinder Programme:** We are working with NWAS to deliver the pathfinder programme during the day in addition to the already established out of hours programme. This service gives NWAS paramedics the ability to direct patient care needs to local primary and community services if these are better able to meet the patient's needs, rather than taking all patients directly to an A&E service.

#### Element 4 - Community specialist services

Specialists would operate across the out of hospital model, providing specialist support for patients, in localities where possible but with good access to hospital based services. They would have an overarching responsibility for the delivery of care and health outcomes for the population in their locality that has diseases covered by their specialities.

In delivering this responsibility specialists would have dedicated time to advise GPs or patients outside a traditional clinic environment. Specialists would have a key role in the education and support of other professionals. Clinical nurse specialists, GPs with a special interest, other community health professionals and social care professionals would have a greater role in the direct delivery of patient care and patient education.

The role of the specialist will evolve and whilst it will still include direct clinical care it will also have a key role in skilling up primary care teams, helping coordinate care across pathways and set standards, pathway leadership and a significant increase in direct same day advice and support to colleagues in the primary care community.

A large number of medical specialities from different organisations could join this medical division for example, acute medicine, geriatrics, rheumatology, neurology, diabetes, endocrinology, respiratory medicine etc. All specialities will still in reach to provide acute care within the hospitals but they will become community based specialities.

Use of technology is a key enabler to this element of the model and opportunities can be learnt from remote healthcare systems and how they use non face to face interaction to diagnose, offer advice and support and maintain follow up care without the patient travelling to hospital. For example, the model includes a clinical support service for nursing homes, providing from the bedside advice on appropriate care, removing the need for residents to be taken to other care facilities unless that best meets their needs.

## Element 5 - Referral support system

This element is a number of activities and approaches that together provide a more effective and efficient system for the pre-operative or pre-acute intervention phase of a patients care pathway. Many of the functions below are already in place. We now need to deliver these more consistently across north Cumbria in a more focused way.

The referral support system will encompass:

- Access to specialist advice and guidance
- Improved access to diagnostic investigations for community based health professionals
- The development of care pathways across specialities including the use of shared decision aids
- Making these pathways clearly available for viewing by all those involved in patient care
- Referral templates
- Peer review of referrals for specialist opinion
- An advice and guidance tool
- Co-consultation in for example outpatient community settings between specialist and members of the primary care community team.

The system will help reduce the need for specialist follow up, including discharge from specialist follow up, but facilitating quick access to specialist review when appropriate. The service will also aim to up-skill community based health professionals' referral skills.

## 2.4 Potential Scale and Impact

We know that there is a major opportunity to refocus the whole system towards providing care closer to home in patients own homes and the community. This requires delivering the out of hospital model at real scale. Realistically, this will require a continual additional investment in each of the next five years, at a pace that is deliverable in terms of the workforce, the impact on hospital services, and financially.

Our provisional analysis has shown the investment by 2018/19 is likely to be in excess of £10M recurring, and that potentially this could reduce costs in the hospital system up to £20M, as well as deliver huge improvements to outcomes and quality. This is based on detailed modelling undertaken in other distressed health economies, and provisionally applied to north Cumbria. We also know that some systems in England, for example Torbay in Devon, have delivered major improvements through a joined up, integrated out of hospital system that reduces reliance on hospital services.

We also have some very positive local experience to draw upon. Cockermouth was a national integrated care pilot and a prototype for the primary care community concept. It developed a 'one team' approach to primary and community care and managed its provider and payment by results (PbR) budgets at town level. It won three national awards during this period for best integrated care and care closer to home. During this period:

- Throughput per bed in the community hospital increased from 6.8 to 31 and 28 days was taken of the average length of stay. The cost per admission reduced by £3, 600
- Acute hospital non elective bed days reduced by 40%
- There were significant savings each year on prescribing budgets
- A 'one team' approach was created with re-modelling of whole workforce. District nurses, practice nurses, community hospital nurses, and therapists as one team
- A rapid response integrated community team (social worker, district nurses, occupational therapists, physiotherapists, admin support and home care practitioners) was created
- There were large number of quality improvement initiatives such as early adoption of saving lives campaign and best practice approaches to nutrition

Major success factors were the two years of national funding that enabled local GPs to step up into leadership and development roles and taking the budget down to town level with agreement to invest a percentage of savings locally. The savings for example funded the addition of home care practitioners to the team.

We have similar examples of pocket of the model working well across north Cumbria, that gives us confidence that with a full and systematic roll out across the whole area we can credibly meet our aspirations.

### **3 Community Hospitals and Minor Injury Units**

There are eight traditional community hospitals in north Cumbria at Alston, Brampton, Cockermouth, Keswick, Maryport, Penrith, Wigton and Workington, and two step up step down (SUSD) units created in 2010 on the Cumberland Infirmary Carlisle and West Cumberland Hospital. We are committed to a positive future for all of the community hospitals. They provide a vital role in ensuring local access to services and enabling needs to be met in the most appropriate care environment. At an overarching level, the community units should provide two clear functions:

- They should be used for step down (after a very short stay in the acute) and step up care, as an integral part of the whole elderly care bed base run by a team of GPs from local practices and elderly care physicians
- They should provide enhanced admission avoidance hubs, acting as 'Frailty units' - one stop assessment centres for the frail elderly (replacing outpatient clinics), focusing on comprehensive geriatric assessment, reablement and rehab, prevention (co-opting third sector and community resource) and admission avoidance such as falls assessments.

The resources used to deliver Reiver House at Cumberland Infirmary Carlisle will be deployed to support hospital at home services, significantly increasing the number of patient receiving care and supporting the closer to home agenda.

Our approach to maximising the contribution of community hospitals will be guided by the following principles:

- The community hospital and SUSD beds should be combined with the elderly care beds in North Cumbria University Hospitals NHS Trust to form a joint bed base for older people.

- This should be run within a new ‘medical divisions’, with medical leadership from GPs and elderly care physicians working as one team.
- The norm for acute trust admissions should be short stays for older people with rapid transfer out to home (‘home first’) or one of the community facilities (which may include sub-acute wards in the acute trust setting) within the medical division for further assessment and treatment. This is in keeping with the findings from the Oak Group audit.
- There should be day case/ambulatory units within each locality where transfusions and other IV therapies can be *reliably* delivered. The portfolio of these ambulatory treatment centres should be developed in partnership with North Cumbria University Hospitals NHS Trust to deliver whatever treatments currently delivered in the acute trusts that can safely and feasibly be done in the community.
- Each of the minor injury units will either become a part of the Primary Care Community, offering local extended access to community services, or will be aligned to the type 1 accident and emergency units as part of the joint medical division working to shared governance and standards.

## 4 Hospital Services

We are committed to a successful future for both Cumberland Infirmary Carlisle and West Cumberland Hospital. Those hospitals are very highly valued by our communities, and provide local access to vital clinical services. There are real challenges in delivering quality care in our hospitals however, and in order to secure consistently delivered high quality care, with a clinically and financially sustainable workforce, the service model needs to change.

We have not developed options for the required change. Rather, we have developed scenarios across a continuum of change, which will be continually reviewed. We will carefully gather and consider the evidence, including operational risks, to support any moves along the continuum. Potentially, this could include a further consolidation of all acute medicine at Cumberland Infirmary Carlisle, or the closure to medical admissions at West Cumberland Hospital late at night. However, such a consolidation would require extensive planning and risk assessment, including the difficult challenge around emergency transport and the safe conveyance of patients.

All changes will need to be supported by strong evidence and will take into consideration the views of patients, the public and our key stakeholders. We fully recognise our statutory obligations in relation to public consultation and we are committed to working with the overview and scrutiny committee to ensure these are carried out in line with requirements. The chart below gives a very basic representation of the continuum across urgent and elective care.

Level of Consolidation
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Low	Medium	High
Continuous improvement to meet current and new standards	Reconfiguration of most unsustainable / highest risk services	Planned reconfiguration of whole service model to provide consolidated clinical capacity to adhere to standards and drive quality and efficiency
Continuous review of workforce models and safe staffing	Reconfiguration of elective services informed by public and patient engagement	Increased use of emergency transport
Continuous review of clinical risk and outcomes	Continuous review of all other services	

Figure 9 : Continuum of Consolidation

## 4.1 Elective Care

There are clear advantages in consolidating the provision of elective services, including reducing duplication, improving efficiency, and ultimately improving patient outcomes. We have the opportunity to maximise the benefits from the redeveloped West Cumberland Hospital to deliver an elective centre of excellence for low risk, high volume procedures, that will reduce the risk of operations being cancelled due to emergencies taking priority. Recognising the interdependencies with critical care on both sites, our direction of travel over time is therefore:

- To significantly increase the total number of elective in-patient episodes at West Cumberland Hospital. This will support the delivery of the 18 week referral to treatment standard, reduce cancelled operations, and improve outcomes.
- To develop Cumberland Infirmary Carlisle to deliver higher risk elective procedures, but with a reduction in the total number of in-patient elective procedures at the site. This will ensure the right clinical capacity and capability to improve outcomes for more complex / higher risk patients and procedures.
- To continue to provide outpatient appointments and procedures, day cases and diagnostics will continue at both sites to ensure access.

## 4.2 Unscheduled care

High quality unscheduled care, on a seven day a week basis, can only be reliably delivered by ensuring the right clinical capacity and capability can be provided on a sustainable basis. This will require changes to our current service model, primarily through an increased consolidation of higher risk / complexity unscheduled care at Cumberland Infirmary Carlisle.

The population of west Cumbria will continue to need to be able to access accident and emergency services at West Cumberland Hospital, and to access the continued provision of lower risk medical interventions and admissions. In order to reliably meet the needs of those patients though, over time, higher risk / complexity patients will need to be admitted to Cumberland Infirmary Carlisle, in some cases following stabilisation at West Cumberland Hospital.

### 4.3 Maternity Services

In 2013/14 there were approximately 3,200 births for north Cumbria residents, with around 1,800 births at Cumberland Infirmary Carlisle and 1,400 at West Cumberland Hospital. Both hospitals currently deliver a consultant led service.

North Cumbria has a number of challenges in relation to these services. Both units are classified as small, indeed there are only six consultant led units across the whole of England with less than 2,000 births. This size makes it difficult to adhere to all of the relevant clinical standards and guidance, and makes it difficult to recruit staff including across interdependent services such as paediatrics and anaesthetics. North Cumbria is also one of the very few areas in the country which does not offer a choice to expectant mums in relation to accessing a midwifery led unit.

We know however that the units currently deliver good outcomes, and are highly valued by the local population. We also know that local access to consultant led maternity services is not just a patient experience issue, but potentially a clinical safety issue. Maintaining safe levels of service with a limited workforce across two sites is clearly a key challenge for this specialty. Short term risk mitigation and assurance work has included clear escalation plans to manage the anaesthetic risk, and close monitoring of outcomes through a maternity dashboard and patient experience feedback, whilst longer term issues need to be addressed through this strategy.

The future model for the provision of maternity services is clearly connected to interdependent services, and as such the choice of the preferred model will be informed by the broader continuum of consolidation. For example, the safe provision of a Consultant led maternity unit is only possible with the continued availability of a sustainable model of anaesthetics and a full co-located paediatric services. However, you can't really have a continuum of consolidation for maternity services. Although there are many considerations to carefully balance, there are a clearer set of decisions to be made. As such, we developed a long list of options for the future provision of maternity services. From the long list, we have identified three options for maternity services across north Cumbria, as shown below. The options were selected for more detailed work to be undertaken, to identify all the potential risks and benefits.

	West Cumberland Hospital	Cumberland Infirmary Carlisle	Allerdale
<b>Option 1</b>	Midwifery Led Unit and co-located Consultant Led Unit	Midwifery Led Unit and co-located Consultant Led Unit	-
<b>Option 2</b>	Midwifery Led Unit and co-located Consultant Led Unit	-	-
<b>Option 3</b>	-	Midwifery Led Unit and co-located Consultant Led Unit	Stand Alone Midwifery Led Unit

Figure 10 : Maternity Services Options

In all options the home birthing unit at Penrith Hospital will continue on the current model.

We are continuing to work with NHS England and the Royal Colleges to seek to undertake an independent review of the optimal way to configure maternity services across the whole of Cumbria, which would significantly inform our options appraisal in the future.

#### **4.4 What will be Different in Hospital Services?**

As highlighted in Monitor's recently published strategy<sup>[1]</sup> focus needs to be "on maintaining services, not institutions". Our patients do not distinguish between different provider organisations and neither should we: our primary interest is therefore in ensuring delivery of seamless high quality and efficient care with our partners across the health and social care. The key changes we expect to be delivered in conjunction with our partners will shape the care experienced by our patients:

- There will have been a reduction in reliance on in-patient care: more patients will be treated in community or ambulatory care settings involving NCUHT staff directly supporting patients in their own homes, through support of primary and community teams, through high quality outpatient and ambulatory care services, and through integrated approaches to admission avoidance and early discharge. Our focus will be on supporting patients and their families with the *"right care, at the right time, and in the right place"*.
- For those patients who do require hospital inpatient care, high quality, safe and effective care with early senior assessment and rapid access to specialists and diagnostic tests will be provided, with timely onward referral for tertiary support where indicated.
- Delivery will be through 'integrated' teams, both multi-disciplinary and inter-provider/agency, which work to minimise duplication and maximise continuity and efficiency of care: our focus will increasingly be on prevention (both primary and secondary), and included within this as core practice will be patient involvement in proactive care planning and an emphasis on enabling self-management.
- Delivery of care will not just be technically excellent, but will be caring responsive and compassionate, tailored to individual needs and wishes at all times. This will enhance both patient and staff satisfaction: patients and families will meet staff who are proud of their work, and who have time to continually improve their services.
- Patients and their families will be confident that where care has not been delivered to the standards they would wish, that this will be readily acknowledged, fully explained and changes made speedily to rectify problems.
- There will be continued delivery of care locally wherever possible, and 'centrally' where necessary to achieve best clinical outcomes; in this context 'centrally' may be any hospital site, a specific north Cumbria site or beyond: our principle will be that care will be delivered as locally as it is possible to deliver high quality, safe care making best use of finite Cumbria resource.
- The precise configuration of services will have been agreed through comprehensive and transparent engagement processes, with balanced option appraisal supported by clinical and other evidence.

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<sup>[1]</sup> Monitor strategy 2014 to 2017: *Helping to redesign healthcare provision in England*, April 2014

- Patients, carers, communities and other stakeholders will remain fully involved in shaping developing and improving health and care services through ongoing dialogue with health and social care staff, achieved through wide-ranging and accessible mechanisms.

## 5 Children's Services

### 5.1 Developing a strategy for children and young people

Working in partnership, we are developing a Child Health Strategy 2014 -2019: *Building Health with Children and Young People*. The vision underpinning the strategy is that the children and families of Cumbria should expect support to be healthy through:

- Fair access to a range of support and services to prevent ill health, provide early intervention and when required have ready access to safe, sustainable high quality health services that are designed around their needs to achieve the best possible outcomes
- Integrated services delivered as close to home as possible, provided by a team of healthcare professionals working together in partnership with children, their families and other agencies.

### 5.2 Key objectives

The key objectives of the strategy are:

- To support children and young people to be healthy and safe by working with partners to strengthen prevention and early help
- To standardise quality and provide better health outcomes providing more focused and integrated services, including children with long term conditions and complex needs
- To develop and implement services to reduce unnecessary hospital attendance and admission
- To develop the whole system pathway to promote emotional resilience and good mental health
- To develop whole system patient feedback across services for children and young people
- To produce a workforce development plan that addresses the needs of the whole workforce
- To develop ways to effectively monitor and support continuous improvement.

Working in partnership with the wide range of agencies involved in the health, care and safety of children and young people, we are developing a model that will deliver the strategy outlined above.

The model will address the needs of all children including those who are acutely ill and the ongoing needs of children and young people with more complex needs and/or who are particularly vulnerable.

The services will be provided by integrated medical and nursing teams working across community and secondary care. The emphasis will be on supporting children and families in the home

environment, with a renewed focus on assessment rather than admission. A smaller number of children will be admitted

### **5.3 Prevention and early help**

The importance of prevention and early help is a key priority and we are working together as commissioners and providers to support and deliver the prevention agenda and healthy child programme. We will continue to strengthen the partnership with Cumbria County Council children's services to promote early help and the use of Common Assessment Framework (CAF) approach.

Safeguarding practice across the health economy will continue to improve within the Local Children's Safeguarding Board (LSCB) partnership by embedding good practice and developing a culture of learning and continuous improvement.

### **5.4 Primary care**

Primary care will be central to meeting the needs of all children and young people and there is a need to have appropriate skills in place to enable this to happen. An advice and guidance service, established pathways of care, common assessment tool and outreach consultant presence will support primary care.

### **5.5 Unscheduled care**

Children will access the same unscheduled care services as adults, including GPs, GP out-of-hours services, minor injuries and A&E. The specific requirements of the model in relation to children are detailed in *Standards for care of Children and Young People in emergency care settings* and cover the following areas: service design, environment, management of the sick or injured child, staffing and training, safeguarding in emergency care settings, mental health and alcohol substance misuse and major incidents involving children and young people.

When children are acutely ill and require services beyond primary care, GPs will contact a single point of access, where the decision will be made to ensure they receive their treatment in the right place first time. Access will be to an integrated children's nursing team and/or short stay paediatric assessment service for children who require observation and treatment. The SSPA unit operating times will be defined through more detailed analysis of the patient flows. Those children needing care for longer than the short stay unit is in operation should be transferred to an inpatient unit depending on acuity of illness. Assessment and treatment of children and young people with mental health problems will be integral to the model.

### **5.6 Children with complex needs**

Child Health Integration Centres will be based in the localities and will be fully linked to primary care, secondary care and the full health team. The centres will provide a focus for health professionals and partners to work together to ensure the right skills are in the right environment to provide high quality integrated services for children with a wide range of needs. This will include children with more complex needs such as children with disabilities and long term

conditions, Children who are looked after and children with mental health problems. The centres will use single assessment, evidence based pathways and will develop the lead professional role to enhance quality services. Complex needs will be planned in partnership.

## **5.7 Integrated children's nursing**

The integrated children's nursing function will develop so that it can both support children with long term needs as well as working with children who are acutely ill to avoid hospital admission or facilitate early discharge.

## **5.8 Child and adolescent mental health services (CAMHS)**

Work is underway to develop and implement a comprehensive multi agency framework for emotional health and wellbeing for children and young people.

Within the overall model we will work with partners to reduce unnecessary hospital admissions for deliberate and non-deliberate self-harm. The transformation of tier three CAMHS will continue improving the quality of service, response to urgent and non-urgent need and supporting the whole system including supporting and training others.

## **5.9 Transition**

There is also a need to develop services appropriate to the needs of young people as distinct from younger children and also to improve the transitions from adolescent to adult services. This is a theme that will run through the development of the model.

# **6 Mental Health**

## **6.1 Mental Health Strategy**

Partner organisations across Cumbria are working to produce a comprehensive Adult Mental Health Strategy for October 2014, which will provide a fuller direction of travel for those services. An independent review of adult mental health services jointly commissioned by the CCG and local authority and delivered by Cumbria Partnership NHS FT working jointly with Cumbria County Council carried out by the Centre for Mental Health has further identified the service areas we need to improve. Two key commitments in the emerging strategy are:

### **We will develop:**

- A comprehensive primary care treatment service as part of the development of Primary Healthcare Communities
- Integrated delivery between health and social care.

### **We will improve:**

- Patient and public engagement and experience
- The performance of our local recovery and rehabilitation services
- The performance of our NSF target services, particularly in access times

- The relationships with other services and agencies
- The consistency of service standards
- Our approach to improving the physical health of people with mental illnesses
- The relationship between resources and needs.

## **6.2 Access**

We have a very high access rates to Improving Access to Psychological Therapies (IAPT) for patients with anxiety disorders, although waiting times can be far too long. Over time some of the First Step service will need to become fully embedded as a part of the Primary Care Community.

We know that access to services with severe and enduring mental health problems is less good. We will deliver a much improved access model, including clear exit planning for patients to return to primary care, and clear and easy re-entry to secondary care services. Similarly, we will need to make major improvements in the flow between home treatment and in-patient services.

We will develop a single point of access into specialist mental health services, providing:

- Assessment and formulation
- Engagement
- Crisis resolution at home and in inpatient settings
- Signposting
- Home treatment
- Brief interventions.

## **6.3 Psychiatric Liaison**

There is substantial evidence that providing effective psychiatric liaison at scale delivers major benefits to quality and financial sustainability. Effective liaison enables acute trusts to meet the physical health needs of patients with mental health co-morbidities, including cognitive impairment in older people, much more effectively. Liaison also significantly reduces the utilisation of physical health urgent care services, particularly accident and emergency, by people with substance misuse, self-harm, and personality disorder, by enabling their needs to be met in a much more planned way.

We will further develop plans to significantly increase the provision of liaison services working in and out of the Cumberland Infirmary Carlisle and West Cumberland Hospital sites.

## **6.4 Community Mental Health Services – Psychosis and Non-Psychosis Teams**

Community mental health service (P&NP) teams will provide therapeutic interventions and care co-ordination services including:

- Dedicated Cognitive Behavioural Therapy (CBT), pharmacotherapy and care co-ordination response focused on supporting the recovery of people experiencing severe mood and anxiety complaints

- Dedicated Psycho Social Interventions, pharmacotherapy and care co-ordination response focused on supporting the recovery of people experiencing distressing psychotic complaints (and with the capacity to provide CBT, formal family interventions and assertive outreach)
- Rehabilitation/recovery functions, including employment, day care and leisure services aimed at supporting people to experience purpose, inclusion and meaning
- Dedicated dementia and frailty service for older adults
- Crisis resolution and home treatment services.

Additional dedicated expertise for specific presentations to support P&NP Teams will include:

- Personality disorders
- Dual diagnosis (drug and alcohol)
- Eating disorders
- First episode psychosis (early intervention)
- People with learning disabilities who have mental health problems
- Neurological mental health
- Autism and ADHD (see Learning Disabilities & Autism Strategy for further information).

## **6.5 Recovery and Inclusion Resources**

Integral to the delivery of services will be the pooling together of recovery and social inclusion resources to support effective care co-ordination and promote mental and physical wellbeing.

At present significant resources are tied up in traditional rehabilitation services that are predominantly inpatient based. In order to deliver a comprehensive recovery service that emphasises rehabilitation in community settings it is planned that existing resources tied up in rehabilitation wards will be directed into more appropriate community based resources linked to individual service user needs.

It is fundamental to the principle of a person-centred approach to ensure the service user is seen as a person and not an illness. To facilitate this, the P&NP teams need to ensure they can support users to access a range of community-based services that will support them to remain engaged in activities of daily living and find meaning, purpose and connection in their lives. It will be the task of the care co-ordinator to support the service user in engagement with mainstream services, i.e. employment, housing, education and leisure.

The recovery/inclusion resources will act as a 'pick and mix' menu of resources that can be drawn upon by the care co-ordinator and/or service user to ensure they remain engaged and socially included.

## **6.6 In-patient Services**

Mental Health services should be organised on 'least restrictive' principles, whereby service users received treatment and care in an environment as close to the persons own home and the community as possible. Currently, we think that there are major opportunities to improve home



treatment, thereby reducing the number of avoidable unscheduled admissions and also reducing the time patients spend in hospital.

As we improve the effectiveness of our primary care, access and recovery focused mental health services we will also consider the optimal way to configure in-patient services. Initially, we consider that a consolidation of in-patient care across less sites to be a principle that can be applied successfully in both the north and south of Cumbria. We will explore this further with service users, carers and service providers, including consideration of the re-investment back into alternative local services that will be necessary to realise the benefits for patients and their families. In north Cumbria this would mean consolidating acute mental health inpatient services at the Carleton Clinic site in Carlisle, which would require a process of formal public consultation.

## **7 Specialised Commissioning**

NHS England is responsible for commissioning specialist services. We will continue to work with NHS England to ensure that the north Cumbria population has appropriate access to high quality specialist services. A key consideration is the delivery of radiotherapy and clinical oncology. We will work with NHS England to secure the long term, high quality, local provision of clinical oncology and radiotherapy through a well governed clinical network with a specialist Trust delivering services in our local hospitals. This model will also potential apply to a broader range of specialist services.

## D OUR DELIVERY ARRANGEMENTS

### 1 Governance for Implementation

We know that good implementation is much more important than a good plan. We have previously fallen short in successfully delivering our plans. To ensure that we are successful this time, we will work together in a well governed, structured way to collectively agree service changes and to collectively manage the system risks and maximise the system benefits, including:

- Continuing the **Cumbria Health and Care Alliance** providing Chief Executive and Medical Director overarching leadership to support an integrated system across all of the county
- Continuing the **North Cumbria Programme Board** as the main driver of senior cross organisational leadership to ensure delivery
- Ensuring there is an ongoing programme of **patient, public and stakeholder engagement** so that their views inform any proposed changes and future developments.

Our next steps will include:

- Formalising a strong **clinical advisory group**, comprised of senior clinicians from across the organisations, to assess progress and guide decision making
- Exploring options to identify a high performing local system that can work with us to provide challenge, support and guidance, and to also seek an **objective, external source of expertise** to help us to stay focused on delivery
- Developing fuller, more detailed and robust **implementation plans**, including detailed modelling of activity and finance, during July – October
- Instituting a shared **programme office functions**, to keep track of delivery and to enable escalation if we fall behind, and to enable the right skills to support implementation to move across organisational boundaries
- Enabling organisational and cultural development through **Cumbria Learning and Improvement Collaborative (CLIC)** to support front line clinicians and managers to deliver the change

## 2 Timetable

The outline timetable for the next phase of our planning and implementation is shown below:

July	<ul style="list-style-type: none"><li>• Agree public facing version of the plan and continued engagement activity</li><li>• Agree governance and management functions</li><li>• Agree phase 2 detail planning work programme</li><li>• Agree partnership capacity</li></ul>
August	<ul style="list-style-type: none"><li>• Detailed workforce, activity and financial modelling</li><li>• Detailed cost and benefit models</li><li>• Detailed service model narratives agreed</li><li>• Detailed change implementation plan developed (phase 3)</li></ul>
September	<ul style="list-style-type: none"><li>• Agree consultation document and process <b>if required</b></li><li>• Investment, scale, pace and interdependencies agreed</li><li>• Costs and benefits model agreed</li></ul>
October	<ul style="list-style-type: none"><li>• Begin implementation not requiring formal consultation (phase 3)</li><li>• Begin consultation <b>if required</b></li></ul>

## 3 Financial Sustainability

Our early analysis suggests that, without action, the in-year deficit in the north Cumbria NHS system could be as high £87M.

Our provisional analysis shows that this deficit could be addressed on a recurring basis by 2018/19, compared to the 2013/14 baseline, by a combination of approaches such as:

- Trust Cost Improvement Programmes (efficient delivery of services) including the delivery of demographic pressures within existing resources
- Commissioning Cost Improvements (efficient deployment of resources)
- Service consolidation
- Transformation, primarily the implementation of the out of hospital model.

A fundamental objective of the strategic plan is to enable the financial sustainability of the whole system. This can only be determined through the next stage of development when the current outlined plans are assessed in terms of patient activity flows and then identifying the staff, consumables (e.g. drugs, medical devices, etc) and supporting infrastructure required to manage those patients in the appropriate setting. This is undoubtedly an iterative process but the following “next steps” are required to assess financial sustainability alongside the clinical issues.

The stakeholders need to agree the level of cost reduction to be addressed directly through the strategy. This is different to the cost improvements delivered from “business as usual”. The two issues are not mutually exclusive, but it is important that stakeholders have a clear understanding of the financial gap the strategy is intending to address.

For example, it would be expected that commissioners would be expected to manage some demographic growth pressures, and similarly providers will be expected, once on a firm financial

footing, to meet on-going NHS mandated efficiency targets. It is also important that service impact on patients and the system as a whole are considered, and the plan must be sustainable at both economy and organisational level.

As described in the case for change, we have a forecast in year deficit for each of the financial years 2014/15 – 2018/19 if no action is taken.

For each year, we will identify:

- Business as usual cost improvement programme efficiencies each organisation will deliver
- The level of service configuration financial savings (delivered through the strategic plan)
- The level of transformational financial savings (delivered through the plan)
- The system level of deficit.

Additionally, we will then agree the deployment of the financial benefits from the configuration and transformation savings, both in terms of continuing to invest in the service model, and to ensure that existing services are financially sustainable. Where beneficial to the whole system, we will explore the potential benefits of local pricing modification within the context of affordability and the available resource envelope in Cumbria.

The modelling, as described, will be an iterative process, but it is important that identified options are assessed in terms of affordability and formal feedback is provided to the Programme Board to assess issues and reconsider options in light of the outcomes of this work.

The financial planning will also include scenario and sensitivity planning to assess best/case worse case and therefore how robust future services will be to changes in assumptions.

It is likely that in parallel with the activity, financial and service planning a parallel process will be to consider future business/contract models that will ensure risk is appropriately shared between partners and therefore demonstrates on-going system balance.

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# VOLUME 3 THE SUPPORTING DOCUMENTS

**(NOT INCLUDED IN THIS VERSION)**

**A: REPORTS FROM OUR ENGAGEMENT PROCESSES**

- The Write Up from Care Design Groups 1 and 2
- The Write Up from the CLIC Events
- The Write up from the Public Engagement events

**B: MODELLING AND ANALYSIS OF THE CURRENT SYSTEM**

- The Single Version of the Truth
- Summary of the Oak Group Report
- Commissioner Requested Services Analysis

**C: MODELLING AND ANALYSIS OF OUR PROPOSALS**

- Finance Plan
- Workforce Plan
- Activity Plan

The documents listed under section A and B are available on request from NHS Cumbria Clinical Commissioning Group. The documents listed under section C will be developed during July – September and will form part of the next phase of our implementation.

# **VOLUME 4    PUBLIC FACING DOCUMENTS**

**(NOT INCLUDED IN THIS VERSION)**

**A        THE PLAIN ENGLISH VERSION OF THE PLAN**

**ENDS**

## **Emergency Care and Medicine Business Unit:**

### **Clinical Strategy for Acute Medicine WCH**

#### **Introduction**

North Cumbria clinical services have been under significant pressures over recent years related to staff recruitment and retention. This is most marked at West Cumberland Hospital which currently is relying heavily on locums at consultant and junior doctor level including services providing unscheduled care. The North Cumbria Strategy 2014 – 2019. “Together for a Healthier Future” sets out the principles including right care, at the right time, and in the right place. Previously the “Closer to Home” strategy had proposed transfer of high risk services to Cumberland Infirmary but these proposals were never fully implemented.

#### **Background**

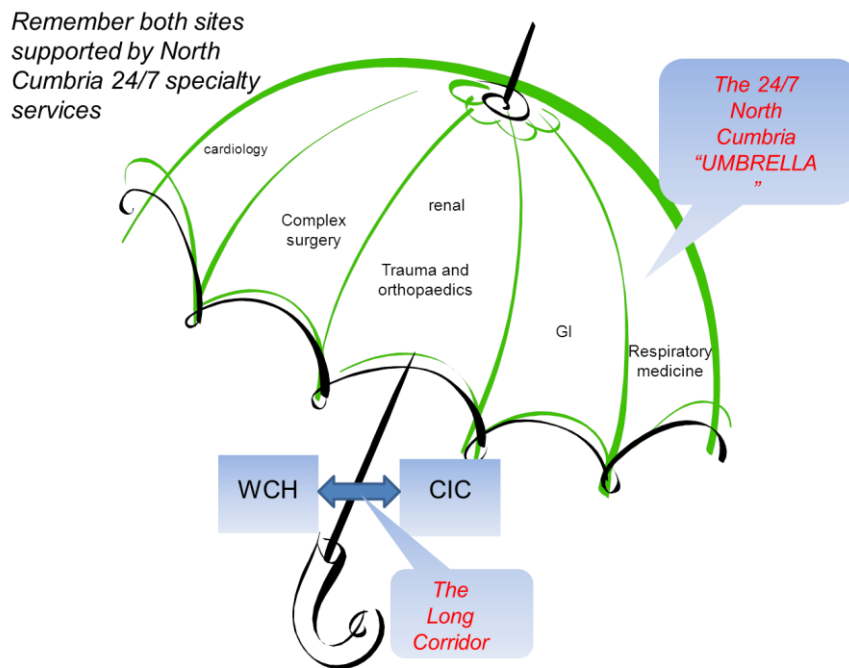
Following the Chief Inspector of Hospitals report, which highlights areas of concern, the Emergency Care and Medicine Business Unit, in conjunction with the wider discussions held at CPG we have drawn together proposals to address these concerns.

Workforce changes occurring secondary to the Deanery withdrawing trainees, together with difficulties in recruitment with a reliance on locum staffing means that some services are operationally extremely fragile; this is particularly true of emergency medicine at the West Cumberland Hospital (WCH). This has been highlighted by the Chief Inspector as of major concern.

We believe that the proposals address some immediate issues around safety but lay the foundations to build upon to meet the future needs for safe 7 day working. This strategy needs to run in parallel to the intensive recruitment programme that is necessary to develop a sustainable workforce.

We need to enhance the use of clinical networks across the 2 sites to optimise the use of the limited amount of medical staffing resources to ensure the optimal access to specialist care. Within unscheduled care these clinical networks need to provide an “Umbrella of care”.





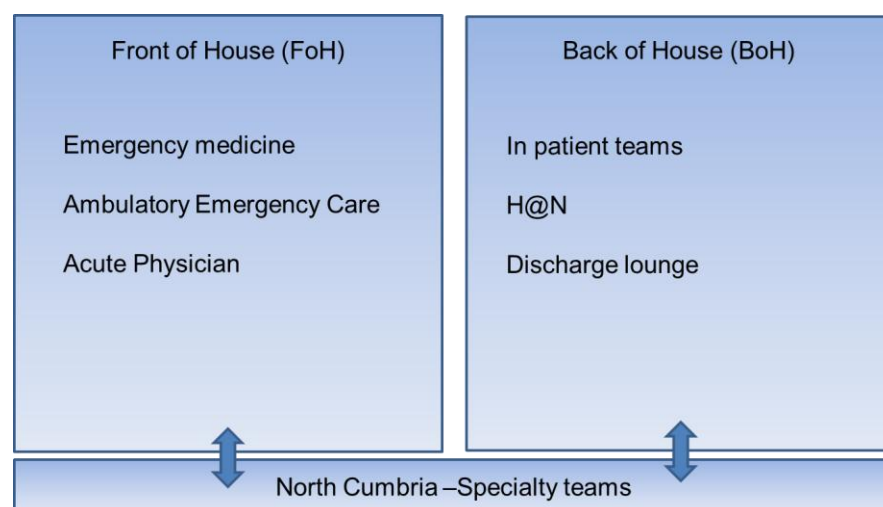
The vision is of the North Cumbria University Hospitals Trust working as a single entity, delivering services across North Cumbria, with clinical networks supported by flexible working of its staff.

Reconfiguration of services for safety issues but also sustainability will be required to enable the need for 7 day services consistent with the national clinical standards.

Therefore the aim is to consolidate services where beneficial and localise where possible.

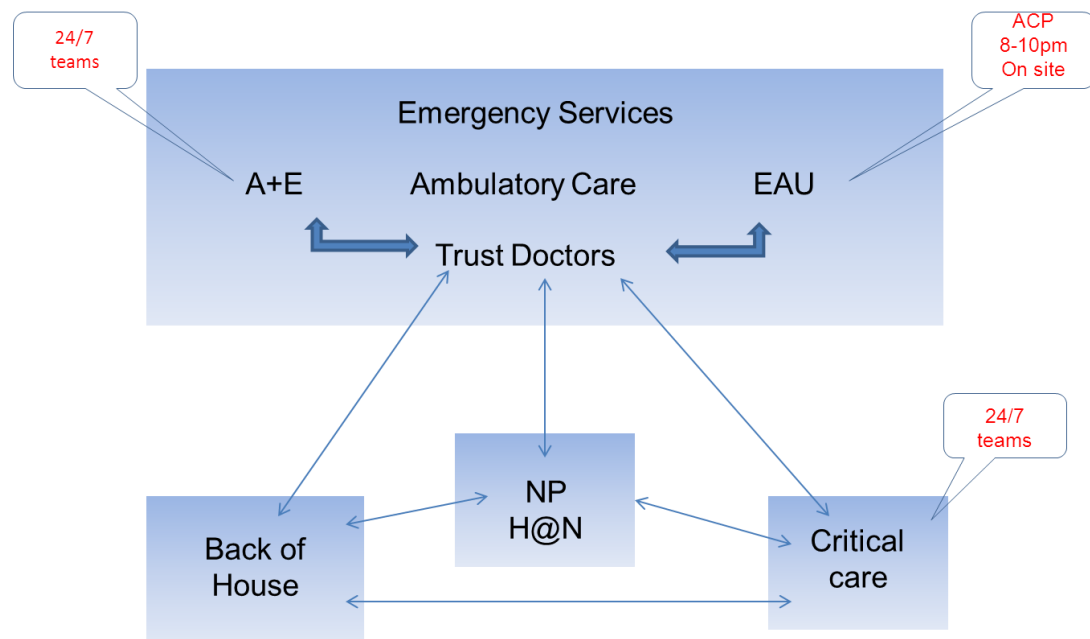
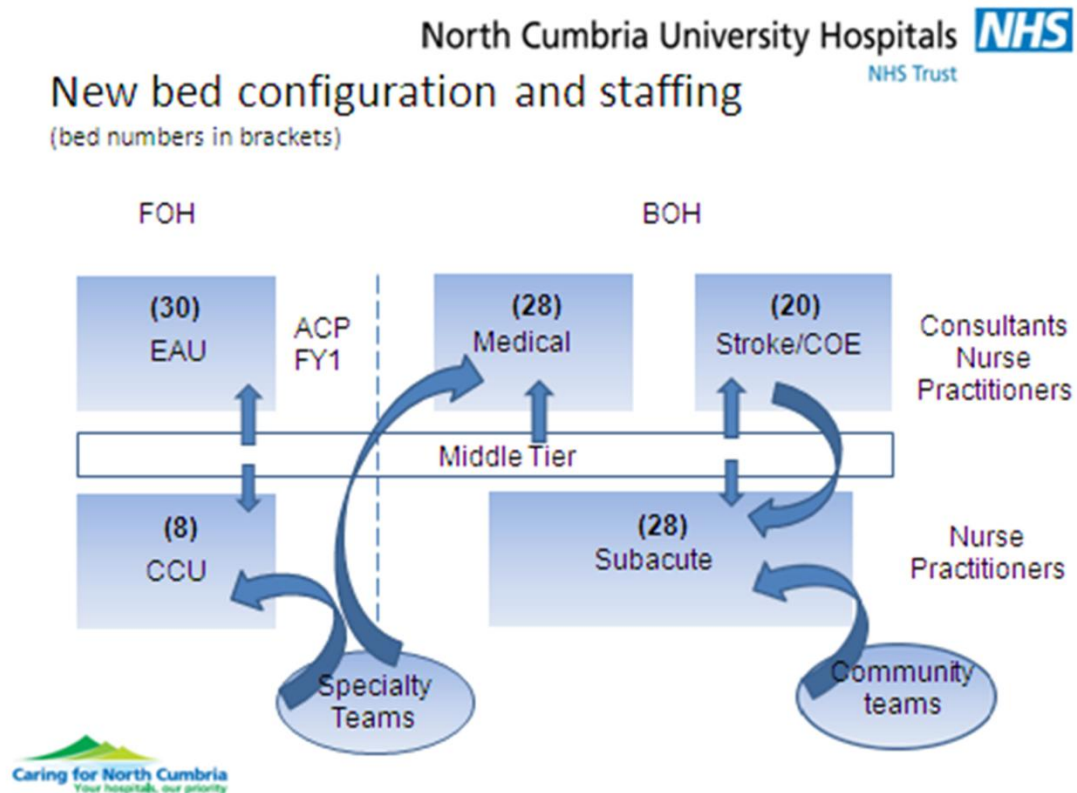
### The Model of care

Across our Trust we have introduced a Front of House – back of house model of care within medicine.



For acute medicine we have introduced acute care physicians (ACPs) to run our medical assessment units and we provide consultant presence 8am-10pm 7 days a week.

As we plan the move to the new West Cumberland Hospital taking into account the FOH-BOH model and staffing the bed configuration at WCH is shown below.



To address some of the staffing issues we have invested in nurse practitioner support to provide continuity of care and supervision of patients back of house supervised by consultants.

In-reach together with hub and spoke services from medical specialties forms part of the strategies for cardiology, gastro, renal and respiratory. Whilst these services operate to some degree currently the frequency will increase as recruitment occurs in line with the strategies. There is great support to offer a sustainable service from the specialties for daily review of patients referred for specialist advice, out-patient clinics and procedures where appropriate. This will enable the majority of care to still be provided close to home.

To de-risk the situation for West Cumberland Hospital for the level of staffing that would be sustainable we have initiated the transfer of high risk patients to the Cumberland Infirmary site, firstly surgery, trauma and orthopaedics. Our proposals are to address how we manage high risk medical patients.

Our clinical teams have identified 3 key areas whereby transfer not only de-risks WCH but also allows the consolidation of services to provide care that can meet recognised standards, namely

- **Acute stroke**
- **GI bleeding**
- **Acute coronary syndrome/non STEMI**

In addition, the BU and CPG have proposed the use of NEWS to identify other groups who will benefit from transfer. While this group may cover an array of conditions it is their level of physiological disturbance that will determine where best to provide their care and have access to other services that may be necessary and only available at CIC.

The initial discussions identified the groups above but with further specialty discussions we also propose

- **Transfer cards**
- **Sub group of respiratory disorders**
- **Augmented HDU**

## **Acute Stroke**

The strategy and business case to support this (to be ratified by EMOB) proposes the development of a hyper-acute stroke service based at CIC with early repatriation and rehabilitation continuing at WCH. This is in line with national developments to provide best care and is supported national outcome data.

The national stroke lead is due to visit North Cumbria this autumn to help in our discussions around planned changes to our service in a rural environment.

## Appendix 1 – Stroke Strategy



2 year clinical  
strategy stroke (3).doc

## Appendix 2 – Stroke BC



Appendix\_2.doc

## Appendix 3 – National Stroke Lead Presentation Tony Rudd



Appendix\_3.pdf

## GI bleeding

This service has already been introduced for OOH GI bleeding, but it is proposed that this is extended to 24/7 using validated scoring criteria to identify the high risks cases that will benefit from transfer and meet national standards. Following the implementation of the OOH rota there are other measures that we need to institute to fully meet NICE criteria

### Compliance template



NICE guidance QS 38  
Acute upper GI bleed

### Stepwise development of GI bleed service



UGI bleed service  
North Cumbria.docx

**Draft Pathways for suspected UGI Bleeding presenting in West Cumbria**  
**Date 23/9/2014 Author: Dr D Burke**  
**Version. 1.1**

Patients with Transfer Admission  
Cards should be taken directly to CIC  
by the ambulance service

Suspected UGI bleeding

**GROUP 1**

**Transfer direct to  
CIC**

(i) Patients with  
Transfer Admission  
Cards

(ii) Patients with  
confirmed melaena

(iii) Patients with  
confirmed  
haematemesis with  
any of

p>100  
systolic bp  
<100  
syncope  
hepatic disease  
cardiac failure

(iv) Suspected  
variceal bleeding

**GROUP 2**

Patients with a suspected UGI bleed who have been  
assessed by an experienced clinical decision maker, if GI  
bleeding is still the most likely diagnosis and do not fulfil the  
criteria for group 1, or who present to WCH (including IP)

Assess using Blatchford score (for non variceal bleeding)

SCORE	1	2	3	4	6
Blood urea		>6.5-<8.0	≥8.0-<10	≥10-<25	≥25
Hb women	≥100- <120				<100
Hb men	≥120-<130		≥100-<120		<100
Systolic bp	100-109	90-99	<90		
Other markers	melaena	Syncope Hepatic disease Cardiac failure			

Patients with a Blatchford score of zero may be considered  
for discharge and urgent OP endoscopy

Patients with a score of ≥ 1 transfer to medicine CIC

Access to UGI endoscopy is available at CIC 24/7 following  
assessment and resuscitation by the receiving medical team

## **ACS/NSTEMI**

Again many of these cases already transfer. ST-elevation MI come direct to the heart centre at CIC for consideration of primary PCI.

These pathways will expedite the transfer of additional patients who will benefit from specialist intervention.

## **NSTEMI**



Patient Pathway  
Document NSTEMI at

## **STEMI**



Patient Pathway  
Document STEMI at V

**Draft Pathways for Cardiology Patients at WCH**  
**Date 04/09/2014 Author: Dr R Moore, Clinical Director**  
**Cardiology**  
**Version 1**

Patients arriving at WCH should be stabilised by A+E staff and transferred as follows

**GROUP 1**

**Transfer to CIC**

ST Elevation MI

Non ST Elevation MI/Acute Coronary Syndrome

Confirmed by:

- TIMI/GRACE Score
- Troponin T result

And suitable for angiography

Endocarditis confirmed by Echo

Pericardial Tamponade confirmed by Echo

Bradycardia:

- Sinus bradycardia with HR <40
- 2<sup>nd</sup> or 3<sup>rd</sup> degree heart block HR <40
- >= 3 second pauses

Ventricular Tachycardia

**GROUP 2**

**Move to CCU/HDU facility at WCH**

(Supported by resident Senior ICU staff 24/7, WCH Cardiologist and in-reach from substantive CIC Cardiologists up to 5 days per week)

Where capacity does not exist patients should be moved to CIC

Heart Failure

Drug-induced Bradycardia

Post Cardiac Arrest  
(Discuss with CIC Cardiologist of the Week for consideration of transfer for angiography/revascularisation/cardiac pacing.

**GROUP 3**

**Move to General Ward at WCH**

Atrial arrhythmia:

- Atrial fibrillation
- Atrial flutter
- Supraventricular tachycardia

Syncope

If patient deteriorates and meets the criteria in Group 2, patients should be moved to CCU/HDU

A Cardiologist will be available 9-5pm Monday to Friday for support either at WCH or by phone from CIC

## **Transfer Cards**

This proposal is for specialties who identify (usually long term conditions or complex morbidity) cases who if they deteriorated would benefit from specialist input should be transferred direct to CIC. Patients and GPs would be aware of the pre-determined criteria that would trigger a direct transfer rather than assessment or treatment at WCH. eg complex respiratory for (some bronchiectasis). in GI some IBD and chronic liver disease particularly those with portal hypertension and decompensated liver disease. In these cases NWAS would be asked to transfer direct to CIC.



## Respiratory cases

### Draft Pathways for Respiratory Patients at WCH

Date 27/08/2014 Author: Dr P.K.Plant Respiratory Clinical Director  
Version. 1.2

Patients with CIC Admission Cards should be taken directly to CIC by the ambulance service

Patients arriving at WCH should be stabilised by A+E staff and transferred as follows:

#### GROUP 1

##### **Transfer from WCH A+E to CIC**

Patients with CIC Admission Cards

Pleural Disease

- Pneumothorax (regardless of whether a drain has been placed).
- Unilateral effusions where empyema suspected

GROUP 2 patients when WCH HDU not available.

#### GROUP 2

Move to augmented HDU facility at WCH

(Supported by resident Senior ICU staff 24/7 and WCH respiratory consultant Mon-Fri 9-5)

Where capacity does not exist patients should be moved to CIC

##### General Group

Respiratory patients with NEWS >5 after immediate treatment

Respiratory patient requiring >40% oxygen to maintain saturations in prescribed range

##### Specific Group

Asthma – severe or life threatening (PEFR < 50% after immediate therapy)

COPD- needing Non-invasive ventilation ie acidotic – pH < 7.35 and PaCO<sub>2</sub> > 6kPa

Community acquired pneumonia CURB3 or higher

PE with haemodynamic compromise/ elevated troponin or thrombolysed.

#### GROUP 3

Move to General Ward at WCH (supported by WCH respiratory consultant Mon-Fri 9-5 and FY2/nurse practitioner at night)

If patient deteriorates and meets the criteria in Group 2, patients should be moved to HDU

A Respiratory Consultant will be available 9-5pm Monday to Friday for support either at WCH or by phone from CIC

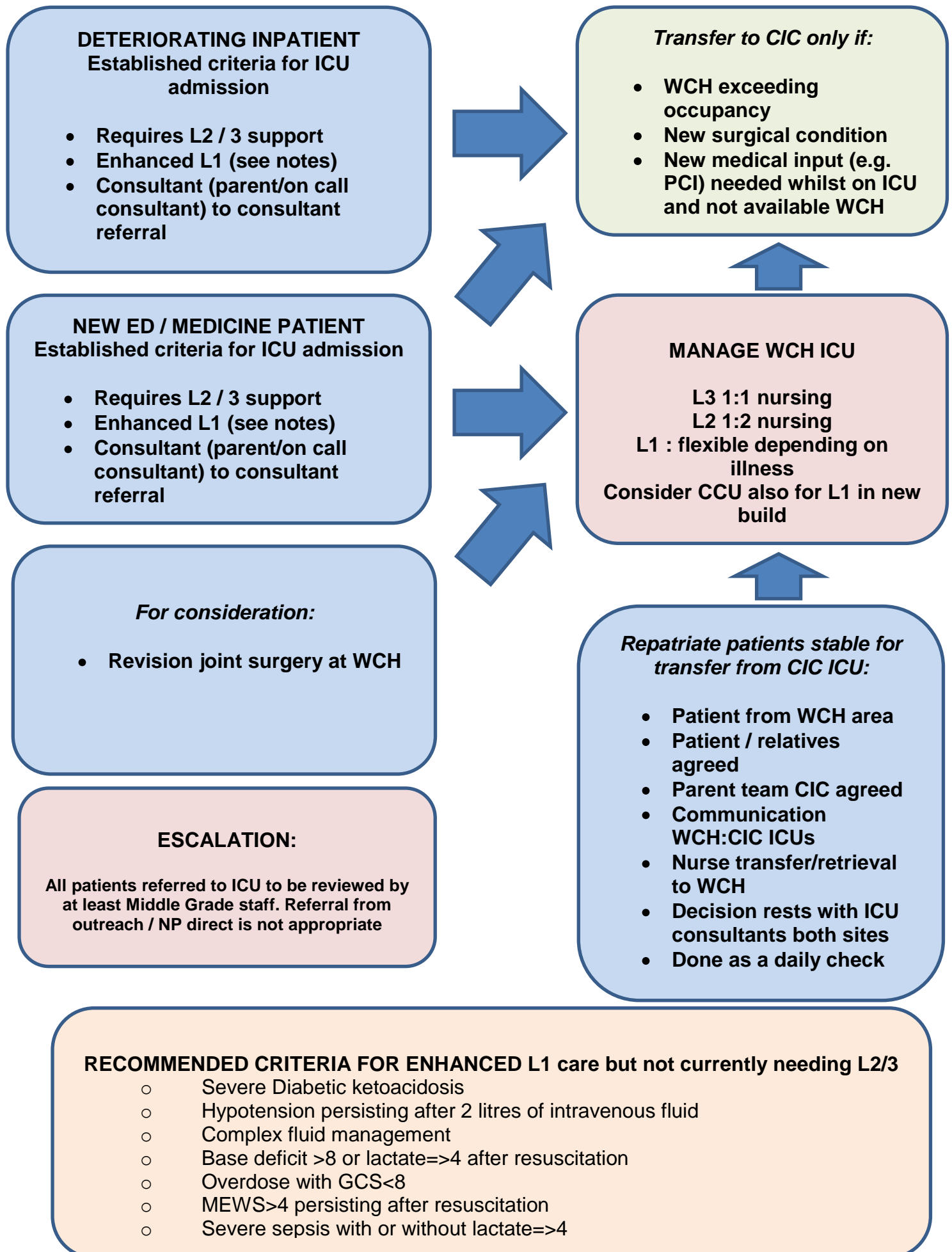
Critical care will still be present 24/7 at WCH and this proposal makes best use of these resources to support the initial stabilisation and treatment whereby transfer may be detrimental until stabilised or their care can be managed safely utilising the critical care team e.g. short term monitoring of poisoning/deliberate self-harm requiring support and monitoring, DKA

ICU wch document



WCH ICU strategic  
planning Aug 2014.doc

## WCH ICU usage: Proposed flowchart summary Sept 2014



Please note we have already met with CCG representatives, primary and secondary care colleagues in two workshop meetings to discuss the principles and reasoning behind our proposals

Feedback on refining these draft changes has been received and revolves around ensuring that the services proposed offer benefit to our patients (safer and or enhanced services) and advice on communication and engagement around implementation. Within these caveats there was agreement to proceed with the development of these proposals

Our Ref: NM14/154spr

Monday 20 October 2014

NHS Cumbria Clinical Commissioning Group  
Lonsdale Unit, Penrith Hospital, Bridge Lane  
Penrith, Cumbria, CA11 8HX

tel. 01768 245 486

email. [enquiries@cumbriaccg.nhs.uk](mailto:enquiries@cumbriaccg.nhs.uk)

web. [www.cumbriaccg.nhs.uk](http://www.cumbriaccg.nhs.uk)

Prof Andrew Cant  
Chair Northern England Clinical Senate  
Waterfront 4  
Newburn Riverside  
Newcastle upon Tyne  
NE15 8NY

Dear Andrew

Further to our correspondence about the Northern Clinical Senate Visit to north Cumbria in early November and the subsequent conversations you have had with Rosemary Granger, I am writing to share with you a revision of NHS Cumbria Clinical Commissioning Group's original request for a Clinical Senate Review.

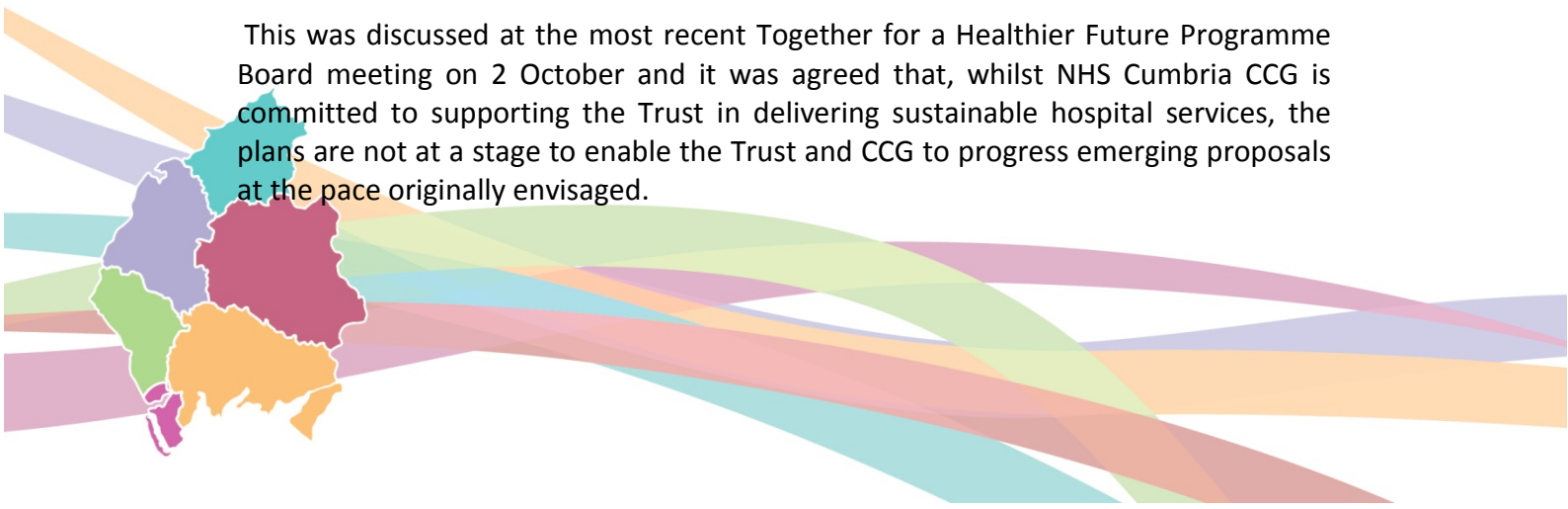
Initially the request had been for the Clinical Senate to carry out a review of proposals for changes to acute medicine high risk pathways at North Cumbria University Hospitals NHS Trust as part of the NHS England Assurance process for service change, with a view to moving to consultation on any proposed changes in the relatively near future.

NHS Cumbria CCG is supportive of changes to pathways and service configuration, providing that as a system, we are able to demonstrate that those changes would make a positive contribution to:

- Improving quality, by which we mean clinical safety, clinical outcome and patient experience
- Improving sustainability, by which we mean adherence to standards, workforce, and finance

However, it has become apparent in the last few weeks that the Trust's plans are not yet sufficiently well developed to demonstrate that such improvements would be delivered nor would we, as a system, be in a position to demonstrate how any major change would meet the four tests set out by the previous Secretary of State.

This was discussed at the most recent Together for a Healthier Future Programme Board meeting on 2 October and it was agreed that, whilst NHS Cumbria CCG is committed to supporting the Trust in delivering sustainable hospital services, the plans are not at a stage to enable the Trust and CCG to progress emerging proposals at the pace originally envisaged.



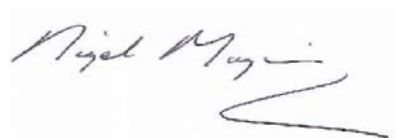
There was also agreement that we could derive great benefit from a review by the Clinical Senate which would be more of a stock take of where the trust are up to in developing their plans for these pathways. In so doing, we would hope that the Clinical Senate would provide external challenge and checks in the system to ensure proposals that are developed are clinically robust.

I am writing therefore to ask you to reposition the Clinical Senate visit to north Cumbria as an interim review as I have described above and I hope you feel that this is consistent with the role of the Senate to provide a source of strategic, independent clinical advice and leadership on how services should be designed to provide the best overall care and outcomes for patients.

Having looked at the draft terms of reference that you sent us, I feel that these remain relevant for this type of review. I would also iterate the request that Rosemary has already made that the review team contains professionals with relevant knowledge and experience in the fields of GI services, stroke, cardiology and ED services so that we obtain the maximum benefit from the review.

We are looking forward to welcoming the Clinical Senate Review Team to North Cumbria in early November.

Yours sincerely



**Nigel Maguire**  
Chief Officer,  
NHS Cumbria Clinical Commissioning Group

Cc     David Rogers, Medical Director, NHS Cumbria Clinical Commissioning Group  
        Peter Rooney, Director of Strategic Planning and Performance, NHS Cumbria  
        Clinical Commissioning Group  
        Rosemary Granger, Programme Co-ordinator, North Cumbria Programme,  
        NHS Cumbria Clinical Commissioning Group  
        Lynda Dearden, Network Manager and Acting Senate Manager

## **SENATE CLINICAL REVIEW**

### **TERMS OF REFERENCE**

**Title:** High Risk Pathways for surgery and medicine in North Cumbria University Hospitals NHS Trust

**Sponsoring Organisation:** NHS Cumbria Clinical Commissioning Group

**Clinical Senate:** Northern

**NHS England regional or area team:** NHS Cumbria, Northumberland, Tyne and Wear Area Team

**Terms of reference agreed by:**

**(Name)**

**on behalf (name)                      Clinical Senate and**

**(Name)**

**on behalf of sponsoring organisation (name)**

**Date:**

#### **Clinical review team members**

Chair Andrew Cant – Clinical Senate Chair and Consultant in Paediatric Immunology and Infection , Newcastle upon Tyne Hospitals Foundation Trust

Robin Mitchell – Clinical Director, North of England Strategic Clinical Networks

Hilary Lloyd – Director of Nursing, Gateshead Health NHS Foundation Trust

Paul Fell – Consultant Paramedic, North East NHS Ambulance Service Trust

Lesley Kay – Clinical Senate Vice Chair and Consultant Rheumatologist, Newcastle Upon Tyne Hospitals Foundation Trust

Lynda Dearden – Network Manager of the Northern Clinical Networks and Senate

Jon Scott – Stroke Consultant, South Tyneside NHS Foundation Trust

Phil Adams – Consultant Cardiologist (retired)

Chris Plummer – Consultant Cardiologist, Newcastle upon Tyne Hospitals Foundation Trust

Mark Hudson - Consultant Hepatologist & Gastroenterologist, Newcastle upon Tyne hospitals Foundation Trust

Andrew Simpson – Consultant in Accident & Emergency Medicine, North Tees & Hartlepool NHS Trust

### **Aims and objectives of the clinical review**

To review CCG proposals for high risk pathways for in North Cumbria University Hospitals NHS Trust in surgery and medicine

### **Scope of the review**

To include G.I Bleeds, Cardiac and Stroke pathways. Any others to be determined by the CCG and Trust

### **Timeline**

The review visit will take place over 2days 4<sup>th</sup> and 5<sup>th</sup> November 2014.

### **Reporting arrangements**

The clinical review team will report to the clinical senate council which will agree the report and be accountable for the advice contained in the final report. Clinical senate council will submit the report to the sponsoring organisation and this clinical advice will be considered as part of the NHS England assurance process for service change proposals.

### **Methodology**

Information collated by the sponsoring organisation to be presented to the senate review team before the actual visit: including demographic data, organisational information, site maps, patient flows and any other information that the sponsoring organisation thinks will help the reviewers understand the issues surrounding the services under review. (*Action Rosemary Granger and Seema Srihari*)

Reviewers will meet in Cumbria the evening of 3<sup>rd</sup> November to discuss the information received and plan for the following 2 days



### Day 1 (4<sup>th</sup> November 2014)

Reviewers will meet with Clinical Directors and clinical colleagues across both hospital sites (Carlisle and Whitehaven) and will meet Trust Chief Executive, Medical Director and Nurse Director.

### Day 2 (5<sup>th</sup> November 2014)

Reviewers will meet with CCG leads, health watch, MP's and patient groups.

Later afternoon reviewers will set aside for discussion.

### **Report**

A draft clinical senate assurance report will be circulated within 48 hours from the visit to the review team and the sponsoring organisation for factual accuracy.

Comments/ correction must be received within [5] working days.

The final report will be submitted to the sponsoring organisation by [1<sup>st</sup> December 2014]

### **Communication and media handling**

The arrangements for any publication and dissemination of the clinical senate assurance report and associated information will be decided by the sponsoring organisation. The sponsoring organisation identified communication lead (Rachel Chapman?), to advise on publication of the report and organise press releases/conferences, meetings with patient groups, public, staff and boards, health and wellbeing boards and Health overview and scrutiny committees as deemed appropriate.

### **Resources**

The Northern 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.

## **Accountability and Governance**

The clinical review team is part of the Northern Clinical Senate accountability and governance structure.

The Northern clinical senate is a non statutory advisory body and will submit the report to the sponsoring organisation.

The sponsoring organisation remains accountable for decision making but the review report may wish to draw attention to any risks that the sponsoring organisation may wish to fully consider and address before progressing their proposals.

## **Functions, responsibilities and roles**

The **sponsoring organisation** will

- i. provide the clinical review panel with the case for change, options appraisal and relevant background and current information, identifying relevant best practice and guidance. Background information may include, among other things, 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). The sponsoring organisation will provide any other additional background information requested by the clinical review team.
- ii. respond within the agreed timescale to the draft report on matter of factual inaccuracy.
- iii. undertake not to attempt to unduly influence any members of the clinical review team during the review.
- iv. submit the final report to NHS England for inclusion in its formal service change assurance process.

**Clinical senate council and the sponsoring organisation** will

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

**Clinical Senate council will**

- i. 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.
- ii. endorse the terms of reference, timetable and methodology for the review
- iii. consider the review recommendations and report (and may wish to make further recommendations)
- iv. provide suitable support to the team and
- v. submit the final report to the sponsoring organisation

**Clinical review team will**

- i. undertake its review in line the methodology agreed in the terms of reference
- ii. follow the report template and provide the sponsoring organisation with a draft report to check for factual inaccuracies.
- iii. submit the draft report to clinical senate council for comments and will consider any such comments and incorporate relevant amendments to the report. The team will subsequently submit final draft of the report to the Clinical Senate Council.
- iv. keep accurate notes of meetings.

**Clinical review team members will undertake to**

- i. commit fully to the review and attend all briefings, meetings, interviews, panels etc that are part of the review ( as defined in methodology).
- ii. contribute fully to the process and review report
- iii. ensure that the report accurately represents the consensus of opinion of the clinical review team
- iv. 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. Additionally they will declare, to the chair or lead member of the clinical review team and the clinical senate manager, any conflict of interest prior to the start of the review and /or materialise during the review.

END

## Northern Clinical Senate

### Northern Cumbria Services Review Phase 1 Visit

**A G E N D A FOR PRE-REVIEW MEETING ON 03 11 2014 – 06:00-08:30 PM**

**CONFERENCE HALL, ARMATHWAITE HOTEL, KESWICK**

Item	Time	Items	Lead
<b>Meeting - Part 1</b>			
1	18:00	Welcome and introductions	Andrew Cant, Senate Chair
2	18:10	Setting The Scene	Nigel McGuire and Rosemary Grainger
3	18:20	Questions to Nigel and Rosemary arising from the previously received information pack	All
<b>Meeting Part 2 – Review Panel members only</b>			
5	18:45	Agenda for 4 <sup>th</sup> and 5 <sup>th</sup> November	Andrew Cant
5	19:15	Confidentiality agreement/ Code of conduct	Lynda Dearden
6	19:20	Decide and agree question framework to be used when meeting clinical teams, Trust management and patient/public groups	All
7	19:45	Potential issues	All
8	20:00	Senate response to outside queries	Andrew Cant and Lynda Dearden
9	20:20	Any other issues /comments	All
	20:30	Dinner	

## CLINICAL SENATE REVIEW OF POTENTIAL HIGH RISK PATHWAY CHANGES AT NCUHT

### DRAFT PROGRAMME V8

Day	Time	Where	Who/ what	
Monday 3 Nov	6pm	Hotel for dinner and planning meeting	Senate Review Team (Nigel Maguire and Rosemary Granger to join for first hour)	
Tuesday 4 November	9am – 10am	Hallmark Hotel	Meet with Emergency Department Staff , Dr Peter Weaving GP Clinical Director and Elizabeth Klein, Matron Emergency Care	
	10am – 10.30am		Travel to CIC	Parking space allocated at the front of the Pillars Building (will be cordoned off)
Tuesday 4 November	10.30am -12 noon	CIC – Seminar Room 2 Education Centre	Clinical Directors and other clinical and nursing colleagues	Lynn Anderson, Paul Davies, Roger Moore, Jon Sturman, Judith Brannen (mixture of consultants from different specialties, senior matron from Medical Business Unit and cardio nurse)
“	12 – 1.15		Travel to WCH	Parking space allocated at the front of the Main Hospital entrance (will be cordoned off)
“	1.15 – 1.45	WCH	Lunch – Management Suite CEO Office WCH	
“	1.45 – 2.45	WCH – Classroom 2, Education Centre WCH	Meet with Claire Summers A&E Consultant, Lesley Carruthers Deputy Director of Nursing and Dave Glover, OSM Emergency Medical Unit, Les Morgan, WCH Director	
	2.45 – 3.45	WCH – Classroom 2, Education Centre WCH	Meet with Joanna Cox, Consultant in Elderly Care, Rachel Glover – Stroke Nurse, Olu Orugun, Consultant in Elderly Care Medicine, Joanne Pickering, Matron Emergency Medicine	
	3.45 – 4.30pm	CEO Office Management Suite WCH	Break	
	4.30pm – 5.15pm	CEO Office Management Suite WCH	Dr Debbie Freake, Director of Strategy	

	5.15 – 6.15	WCH CEO Office, Management Suite	Jeremy Rushmer,	NCUHT Medical Director
	6.15 – 6.45	CEO Office, WCH Management Suite	Gail Naylor	NCUHT Dir of Nursing and Midwifery
Wednesday 5 November	8.30 – 9.00	Penrith, Lonsdale Unit	Ann Farrar	NCUHT Chief Executive
	9 – 10.30	Penrith, Lonsdale Unit	David Rogers, Hugh Reeve, Rosemary Granger,	CCG Medical Director CCG Clinical Chair TfHF Programme Coordinator
“	10.30 – 11.30	Penrith, Lonsdale Unit	Cllr Rod Wilson Cllr Geoff Garrity	OSC chair and vice chair
	11.30 – 12.30		Travel to WCH	Car parking spot will be allocated at the front of the main hospital entrance (will be cordoned off)
	12.30 – 1pm	WCH	Lunch – Management Suite CEO Office WCH	
	1.00 – 2.00pm	WCH – Classroom 3 Education Centre WCH	Healthwatch	David Blacklock. HW CE
	2.00 – 3.00pm	WCH – Classroom 3 Education Centre WCH	Patient Groups	Siobhan Gearing + 3
	3.00 – 6.00	WCH - can move back to the CEO Office, Mgt Suite WCH	Clinical Senate review team only	
	6.00		CLOSE	

# Clinical Senates in England

## Single Operating Framework





# Clinical Senates in England

## Single Operating Framework 2014-15

### 1 Introduction

This paper proposes the Single Operating Framework that will be used by all 12 Clinical Senates in England from April 2014 to deliver their non-statutory clinical advisory role for commissioners including the role they play in contributing to the NHS England assurance process in major service change.

### 2 Purpose of Clinical Senates

- Support commissioners to make the best decisions about health care for the populations.
- Bring together a range of health and social care professionals, with patients, to take an overview of health and healthcare for local populations.
- Provide a source of strategic, independent clinical advice and leadership on how services should be designed to provide the best overall care and outcomes for patients.
- Provide clinical advice to inform the NHS England service change assurance process.

### 3 Context

Clinical Senates were set up in April 2013 as a result of the Future Forum<sup>1</sup> consultation prior to the Health and Social Care Act of 2012 which recommended that “multi-speciality Clinical Senates should be established to provide strategic advice to local commissioning consortia, health and wellbeing boards and the NHS Commissioning Board” Page 11.

A number of national reference documents have been published since the Future Forum report that have guided the development of Clinical Senates during 2013-14 (See Appendix 1). However, unlike the Strategic Clinical Networks, there was no Single Operating Framework issued by the NHS Commissioning Board.

“Clinical Senates will be developed in such a way that their members will be able to take a broader, strategic view on the totality of healthcare within a particular geographical area. This will ensure that future clinical configuration of services is

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<sup>1</sup> NHS Future Forum “Summary Report on proposed changes to the NHS” Page 11  
[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/213748/dh\\_127540.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213748/dh_127540.pdf)

based on the considered views of local clinicians and in the best interests of patients.” The Way Forward: Clinical Senates January 2013.

## 4 Guiding principles

Clinical Senates will have a set of values to guide their work, consistent with the NHS Constitution.

- There will be commonality, joint working and consistency between the 12 Clinical Senates that ensures do once and share;
- Through their members, Clinical Senates will support commissioners to put outcomes and quality at the heart of commissioning, to increase efficiency and promote the needs of patients above the needs of organisations or professions;
- Members will be expected to maintain an objective and independent view and declare conflicts of interest;
- Business processes, decision making, governance and accountability will be open and transparent and adhere to the Nolan principles<sup>2</sup>;
- Patients and citizens will have a voice in the Clinical Senates ' work;
- Clinical Senates should not revisit strategic decisions or advice that have already been made within the health and care system unless specifically required within the scope of the review.
- Diversity will be valued and equality promoted.

## 5 Organisational model

Clinical Senates are comprised of a core Clinical Senate **Council** and a wider Clinical Senate **Assembly or Forum**. Each Senate has a clinical chair.

The Clinical Senate **Assembly or Forum** is a diverse multi-professional forum providing the Council with ready access to experts from a broad range of health and care professions. Membership of the assembly will encompass the 'birth to death' spectrum of NHS care and will include patient representatives.

The Clinical Senate **Council** is a small multi-professional steering group. This group co-ordinates and manages the Clinical Senate's business. It will maintain a strategic overview across their region and be responsible for the formulation and provision of

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<sup>2</sup> Nolan Principles: *The Seven Principles of Public Life* First Report 1995.

advice working with the broader Clinical Senate **Assembly**.

Clinical Senates will run a **Clinical Review Team**, as required, to provide the clinical advice that informs the NHS England service change assurance process.

Each of the geographical areas covered by the 12 Clinical Senates has a **core management team** who are employed by or contracted to NHS England to provide business and management support. The composition and role of the support team is outlined in [The Way Forward: Clinical Senates](#) NHS Commissioning Board, January 2013.

Each of the 12 clinical senate support teams and the running costs of the Clinical Senates areas are funded through a budget allocation from NHS England. The approximate cost anticipated by NHS England in November 2012 was £250k (Strategic Clinical Networks - Single Operating Framework November, NHS Commissioning Board, 2012).

## **6 Accountability and governance**

Clinical Senates are a non-statutory organisational model for the provision of independent strategic clinical advice and clinical leadership. Within this model, commissioners, the CCGs and NHS England, remain accountable for the commissioning of services and the providers are accountable for the quality of service delivery.

Each Clinical Senate Support Team will have overall management responsibility for the delivery of the Clinical Senate function of their geographical area, are funded by and are accountable to NHS England and responsible for delivering this Single Operating Framework in line with NHS England Area Team and Regional arrangements.

The Clinical Senate Chair will be accountable for ensuring the Senate is a credible and respected source of safe, evidence based, independent strategic clinical advice. The Clinical Senate Chair should also ensure that Clinical Senates are able to demonstrate how they have applied the guiding principles in the formulation of their advice.

NHS England allocates funding and assures use of that funding and business processes employed by each Clinical Senate. NHS England appoints the chair and support team.

Each Senate Council assures itself it is compliant with minimum requirements to deliver senate business set out in Table 1.

**Table 1: Minimum requirements each Council ensures is in place**

<b>Minimum requirement to deliver Senate business</b>
Council membership recruited and meeting at least quarterly
Clinical assembly /forum established and process for establishing assembly/forum documented
Citizen representative(s) on Senate Council
Agreed and up to date transparent decision making process
Agreed and up to date terms of reference including method of collaboration with other Clinical Senates
Agreed and up to date process for requesting and delivering clinical advice that clearly describes how the council sources advice from the Assembly
Agreed and up to date conflict of interest policy, declaration of interests process and maintained register
Agreed and up to date process for running independent clinical review teams that support NHS England assurance process
Annual Report published
Digital communication platform with published clinical advice
Each support team will upload all the core minimum required documents onto the NHS England 365 extranet sharepoint facility

## **7 Success criteria for Clinical Senates to support evaluation**

- Evidence that stakeholders understand and use the Senate as a source of independent strategic clinical advice
- Clinical advice issued
- Feedback from commissioners actively sought including impact of clinical advice and outcome indicators
- Evidence each clinical senate meets minimum requirements to deliver senate business
- Annual Report published.

## Document Control

Version	Comments	Author	Sent to	Date
0.1	Collation of all national documents and draft template for populating	Deborah Tomalin	Senate Managers Associate Directors	16/4/14
0.2	Collation of status of national documents from Debbie Kennedy	DT	Senate Managers Associate Directors	28/4/14
0.3	Further input from Debbie Kennedy; Aarti Chapman	DT	Senate Managers and Associate Directors	30/4/14
0.4	Redraft by group of Senate Managers and Associate Directors – Sue Dutch, Angela Knight Jackson, Ellie Devine; Wendy Ryder; Juliette Kumar, Ali Parsons, Sue Edwards, Sarah Hughes, Anna Morton; Ruth Ashmore; Deborah Tomalin	DT	All Senate Managers, Associate Directors, Clinical Senate Chairs	30/04/14
2. final	Amended as per comments at national meeting. Final version subject to legal advice re use of 'impartial / independent'	SE	Senate managers, Associate director (for forwarding)	18/06/14
V3 July20 14	Amended and agreed at Clinical Senates devp workshop 16 July. “ independent” preferred.	G Dalton	Senate managers for forwarding .  For Oversight Group 5 August	17.7.14

## Appendix 1 - Reference Documents

- NHS Future Forum “Summary Report on proposed changes to the NHS” Page 11. January 2012.
- The Way forward - Strategic Clinical Networks. July 2012. NHS Commissioning Board.
- Strategic Clinical Networks - Single Operating Framework. November 2012. NHS Commissioning Board.
- The Way Forward - Clinical Senates . 25<sup>th</sup> January 2013. NHS Commissioning Board.
- Draft national “Accountability and governance arrangements for Clinical Senates ” (version 0.10) led by David Levy (October 2013 version 0.10).
- Clinical Senates Update. October 2013. NHS England. David Levy and Genevieve Dalton.
- Draft letter “Accountability and Governance arrangements for Clinical Senates ” – version 0.11 (sent by Genevieve Dalton to senate managers, associate directors, senate clinical chairs March 2014).
- Draft “Clinical Senates role in service change” version 0.3. National Task and Finish Group led by Tim Barton, NHS England. March 2014.
- Draft “Clinical Senates : support to the independent clinical review process for service change proposals” – Technical guidance, March 2014, Tim Barton, NHS England.
- Draft “Clinical Senate Review” Nigel Beasley. March 2014 sent to Task and Finish Group.
- Planning and delivering service changes for patients. NHS England. December 2013.
- Working draft 8.4. “Effective service change – A support and guidance toolkit”. NHS England. Gateway Reference 00814.

## **APPENDIX 8**

### **Key options / themes from previous documents, pertinent to this review**

#### **Closer to home 2008**

**Option 1:** Suggests that CIC would function as the large acute centre and WCH would provide a full range of services, the exception being some paediatric, complex elective and emergency surgery (including major trauma) which would transfer to CIC.

Acute Stroke beds available at WCH

**Option 2:** One acute hospital based at CIC

**Option 3:** One acute hospital at CIC providing all acute services and a much smaller hospital at WCH providing an emergency treatment centre, scheduled day case treatment and outpatient services.

#### **North Cumbria Clinical Strategy - NHS Cumbria & North Cumbria University Hospitals NHS Trust -2011**

**Section 3:** Highlights a model of concentrating acute cardiac care on the CIC site to facilitate PPCI. This would also apply to acute GI bleeds out of hours and acute stroke services would be provided on both sites.

#### **Together for a Healthier Future June 2014 – North Cumbria Strategy 2014 - 2019**

Clearly outlines the case for change, highlights the challenges with agreement that any changes need to be supported by strong evidence with open and honest patient and public consultation. It discusses the consolidation of all acute medicine to CIC and the possible closure to medical admissions at WCH out of hours. It acknowledges this would require extensive planning and risk assessment, including the difficult challenge around emergency transport and the safety of patients.

#### **North Cumbria University Hospitals NHS Trust Clinical Strategy for Acute Care – October 2014**

**Page 14:** Talks about the early identification of high risk patients by protocols for direct diversion (from the community or transfer to from ED at WCH to CIC).

**Page 16:** Suggests that depending on the chosen option, 24/7 provision of care for 'high risk' medical pathways e.g. Non ST elevation myocardial infarctions, hyper-acute stroke, significant GI bleeds and those patients with high NEWS scores would all transfer to CIC.

Overall it appears the preferred option is for all high risk acute medical and surgical patients are transferred from WCH to CIC with potential to shut WCH at night.