

Cumbria Clinical Commissioning Group

# The Case for Change

PRE-CONSULTATION BUSINESS CASE



**Preliminary Case**

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## Document Status

*This is a confidential document for discussion purposes and any application for disclosure under the Freedom of Information Act 2000 should be considered against the potential exemptions contained in s.22 (Information intended for future publication), s.36 (Prejudice to effective conduct of public affairs) and s.43 (Commercial Interests). Prior to any disclosure under the FoIA the parties should discuss the potential impact of releasing such information as is requested.*

*The options set out in this document are for discussion purposes. The involved NHS bodies understand and will comply with their statutory obligations when seeking to make decisions that will have an impact on the provision of care services. The options set out do not represent a commitment to any particular course of action on the part of the organisations involved but instead act as a catalyst for continuing discussion.*

## Disclaimer

*Throughout this document references have been made to the commissioning intentions of Cumbria CCG and other joint commissioners. Commissioning statements made herein, should not be construed to be final or to represent approved policy. CCG policy in this regard will be subject to CCG Governing Body scrutiny and full consultation with health professionals, member practices and other stakeholders within the local health system. Solutions proposed within this document are therefore preliminary only and will evolve in harmony with the evolving integrated commissioning policies and the transformation and sustainability agenda. Assumptions made within the document will be subject to full financial due diligence to ensure initiatives are affordable within the overall resources available to the local health and social care system.*

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# Key Messages

## About Proposed Changes to West North and East Cumbria

### Health and Social Care Services

1. All partner agencies have worked together to understand the collective needs of our local population and the geography of WNE Cumbria.
2. A focus on prevention of ill health through investment in a world-class health and social wellbeing system will keep people well and independent for as long as possible.
3. We will retain and develop our two acute hospitals – Cumberland Infirmary, Carlisle (CIC) and West Cumberland Hospital (WCH). They will comply with national standards for the best clinical care, seven days a week.
4. Our Integrated Care Community (ICC) model will improve Out of Hospital services, enabling more care to be provided in the community, closer to home – in the right place at the right time.
5. Support for our local primary care services – specifically general practice – will form the bedrock of the development of our ICCs.
6. New models of care, provided using new technologies, will be co-ordinated from Community Hubs.
7. The NHS in WNE Cumbria will be a great place to work, attracting and retaining key staff.
8. By improving our efficiency and effectiveness we will turn around and stabilise our financial position.
9. The development of mental health services in parity to physical health services to promote population health and well being (from prevention to treatment and care) is fundamental to our proposals. Statutory consultation on our wider plans to transform mental health services will take place as part of a related Cumbria-wide process.



## FOREWORD BY CUMBRIA CLINICAL COMMISSIONING GROUP

This Pre Consultation Business Case (PCBC) sets out our journey so far in making the case for transforming health and social care services in WNE Cumbria. It explains how we have arrived at what we believe to be a sustainable model of care for the future and the options for change we wish to test and consult upon.

In an open letter from North Cumbria University Hospitals Trust (NCUHT), Cumbria CCG, North West Ambulance Service NHS Trust (NWAS), Cumbria Partnership NHS Foundation Trust (CPFT) and NHS England (NHSE) on 18<sup>th</sup> November 2015, we acknowledged that patients, staff and the public have ongoing concerns about the future of hospital services in WNE Cumbria, and particularly at West Cumberland Hospital, Whitehaven. We committed to developing a clinical strategy that would set out a clear plan for local services through the Success Regime, a new national initiative to provide support to the most challenged health economies in England. We confirmed that no further changes to any of the clinical services currently provided at West Cumberland Hospital (WCH) or Cumberland Infirmary Carlisle (CIC) would be made prior to the development of our clinical strategy. If this strategy included any proposals for major service change in the configuration of services, we confirmed that these would be subject to full public consultation.<sup>1</sup>

To deliver this commitment, the CCG has been working with key partners through the Success Regime to support local clinicians in developing proposals to deliver safe and sustainable services for WNE Cumbria. This work has been informed by feedback from extensive engagement activity to understand the concerns, aspirations and expectations of local people and with input from a wide range of highly skilled professionals.

From this work, we are clear that the way in which our health and social care services in WNE Cumbria are currently provided is not sustainable. Simply going forward and accepting the status quo will not enable us to deliver the quality of care that we believe local residents deserve, or which our dedicated and skilled staff wish to provide. Furthermore, it will not provide our primary care teams, our community services or our hospital based services with the financial sustainability required to enable them to continue to deliver safe services. Things have to change and change for the better.

In looking to the future, we remain both ambitious and optimistic. We want to work with our local population and our dedicated staff to deliver more services within the community, protecting and enhancing primary care and strengthening out-of-hospital services, while also encouraging individuals to change their behaviour to prevent poor health and reduce overall demand. We are setting out the actions we are taking to make these changes happen. Our plans also confirm our commitment to maintain and develop the two acute hospitals in WNE Cumbria, working together to deliver the kind of improved, high quality specialist care we want our residents to receive as efficiently and effectively as possible. To do this will require significant investment from the government.

Whilst we recognise that some difficult choices will have to be made, we are clear that the benefits that will result from this investment, if the choices are supported through public

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<sup>1</sup> It is noted that if any service needs to change as a result of safety issues, then in doing so without consultation, which is allowed under regulation 23(2) of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny Regulations 2013), it is accepted this is a temporary measure and will require a permanent solution following a proper process.

consultation, will enable us to maintain high quality services within the resources that we believe will be available to us in the years to come.

We believe that without the changes we are proposing our services are simply not sustainable; standards of care will fall, our primary care services will collapse, our hospitals will become unsafe, we will not be able to recruit and retain the specialist expertise that we need, and we will see the gradual movement away of services from WNE Cumbria, resulting in patients having to travel even further in order to get the care they need.

To ensure understanding of our proposals and to secure significant financial investment over the next five years to help us achieve a clinically and financially sustainable solution, we will need both the people who use our services and those who deliver them to engage and participate in the consultation process. In essence, what we are asking for is the opportunity to significantly improve the way our health and social services are delivered, for all our residents.

In developing our plans for the future we believe that it is important to recognise that health care is changing. There continues to be great advances in medical knowledge and technology, alongside the development of increasingly sophisticated and specialist treatments and procedures. This is enabling more services to be provided outside of hospitals, in our own homes, in GP practices and in community-settings, while hospitals are increasingly focusing on the most seriously ill patients.

Our own health needs are also changing rapidly. People are living longer and we are seeing new disease patterns – dementia, obesity and alcohol-related disease have become major issues and more and more of us have long-term health conditions that require ongoing support and management. The way we expect to access our health and social care services is changing rapidly, with the role of new technology playing an increasing role. The decisions we make now must enable us to respond to future changes in health and social care delivery and needs.

We must also develop our plans for the future mindful of the resources that we will have available. The national NHS and local authority financial climate means that there is an increasing need to use resources effectively and efficiently. Our system is currently facing significant financial pressures with an overspend of circa £86m across providers and commissioners in 2015/16. Inflationary pressures and increasingly complex population needs mean that the system will be even more stretched in the future, with the gap potentially increasing to £165m in 2020/21. We must achieve the best outcomes for our patients within the available budget. We must grapple with improving safety, value and sustainability in financially more austere times.

All of this means that we must review the type of services that are available within our communities and those that are delivered in hospital. We also need to look at integrating some services and providing community outreach services so that more can be delivered locally, close to where people live. We must work to ensure that mental and physical health services are given equal importance.

Our proposals will also support greater collaboration between the providers of health and social care. For hospital services, the development of shared, single services, working across organisational boundaries on a bigger footprint, will deliver better patient outcomes, better patient experience, make best use of the limited specialist workforce, and deliver significant efficiencies. This approach will safeguard the future of our primary and community services, and our hospitals and emergency care services.

We believe the case for change outlined is overwhelming, and that we should now consult the public on our proposals in order that we can begin the work needed to transform health and social care services across WNE Cumbria.



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# SECTION A

## Where are we now?

This section considers the current position and explains why change is needed – now.

### Section checklist

#### **Creating the conditions for success in WNE Cumbria**

CCG strategic planning

WNE Cumbria Success Regime

#### **The case for change – key considerations**

Health and wellbeing

Care and quality

Workforce

Financial

#### **The inclusive approach to our development of the case for change**

How we are connecting with service users, providers and commissioners – and the wider community

# 1 INTRODUCTION AND BACKGROUND

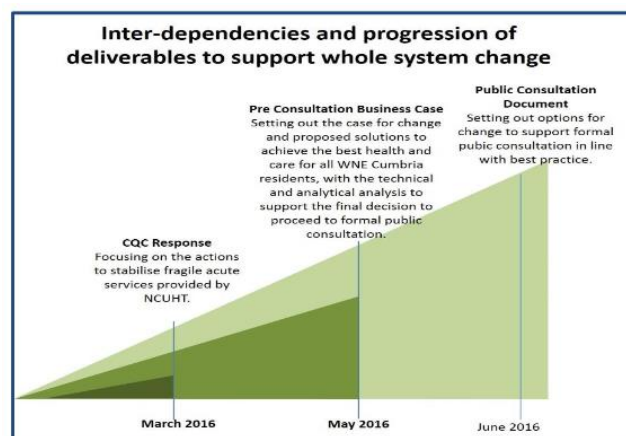
*Chapter One outlines the purpose of The Case for Change for the WNE Cumbria health economy and introduces key organisations involved in its development.*

## 1.1 This Document

This Pre-Consultation Business Case (PCBC), *The Case for Change*, is a ‘live’ strategic planning document that is being updated through an ongoing process of engagement with key stakeholders. Principally it seeks support from NHS England in the form of the investment required over the next five years (2016/17-2021/22) to implement necessary transformative improvements in local care services.

Developed by Cumbria Clinical Commissioning Group (CCG)<sup>2</sup> as an intrinsic part of the process of transforming the West North and East (WNE)<sup>3</sup> Cumbria health economy, *The Case for Change* sets out in three sections (‘Where are we now?’, ‘Where do we want to be?’, ‘How do we get there?’) the following:

- Our journey so far in making the case for transforming health and social care services in WNE Cumbria.
- Proposals for a sustainable future model of care.
- Identified options for change, which will be developed further through public consultation<sup>4</sup> and thorough testing prior to implementation.



This PCBC references the WNE Cumbria Success Regime Clinical Strategy (March 2016) – see **Appendix A**.

<sup>2</sup> Cumbria Clinical Commissioning Group is an NHS organisation set up by the Health and Social Care Act 2012. It is the main commissioner of local NHS services in the county, responsible for identifying the specific health needs of people in Cumbria, and ensuring that these needs are met. An annual NHS budget for Cumbria from the Department of Health is used by the CCG to plan and deliver NHS services including acute hospitals, community hospitals, community-based and mental health services. CCGs do not manage hospitals or community and mental health services: they work very closely with providers to oversee how they are run and work together to integrate primary, secondary and community services. Primary care in Cumbria (GPs, opticians, dentists, pharmacies) is commissioned by NHS England. See <http://www.cumbriaccg.nhs.uk/>

<sup>3</sup> West North and East Cumbria comprises the districts of Allerdale, Copeland, Carlisle and Eden.

<sup>4</sup> The scale of the transformation proposed by *The Case for Change* in the organisation of care and the infrastructure by which it is delivered will constitute a ‘major change’ under section 244 on the NHS Act 2006. Certain proposals within it will require formal public consultation.

## 1.2 Aims and Objectives of this PCBC

The aims of this PCBC are to:

- Make the case for transforming health and social care services in WNE Cumbria.
- Describe the future model of care and how our proposals are being developed.
- Provide details of the pre-consultation engagement that has been undertaken with the public, clinicians, staff and other stakeholders in developing our proposals for change.
- Request commencement of formal public consultation on our proposals for major service change.

The objectives of this PCBC are to:

- Demonstrate anticipated benefits for patients, quality and finance.
- Provide evidence that the clinical case complies with national best practice, the recommendations for the North East Clinical Senate, the Care Quality Commission report (and other relevant clinical reviews).
- Provide assurance that our plans are aligned with:
  - Long-term strategic plans for the CCG and Cumbria Council.
  - Cumbria-wide strategies for mental health and learning disability services.
  - Health and Wellbeing Board strategic priorities.
  - NHS England commissioning plans for primary care as well as specialised services.
  - QIPP work streams.
- Demonstrate compliance with the Department of Health '*four tests*'<sup>5</sup>:
  - Support from GP Commissioners.
  - Strengthened public and patient engagement, together with details of how we have engaged and how we will prepare for formal consultation.
  - Clarity on the clinical evidence base.
  - Consistency with current and prospective patient choice.

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<sup>5</sup> See A mandate from the Government to the NHS Commissioning Board: April 2013 to March 2015  
[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/256497/13-15\\_mandate.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/256497/13-15_mandate.pdf)

### 1.3 Our Vision and Commitment

We are committed to working in partnership to deliver the transformation in care services that will achieve improved outcomes for our population:

- Ensuring that all who use our services are at the centre of everything we do.
- Becoming world leaders in how to run the most efficient, safe and effective hospital services in remote and rural settings.
- Cultivating first class responsive and accessible community services, tailored around the needs of their communities.
- Returning our health and social care system to financial balance.

Our vision<sup>6</sup> is to develop WNE Cumbria as

*“a centre of excellence for integrated health and social care provision in rural, remote and dispersed communities”*

Our model of patient-centred efficiency and truly integrated care will support our workforce to grow and develop in their roles and careers – and to stay in WNE Cumbria. It will also attract new staff to help meet recruitment and retention challenges.

While we have already fixed a number of safety issues, we will need to consult widely on any service reconfiguration options that have the potential to increase safety and service resilience.

We propose to support transformation with:

- Innovative use of information technology and telehealth.
- A culture of continuous improvement led by happy, engaged staff.
- Excellent clinical and social care partnerships and networks.

#### 1.3.1 Three Major Developments

Three major developments are proposed that will improve the future pattern of need and demand:

1. Establishment of **integrated care communities** that will provide strong, place-based, proactive care for local people. Either in their own homes or in locally based facilities.
2. Support for and encouragement of fully engaged, **expert patients** better able to manage their conditions and their use of health and social care services.
3. Investment in a **comprehensive public health strategy** that will have a real impact on each individual's health and wellbeing now and in the future.

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<sup>6</sup> Shared by all partners of the WNE Cumbria Success Regime.

## 1.4 About WNE Cumbria

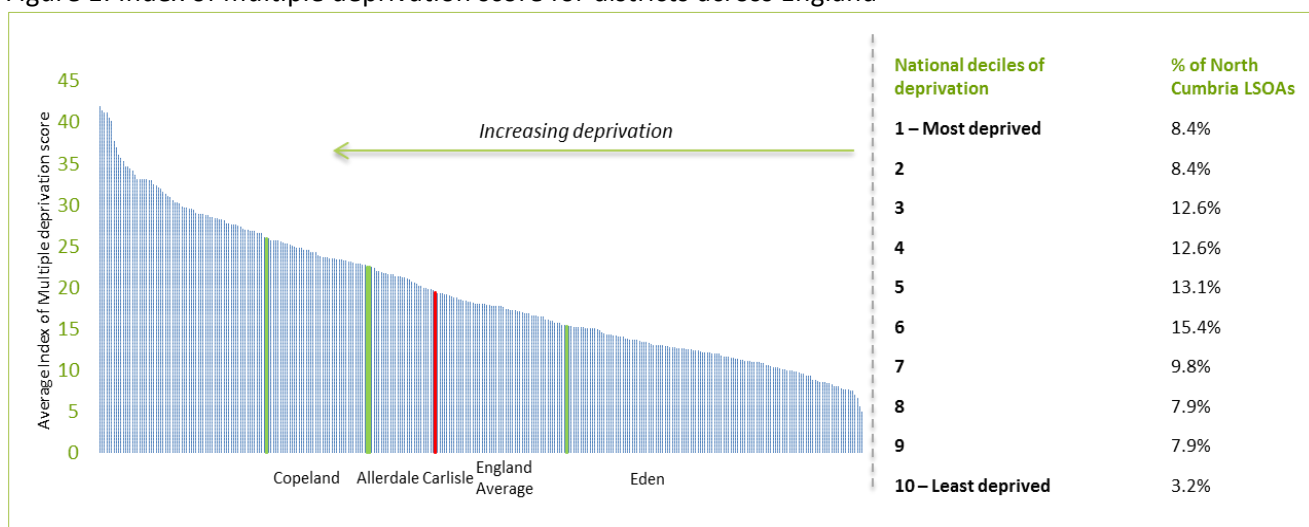
### 1.4.1 Geography and Demographics

WNE Cumbria represents approximately 65% of the total population of Cumbria. Geographically, it is defined as the four districts of:

- **Allerdale** – 96,471 residents.
- **Copeland** – 69,832 residents (includes circa 8,400 citizens who access services in South Cumbria).
- **Carlisle** - 108,022 residents.
- **Eden** – 52,630 residents.

WNE Cumbria is a rural area characterised by a complex socio-economic structure that creates significant demand and cost pressures on the health and social care system and difficulties in providing access to appropriate health and social care services (see Figure 1 below).

Figure 1: Index of multiple deprivation score for districts across England



Source: Department for Communities and Local Government, 2015

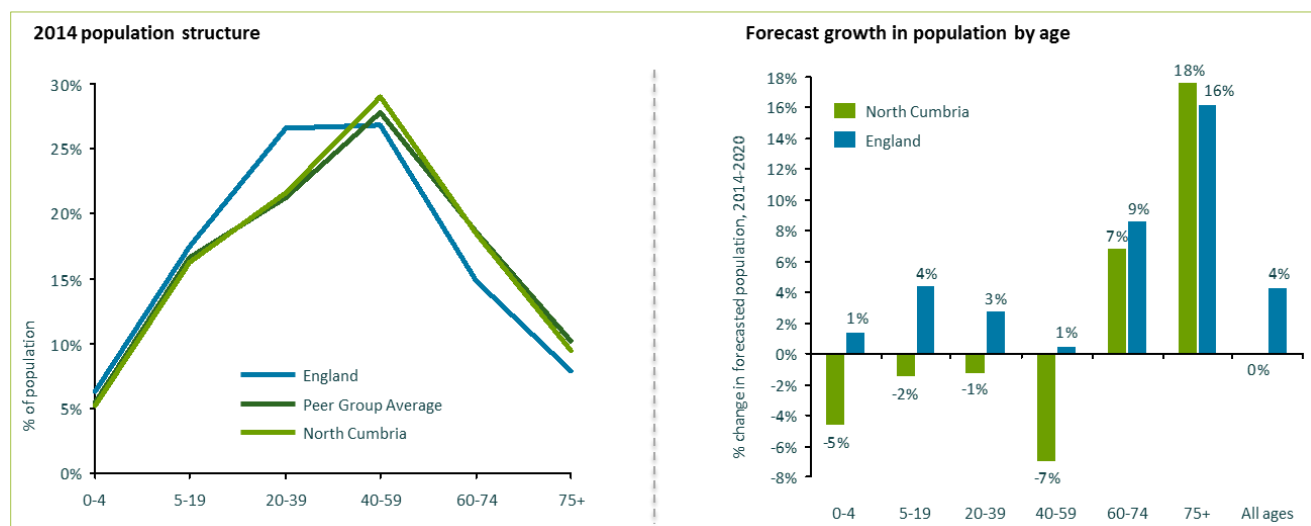
The population is ageing and is more deprived than the national picture (see Figure 2 below). The isolated and sparsely populated geography means that it takes twice as long as the English average travel time to get to a GP. There are also additional difficulties associated with provision of care to an area with a population density that is 80% lower than the national average.



The west coast of Cumbria, with just over 120,000 residents, is especially isolated from the rest of Cumbria as well as the rest of England. For example, the towns of Whitehaven and Workington, with populations of roughly 25,000 each, are about 39 and 30 miles respectively from Cumbria's largest urban centre of Carlisle, and 100 miles from Newcastle (the nearest metropolitan city).

Consideration has also been given to the proposals for a new nuclear power station at Moorside in West Cumbria and the possible fluctuation in population as a result. Subject to consultation, we understand that construction could start as early as 2017, employing up to 6,500 people at its peak with approx. 1,000 workers once operational.

Figure 2: 2014 population structure and 2012/13 population growth



Source: ONS 2014 population figures

#### 1.4.2 Cumbria Clinical Commissioning Group

Cumbria CCG, led by local GPs, commissions the majority of hospital and community health and social care services for our local population. We ensure that the services we commission are high-quality, safe and sustainable and that budgets are managed efficiently and effectively. Whilst services in WNE Cumbria are not unsafe, there are significant quality issues closely interconnected with the financial and strategic issues and we face substantial challenges to improve hospital and community health and social care services in WNE Cumbria and South Cumbria. We are working in partnership with the WNE Cumbria Success Regime to develop our strategic plans for the area.

#### 1.4.3 WNE Cumbria Success Regime

The challenges for health and social care in WNE Cumbria are deep-rooted, long-standing and spread across the whole system as opposed to individual organisations. Local and national organisations have worked hard for some time to improve services for patients and the public, but have not made the progress needed. In recognition of this, WNE Cumbria was identified on 3<sup>rd</sup> June 2015 as one of the three areas to be included in the Success Regime<sup>7</sup>, a new national initiative to help the most challenged health and social care economies in England.

<sup>7</sup> See <http://www.successregimecumbria.nhs.uk/>

Launched in September 2015, the aim of the WNE Cumbria Success Regime is to provide support and direction so as to secure improvement in three main areas:

- **Short-term improvements** against agreed quality, performance or financial metrics.
- **Medium- and longer-term transformation**, including the application of new care models where applicable and achieve system wide financial balance.
- **Development of sustainable leadership capacity and capability.**

#### 1.4.4 WNE Cumbria Health and Social Care Context

Local health and social care services are delivered by the following organisations:

Figure 3: Care Provider Organisations based within WNE Cumbria

Care provider organisations based within WNE Cumbria	
<b>Primary Care:</b>	45 General Medical Practices Out of Hours: Cumbria Health On Call 65 Community Pharmacies 44 Dental Providers 45 Optometrists
<b>Community Care:</b>	Cumbria Partnership NHS Foundation Trust (CPFT)
<b>Public Health</b>	Cumbria County Council
<b>Social Care and Housing:</b>	Cumbria County Council
<b>Secondary Care:</b>	North Cumbria University Hospitals NHS Trust (NCUHT)
<b>Mental Health Care:</b>	CPFT
<b>Ambulance Services:</b>	North West Ambulance Services NHS Trust (NWAS)
Other providers who deliver services to WNE Cumbria Residents	
Northumbria Healthcare NHS Foundation Trust Newcastle Upon Tyne Hospitals NHS Foundation Trust University Hospitals of Morecambe Bay NHS Foundation Trust	

**NCUHT** operates two acute hospitals designed as traditional District General Hospitals (DGHs) with relatively small catchment populations. There are many challenges to overcome:

- Small teams and low activity volumes compound the difficulties of dual-site working.
- Difficulty in maintaining skills and training experience for junior staff.
- High-quality governance arrangements.
- Achievement of regulations and standards, national guidance and Royal College requirements.

There is in turn an adverse impact on Trust recruitment and retention rates, particularly for medical, nursing and administrative staff. This is evidenced by a relatively high number of consultant posts covered by locum staff (28% in April 2016). In consequence, many services are operationally extremely fragile – including accident and emergency (A&E), acute medicine and paediatrics at WCH.

The Trust has been in special measures<sup>8</sup> since 2013. In September 2015, the Care Quality Commission (CQC) rated urgent and emergency services at NCUHT as “requires improvement”; general medical services at WCH were rated “inadequate”<sup>9</sup>. The CQC Chief Inspector of Hospitals highlighted this as being a major concern and required the Trust to urgently address its regulatory compliance shortfalls, workforce challenges, inefficiencies and structural issues in a way that is consistent with the strategy of the wider health and social care economy to be developed by the Success Regime.

The conclusions and recommendations of the CQC were accepted in March 2016 via a response document<sup>10</sup>. This sets out in detail the stabilisation plans that are being progressed (see **Appendix A**) and acknowledges the need to consider requirements for reconfiguration of some services. The response plan aims to increase safety and service resilience, achieve greater efficiency and make better use of limited resources.

**CPFT** provides mental health, learning disability and community-based services. The recently published CQC report on CPFT gave an overall rating for the Trust as “requires improvement”, with particular concerns identified in relation to services for children, young people and families.

**Cumbria County Council** provides public health prevention services, services that support vulnerable people to secure and maintain their accommodation, reablement, telecare, support at home, extra care housing, residential care, learning disability services. The county council is experiencing pressure associated with an increasing need and a significant reduction in budget.

**Primary care** – while WNE Cumbria has historically benefitted from high-quality primary care services (specifically general practice services), these too are experiencing significant pressures associated with an increasing workload; challenges to historical resourcing arrangements; and increasing workforce difficulties. As noted above, the operational fragility and pressures within NCUHT have a particular impact on primary care, creating additional workload and reducing the opportunity to build strong clinical relationships that can support patient care.

However, it is important to recognise that, despite deep-rooted issues, there have been some very positive and notable achievements. Recent examples include:

- 96% of general practices that have been inspected to date have been rated “good” or better.
- There has been national recognition for **#seetheperson** – an initiative to change the culture in dementia care – which was shortlisted in the National Patient Safety Awards and Nursing Times.
- The response to the 2015 floods, which received national recognition.

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<sup>8</sup> When there are concerns about the quality of care that hospitals are delivering, they can be put on special measures. Special measures are designed to offer trusts the support they need to improve, as well as giving the public the ability to hold them to account. [NHS Improvement](http://www.nhs.uk/NHSEngland/specialmeasures/Pages/about-special-measures.aspx) is responsible for putting both foundation trusts and NHS trusts on special measures. NHS Improvement is the operational name for the organisation that brings together Monitor, the NHS Trust Development Authority, Patient Safety, the National Reporting and Learning System, the Advancing Change Team, and the Intensive Support Teams. One trigger for a trust being put on special measures is a recommendation from the Chief Inspector of Hospitals, which may be made after a routine inspection. See <http://www.nhs.uk/NHSEngland/specialmeasures/Pages/about-special-measures.aspx>

<sup>9</sup> See <http://www.cqc.org.uk/content/north-cumbria-university-hospitals-require-improvement-say-cqc>

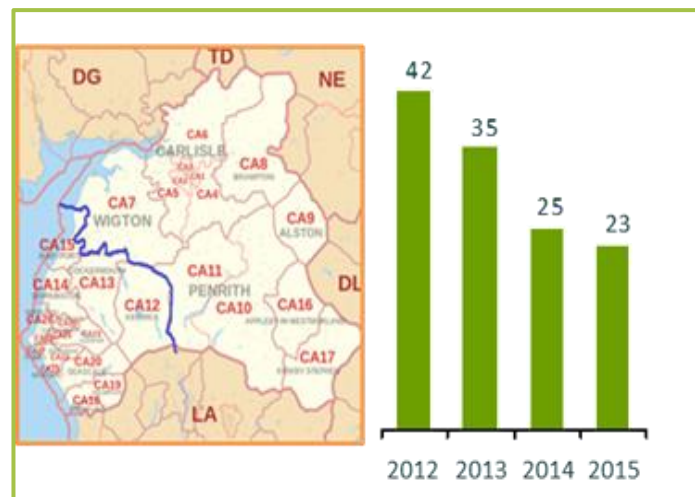
<sup>10</sup> See <http://www.cumbriaccg.nhs.uk/news/2016/April/WNECumbriaSuccessRegimeCQCresponedocument%281%29.pdf>

- Achievement of seven-day 8am-8pm primary care services across five GP practices in Workington offering “same day” GP appointments and a walk-in minor injury service.
- Informatics: Cumbria is leading the way in developing interoperable clinical system including and electronic referral system.

**Service changes for a number of high-risk patient pathways** have been successfully implemented in WNE Cumbria:

- In 2012, high risk surgical pathways were transferred from WCH to CIC process. Figure 4 below illustrates the significant reduction in mortality associated with emergency surgical activity for West Cumbria patients following the decision in 2012 to consolidate all emergency general surgery on CIC.
- In June 2013, the transfer of major and significant trauma including hip fractures from WCH to CIC was implemented.
- In 2014, in response to safety issues, a decision was taken by the Trust to cease the trauma on-call service and associated inpatient admissions and minor trauma operating at WCH.
- In 2015, new evidence-based medical pathways were enacted for specific higher-risk conditions that require rapid access to 24/7 specialist teams. Conditions involved include patients with gastrointestinal bleeds, some types of myocardial infarctions (noting that some were already managed at the CIC Heart Centre), and some patients with particular respiratory conditions. Where these conditions can be readily identified in the community, NWAS now transfers patients directly to CIC, leading to improved patient outcomes.

Figure 4: Changes in mortality  
(West Cumbria postcodes)  
following the transfer of  
emergency general surgery  
(2012-2015)



## 1.5 Creating the Conditions for Success

Essential prerequisites for future success include the following:

- Plans and proposals that we are putting forward will have an impact on – and be affected by – plans being developed in neighbouring systems. We are active participants in discussions about how neighbouring strategic plans and ours align. We are committed to partnership working with our staff, our local communities and our neighbours.
- Integrated care communities will be fundamental to the future model of care.
- We will work to maintain services across two acute hospital sites, ensuring that both WCH and CIC provide safe, high-quality care. This will require introduction of the concept of “single specialist clinical teams” that work across organisational boundaries.
- Specialised and specialist services must be provided through strong network arrangements.
- A higher level of leadership and commitment is required in order to deliver short-, medium- and long-term improvements aligning with CQC requirements and recommendations. A higher level of leadership and commitment is required to drive a positive transformation in health and social care across Cumbria. To achieve this, with our health and social care partners we have developed the Cumbria Learning and Improvement Collaborative (CLIC), which is a shared “umbrella” initiative to embed a culture of collaboration for continuous learning and quality improvement, and living within our means. CLIC’s Organisational Development Objectives are as follows:

### CLIC Organisational Development Objectives

#### We will:

- Build engagement, ownership and happiness amongst staff, patients and the public (the Success Regime communications and engagement plan).
- Build leadership that consistently and unrelentingly shows, supports, directs and rewards the necessary change and development required.
- Develop a single culture (“*the way we do things around here*”), and shared sense of purpose, focused on improving outcomes with and for patients.
- Build capability and resilience, especially focussed on the clinical practice of high-performing teams and continuous system development through the mastery of modern improvement methods.
- Create a place that exemplifies exciting, innovative and compelling organisations and teams to work in, so that we can more easily recruit and retain talented people (exemplified by the Success Regime workforce enabling programme).

A number of building blocks for future success are already in place, including:

- A commitment to learn together through the Cumbria (health and social care) Learning and Improvement Collaborative (CLIC).
- Development programmes within individual organisations and links to support networks such as the North West Leadership Academy (NWLA) and Advancing Quality Alliance (AQuA).
- Guidance from a body of evidence and clear “manifestos” such as the Berwick Report<sup>11</sup> and the work of Michael West<sup>12</sup>.
- An existing nucleus of knowledgeable, experienced and engaged people keen to lead and support the transformation programme.



## 1.6 Introduction and Background – Summary

The proposals set out within this document will highlight the complex challenges that we know are facing us as we work to plan and deliver safe and sustainable health and social care services for people in WNE Cumbria. We recognise that difficult decisions will need to be made and we believe that the proposals we want to consult on reflect the best way forward, and will offer more responsive services able to innovate and adapt – to respond to changing needs and expectations.

<sup>11</sup> See <https://www.england.nhs.uk/tag/berwick-report/> Professor Don Berwick, renowned international expert in patient safety, was asked by the Prime Minister to carry out a review following the publication of the Francis Report.

<sup>12</sup> See <http://www.kingsfund.org.uk/about-us/whos-who/michael-west>: areas of research interest are team and organisational innovation and effectiveness, particularly in relation to the organisation of health services.



## 2 WHY WE NEED TO CHANGE

*Chapter Two sets out the case for change and why carrying on as before is not an option. It considers the current position and sets out ambitions for the future, with a particular focus on health and wellbeing, reducing health inequalities, quality and care and the efficiency and effectiveness of our workforce.*

### 2.1 Improving Health Outcomes

There is consensus across WNE Cumbria that if we do not redesign and transform services to improve quality, using the available resource, our population will experience poorer health outcomes as a direct result. Figure 5 below summarises the key challenges.

Figure 5: Challenges for the WNE health and social care system



Source: WNE Cumbria Success Regime

## 2.2 The Scale of the Challenge – Health and Wellbeing

**Current inequalities in health outcomes are unacceptable and must be addressed.**

WNE Cumbria faces a number of health and wellbeing challenges including an ageing population, a high prevalence for almost all disease groups compared to national and peer groups and a high prevalence of mental health conditions. These prevalence rates are expected to increase significantly over the next few years.

Isolated and rural populations create additional challenges, resulting in areas of high service demand and health inequalities (see Figure 6 below).

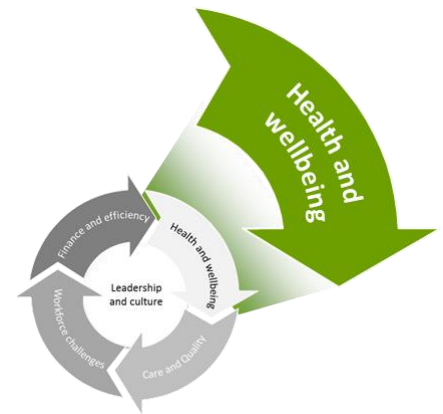
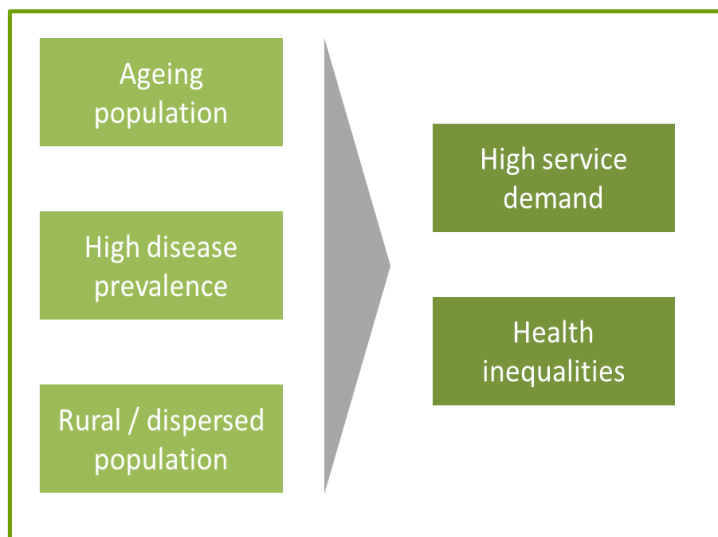


Figure 6: Drivers of demand and inequality



Source: WNE Cumbria Success Regime

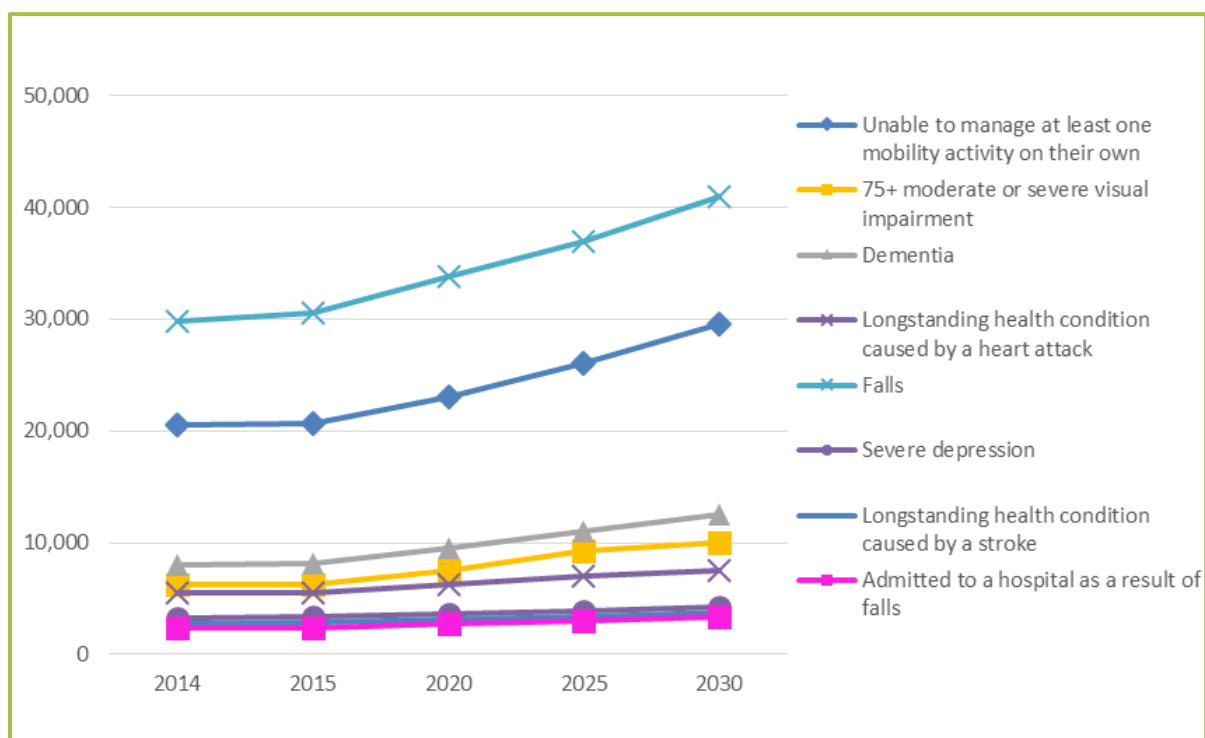
Between 2015 and 2020, the number of people aged under 60 years is expected to *decrease* by 3.4% and those aged 60 years and older is expected to *increase* by 8%. A so-called “super ageing” population increases demand for a number of services, and places particular pressure on social care providers.

The utilisation of long-term residential and nursing care homes for older adults in social care is c.25% higher for Cumbria County Council compared to its peer group. If current demand continues, the projected impact on the overall cost of social care for adults will be an increase of over £10m per year, in today’s prices, by 2020. In addition, local ageing demographics will increase the prevalence of dementia: by 2030, the number of over 65 year olds with dementia is expected to increase by 56%. The projected number of older people accessing social care due to physical disabilities, learning disabilities or mental health problems is projected to increase over the next five years by 14%, 8% and 10% respectively, despite the overall population remaining relatively constant. Costs for younger adults with complex disabilities are expected to increase by £6m per year.

These projections (see Figure 7) need to be considered in the context of anticipated year-on-year reductions in funding available.



Figure 7: Cumbria: Health projections (65+ years population)

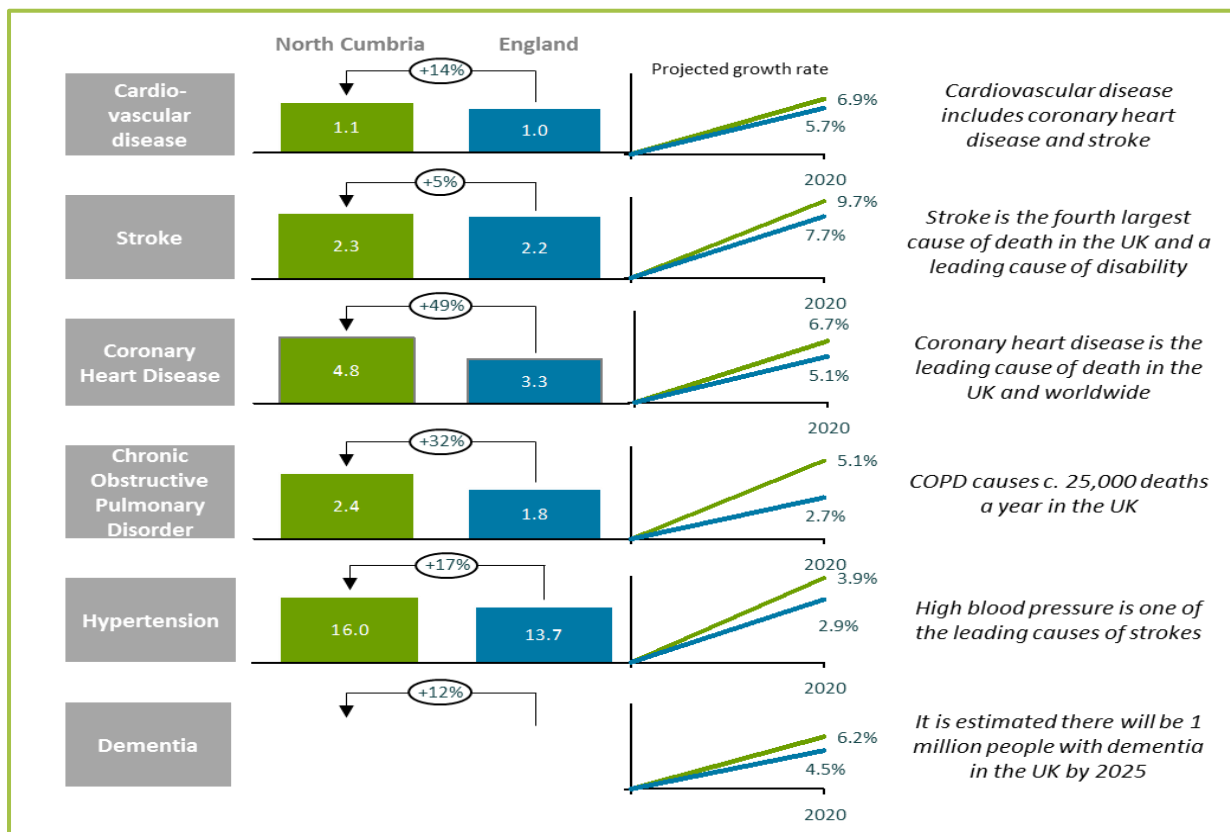


Source: POPPI, Cumbria Health and Wellbeing Strategy 2016-19

WNE Cumbria has higher prevalence rates for *almost all disease groups* compared to the national and peer group average (see Figure 8 below). The difference is more pronounced for some diseases (hypertension rates are c.17% higher than the national average) and less pronounced for others (depression rates are c.4% higher than the national). Mental and physical illnesses often co-exist, with depression noted in 13-57% of cancers and 30-50% of heart attacks<sup>13</sup>. These prevalence levels are also growing at a faster rate in WNE Cumbria than the English average.

<sup>13</sup> Source: Cumbria Joint Service Needs Assessment 2012-15

Figure 8: WNE Cumbria current and projected prevalence rates for major disease groups

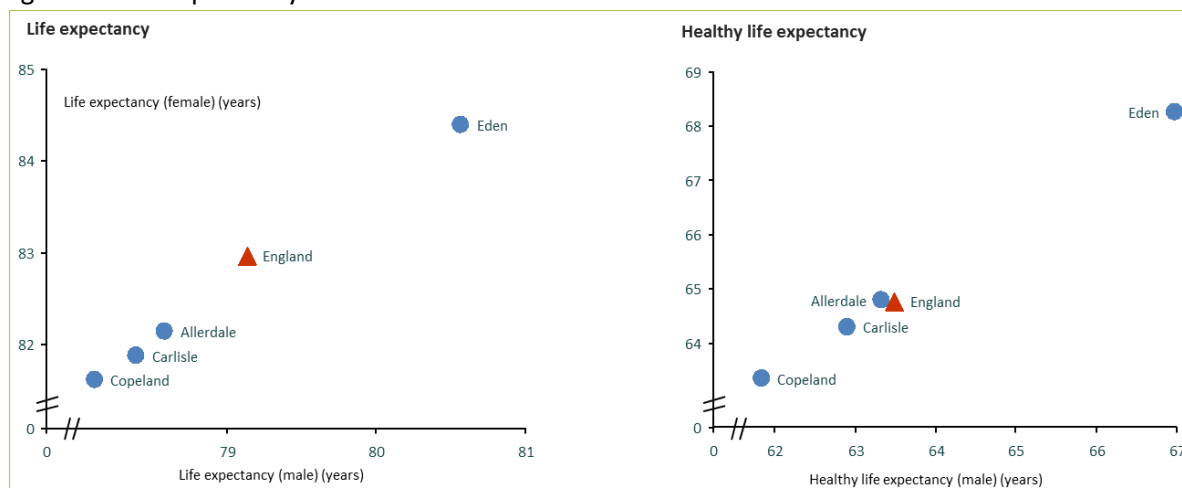


In terms of mental health and wellbeing, Cumbria has a higher than average (and rapidly growing) prevalence of mental health conditions and related mortality rates:

- In 2014/15, 8% of the population of Cumbria (compared to 7% across England) were registered with depression on GP registers, an increase of 12% on the previous year.
- There are currently 10,625 people in Cumbria in contact with services; 2,425 people on a care programme approach and 150 people subject to the Mental Health Act, showing year-on-year increases of 7%, 298% and 178% respectively.
- The rate of emergency hospital admissions for intentional self-harm is 266 compared to the English average of 203.2.
- In 2012/13, premature mortality rates linked to mental illnesses were significantly higher than the rest of England:
  - Excess (<75) mortality in adults with serious mental health illness was 439.5 compared to the English average of 347.2.
  - Premature (>75) mortality in adults with serious mental illnesses per 100,000 was 2,029 compared to the English average of 1,319.
  - Mortality from suicide and injury undetermined per 100,000 was 11.3 compared to the English average of 8.9.

8.4% of the WNE Cumbrian population live in the most deprived decile of England. Average life expectancy and healthy life expectancy reflect these patterns – there is a 19.5-year gap between the wards with the highest and lowest life expectancies with some wards having a life expectancy 8.4 years below the national average (see Figure 9 below).

Figure 9: Life Expectancy in WNE Cumbria



Source: ONS, JSNA 2012 – 2015

Indeed, health disparities are present across WNE Cumbria; for example, Copeland has more than twice the prevalence rate for smoking as Eden, while teenage conception rates are significantly higher in Allerdale and Carlisle. Eden is the only one of the four districts that performs above average on life expectancy and healthy life expectancy rates.

These health disparities are exacerbated by the rural nature of the area – Cumbria is the second least densely populated county in England (73 p/km<sup>2</sup>), which makes travel time for accessing care a perennial issue for the health and wellbeing of the local population. This is also a challenge to any proposed change which potentially increase the travel time for certain groups to access healthcare.

Low or late diagnosis rates have significant impacts on health outcomes, and often also on health inequalities. The earlier diseases are screened for, or diagnoses made, the better the chances of treatment and survival, as well as fewer complications. For example:

- Screening to identify Type 2 diabetes, followed by treatment led to a reduced risk of cardiovascular disease or death within a five-year follow-up period when compared to patients having no screening, according to research from the universities of Michigan and Cambridge<sup>1</sup>.
- Low rates of diagnosis for dementia have resulted in poor access to support, and further exacerbate a 'postcode lottery'; earlier diagnosis of dementia is a key national priority via the Prime Minister's Challenge on Dementia.

It is estimated that there are hundreds of thousands of people living with undiagnosed atrial fibrillation, a condition that increases likelihood of stroke by five times.

Whole-system transformation must focus more resources on prevention and on supporting people to maintain their health and independence, targeting areas of greatest need. We propose to achieve this by:

- Maximising use of the strengths of our local communities.
- Using the opportunities associated with new technology.
- Delivering health and social care services in new ways.

## 2.3 The Scale of the Challenge – Care and Quality

**We must close the “quality gap” and enable all providers of health and social care services to achieve “best in class” outcomes.**

Services across WNE Cumbria are not unsafe; however, there are significant quality issues closely interconnected with the financial and strategic issues outlined in this document.

The case for change for patient safety and quality is closely linked with workforce and financial considerations. We must:

- **Minimise variation in outcomes** by developing robust single pathways and using co-located teams to provide timely access to specialist staff.
- **Provide the opportunity for clinicians to take ownership of patient pathways** by working in a single team around the needs of the patient; and
- **Co-locate support services** to help with patient flow, better management of the increasing acuity of demand and deteriorating patients.



### 2.3.1 NCUHT Performance

In 2011/12 NCUHT was registered without conditions by the CQC. However, in February 2013, NCUHT was one of 14 Trusts reviewed nationally in a process led by Sir Bruce Keogh<sup>14</sup> and deemed to be an outlier for higher than expected rates of mortality. As a result, the Trust was placed in special measures in July 2013.

In 2014 the CQC conducted an inspection of NCUHT and concluded overall that despite progress the Trust still ‘required improvement’. A further inspection in 2015 identified further progress across a number of areas, with a continued ‘Good’ rating for the Caring domain and ‘Good’ ratings for surgery, children and young people and intensive care. However, medical care at WCH was rated as ‘Inadequate’ – largely (although not solely) as a result of continuing over-reliance on agency and locum staff. The overall findings of the 2015 CQC inspection are summarised in Figures 10 and 11 below:

<sup>14</sup> See <http://www.nhs.uk/NHSEngland/bruce-keogh-review/Pages/published-reports.aspx>

Figure 10: CIC CQC ratings 2015

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Requires improvement	Good	Requires improvement	Good	Requires improvement
Medical care	Requires improvement	Requires improvement	Good	Requires improvement	Good	Requires improvement
Surgery	Good	Good	Good	Requires improvement	Good	Good
Critical care	Requires improvement	Good	Good	Good	Good	Good
Maternity and gynaecology	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Services for children and young people	Good	Good	Good	Good	Good	Good
End of life care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Requires improvement	Good	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Source: North Cumbria University Hospitals NHS Trust CQC Inspection Report, 2015

Figure 11: WCH CQC ratings 2015

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Inadequate	Requires improvement	Good	Inadequate	Requires improvement	Inadequate
Surgery	Good	Good	Good	Requires improvement	Good	Good
Critical care	Good	Good	Good	Good	Good	Good
Maternity and gynaecology	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Services for children and young people	Good	Good	Good	Good	Good	Good
End of life care	Good	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Good	Not rated	Good	Requires improvement	Good	Good
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Source: North Cumbria University Hospitals NHS Trust CQC Inspection Report, 2015

While patient experience data demonstrate that services are appreciated, demonstrating delivery of a good standard of care in many areas,<sup>15</sup> the CQC has recognised that the current configuration of services does not and cannot meet aspects of national guidance and Royal College requirements. This particularly focused on staffing levels, and best practice patient pathways, with significant concerns in relation to capacity to improve and/or sustain the safety of services. A review of 89 serious incident investigation reports during 2015/16 undertaken by NCUHT found that 24 (i.e., 26%) identified inappropriate staffing levels as either the root cause or a contributory factor. During 2015/16 there has been continued underperformance against core constitutional standards for the national four-hour waiting time A&E target, Referral to Treatment (RTT) and 62-day cancer waiting times targets (see Figure 12 below).

<sup>15</sup> The Friends and Family Test for patients shows that overall the Trust is in line with national benchmarks. Recommendation rates for inpatients and outpatients are in line with national average, whilst A&E is c.7% below the national average.

Figure 12: Current performance against key constitutional standards for the first three quarters of the year 2015/16

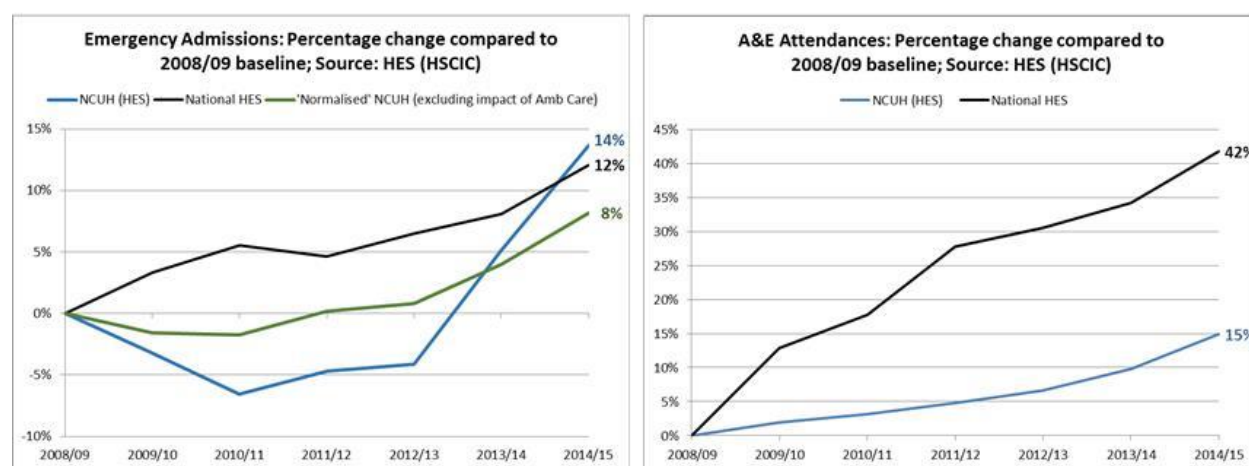
		CCG	NCUHT	National Target
RTT	Incomplete	91.4%	90.5%	90%
	52 week waits	3	0	0
	Diagnostic > 6 weeks	4.8%	7.5%	<1%
A&E	>4 hour waits	88.4%	84.4%	95%
	12-hour trolley wait	0	0	0
Cancer Waiting Times	14 day GP referrals	92.5%	92.7%	93%
	14-day Breast (symptomatic)	89.2%	91.1%	93%
	31 days first treatment	97.4%	96.8%	96%
	62 day GP referral	81.8%	76.2%	85%

Source: Cumbria CCG Governing Body Report, 2016

Emergency admissions at NCUHT have increased by almost 14% since 2008/09 (see Figure 13 below). However, over 5% of the growth is due to the impact of local changes in counting of ambulatory care assessments and new configuration of the emergency floor. Once the growth is normalised, it is significantly below the national growth. Similarly, while A&E attendances at NCUHT have increased by almost 15% since 2008/09, this is significantly below the growth observed nationally.

In 2014/15, 43.7% of A&E attendances at NCUHT resulted in admission (noting that GP referrals are largely routed via A&E), compared to a 24.5% average for England, although this is due, at least in part, to the large number of minor injury units in Cumbria compared to the rest of the country. Waiting times before admission were 18% higher than the English average.

Figure 13: A&E and Emergency Admission Trends in WNE Cumbria



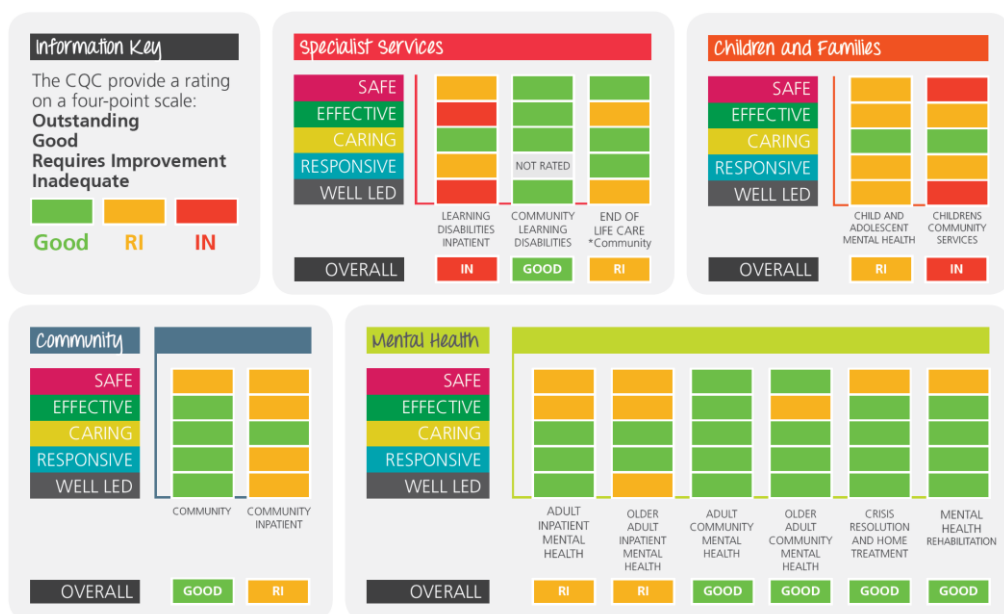
The evidence underpinning Royal College guidance on emergency care<sup>16</sup> and the safer staffing guidance for planned and emergency care for nursing staff both support the strategic need to thoroughly overhaul operational delivery of services (and consider changes in service configuration) in order to comprehensively and systematically achieve the required gains on quality and safety. The Trust has made significant inroads in this area (including the introduction of acute care physician models on both sites), but further improvements and delivery of national Seven Day Hospital Services<sup>17</sup> will require much more fundamental change.

An audit undertaken in April 2014 by the Oak Group<sup>18</sup> found that of 200 inpatients reviewed, 72% were over the age of 70 years of age and 89% had significant risk factors. The audit found that discharge planning was often poorly documented, particularly at WCH. As a result, the audit concluded that 34% of bed days could have been provided at home, with 41% provided at the intermediate level of care. It also found that of the 200 patients reviewed, 37% of admissions and 33% of continuing days could have been provided at home with a variety of services.

In summary, acute care provided by NCUHT is not currently meeting CQC standards and growing service demand and major operational fragilities are increasing pressures. The specific concerns around workforce and quality of service, and the actions taken to mitigate against these risks, are explored in more detail in Chapter 4.

### 2.3.2 CPFT Performance

CPFT was subject to a routine comprehensive CQC inspection in November 2015 and the report was published in February 2016. Of the 13 services rated, six received 'good', five 'requires improvement' and two 'inadequate', with an overall Trust rating of 'requires improvement'. Across the Five Domains (safe/effective/caring/responsive/well-led) ratings were as follows:



<sup>16</sup> Royal College guidance underlines the impact that early senior assessment and specialist intervention in the first hours of emergency assessment/admission can have on reducing mortality, reducing readmission rates, incidents and harm caused to patients, for both adult and paediatric care.

<sup>17</sup> See <https://www.england.nhs.uk/ourwork/qual-clin-lead/7-day-week/>

<sup>18</sup> North Cumbria Audit Results, Service Study Outcomes April 2015, Oak Group International

The CQC report referenced improvements in the culture of the Trust and its governance. It also made recommendations for further improvements that it concluded CPFT is well placed to take forward. Specifically, it highlighted the need to improve **children's community services**, and **adult assessment and treatment for people with learning disabilities**. Both general and mental health community services were rated as good – which gives confidence to continue developing services in these areas for the future.

Previous service-specific CQC inspections have identified good practice in many areas and also areas of ongoing difficulty in some, including concerns on staffing, record-keeping and access to independent advocacy.

These findings are also consistent with the Oak Group audit conducted in April 2014<sup>18</sup> which reviewed two community hospitals (Wigton and Penrith). It identified poor discharge planning and significant delays in discharge, of which over half were in the gift of the respective community hospital to address. The audit also suggested that 37% of bed days could have been provided at home with appropriate support services. It is also of note that the audit identified significant variation between the two community hospitals with 27% bed days at Penrith identified as being able to be provided at home compared to 75% at Wigton.

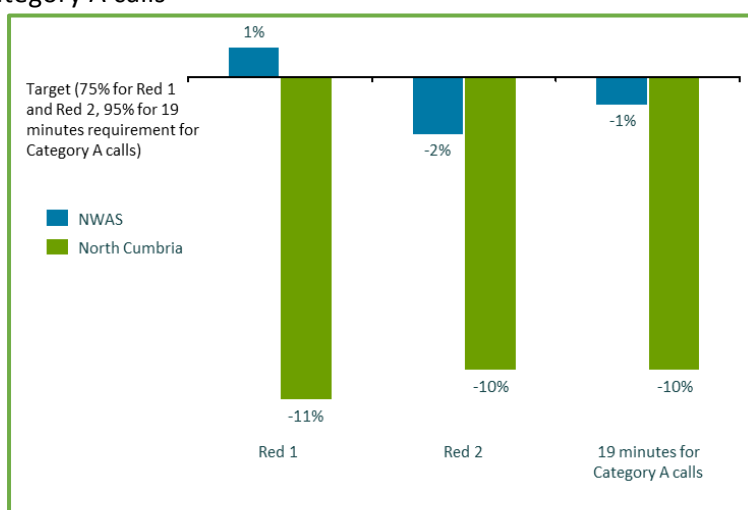
The Trust emerged from enforcement undertakings applied by Monitor in late 2015 following a period of action taken to strengthen governance quality. It is presently RAG-rated 'Green' for governance by NHS Improvement.

### 2.3.3 NWAS Performance

North West Ambulance Service (NWAS) is one of ten ambulance Trusts in England and provides emergency medical services as well as non-emergency Patient Transport services (PTS). It provides services across 5,500 miles for Greater Manchester, Cheshire (not PTS), Merseyside, Lancashire, Cumbria and some north western fringes of the high Peak District. It provides NHS 111 service across the North West.

2015/6 YTD performance (see Figure 14 below) shows that NWAS struggles to meet national response times standards.

Figure 14: NWAS Performance in WNE Cumbria for Red 1, Red 2 and Category A calls





Modelling data from across the UK suggests that with sufficient staff training, utilisation and access to alternatives, more than 40% of calls for ambulance services nationally could be dealt with through “see and treat” and “hear and treat”. For WNE Cumbria this would equate to 45 patients each day: it currently handles 38% of calls through “see and treat” and “hear and treat”.

- “Hear and treat” - using telephone triage in response to 999 calls.
- “See and treat” - an NWAS clinician treats the patient in situ or refers to a service other than an emergency department for instance, a community hospital minor injuries facility.
- “See and convey” - the patient is taken to an emergency department.
- “Acute Visiting Scheme” - a senior clinical decision maker, usually a GP, is contactable and provides relevant advice.

### 2.3.4 Residential and Nursing Homes and Adult Social Care Performance

In 2014 there were 130 care homes for Older People in Cumbria with a total of 4,426 registered places. Of these, 36 are nursing homes and 94 residential care homes, with 917 beds in 29 residential care homes being directly provided by Cumbria County Council. Of these it is estimated that between 20% and 30% are nursing beds.

The CQC has identified significant variability in the quality of care provided in older adults residential and nursing homes across Cumbria. Of those that have been inspected by the CQC, 66% have a rating of ‘Good’, which is higher than the England average of 58%; however, 11% of care homes were rated as ‘Inadequate’ – which is higher than the English average of 5%. 26% of the homes in Cumbria met none of the prescribed National Minimum Standards (NMS) for physical environment. Examples of these include basic room size, the availability of private ensuite bathing facilities, etc. For care homes registered after 2002, 35% met ‘some’ of the NMS, and 39% met all of them. Over the last year there has been a rise in action by regulators against care homes.

Cumbria County Council (CCC) spends more money on the elderly than comparable councils. Additionally, it spends a higher percentage of its resources on residential and nursing care and less on community-based services than comparable councils. Compared to other local authority areas, Cumbria has a low level of supply of Extra Care housing (ECH). The council deals with around 45,000 requests for help for adult social care every year: around 20,000 of the contacts come from professionals in the NHS, housing and other partners. Cumbria is in line with peers for the quantity of care home beds per 100,000; however, it has a much higher proportion of long-term admissions to residential and nursing homes and utilisation is higher than peers (see Figure 15 below).

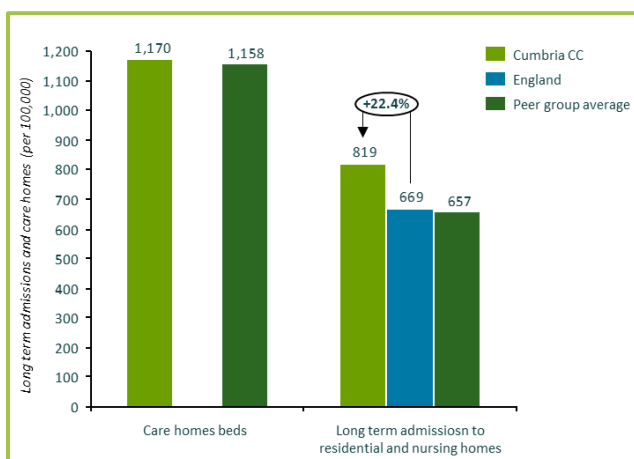


Figure 15: Admissions to residential and nursing care homes

Source: ASCOF 2014/25

Demand pressures are considerable – and rising – for residential and social care:

- Currently, there are nearly 3,700 people living in residential or nursing care homes; by 2020 this will increase by 18% to 4,350 people and by 2030 the increase will be by 64% to c. 6,050 people.
- By 2020, the number of over 65 adult social care (ASC) service users with a physical disability is projected to increase by 15% to 6,751 people; by 2030 it is predicted to increase by 46% to 8,616 people.
- By 2020 the number of over 65 ASC service users with a learning disability is projected to increase by 8% to 170 people; by 2030 it is predicted to increase by 25% to 196 people.
- By 2020 the number of over 65 ASC service users with a functional (non-dementia) mental health issue is projected to increase by 11% to 925 people; by 2030 it is predicted to increase by 33% to 1,113 people.
- By 2020, the number of people aged over 65 with dementia in Cumbria is projected to increase by 16% to 9,086; by 2030 it is projected to increase by 56% to 12,410.
- By 2025, it is predicted that there will be a need for at least 2,100 Extra Care housing units.

### 2.3.5 General Practice Performance

There are 45 general practices in WNE Cumbria: a mix of urban and rural practices and a single provider of general practice Out of Hours services, Cumbria Health on Call (CHOC). As for the rest of the UK, pressures faced include a rise in workload, increased complexity of health needs and considerable workforce difficulties.

Generally, the quality of general practice is high: as at January 2016, 24 General Practices across WNE Cumbria had been inspected and of these 95.6% were rated 'Outstanding' or 'Good' (compared to 85% nationally), as set out in Figure 16 below. This is also reflected in patient-reported satisfaction – 88% of local patients had a good overall experience of their GP surgery (compared to a national average of 85%). However, the ability to maintain the current level of quality is under threat due to increasing workload pressures and significant recruitment and retention pressures in some parts of WNE Cumbria.

Figure 16: CQC Ratings of GP Practice Inspections in WNE Cumbria as at January 2016.

Rating	WNE Cumbria	National
Outstanding	16.5%	4%
Good	79%	81%
Requires Improvement	0%	11%
Inadequate	4%	4%

Source: CQC report, 2016

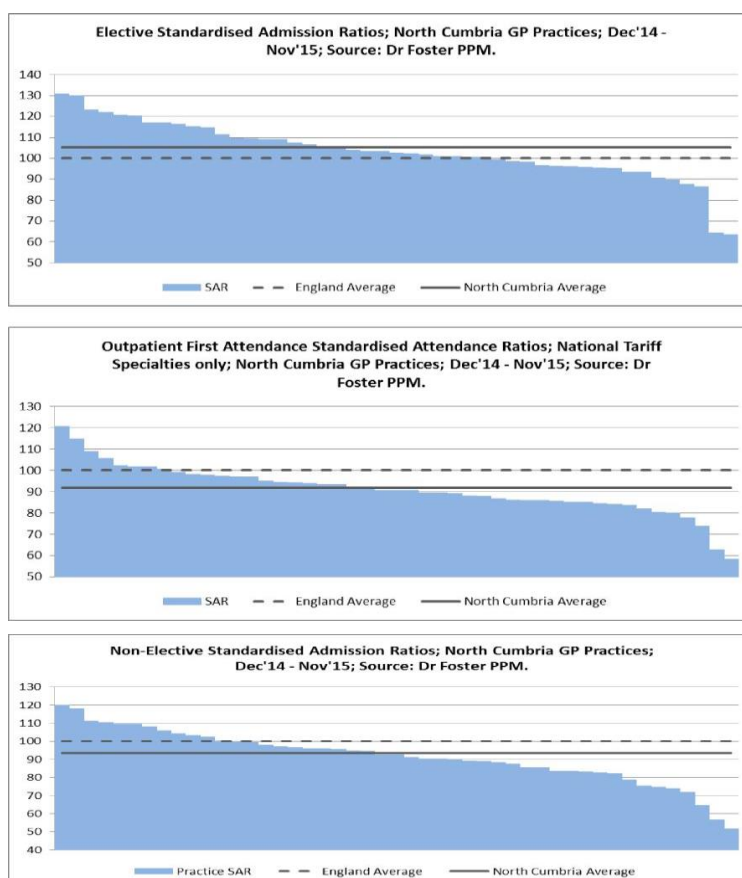
On average, referral and non-elective admission rates are in line with national expectations, but there is a wide range of variation between practices in WNE Cumbria (as shown in Figure 17 below).

Although data is standardised to take into account differences in deprivation, additional variation in disease prevalence and the management of long-term conditions in primary care may impact on the variation observed in secondary care use.

Of the 21 disease prevalences measured as part of QOF 2014-15, Cumbria as a whole was above the national prevalence rate in 20. Cumbria is more than 20% higher than the national rate in 11 (Atrial Fibrillation, Chronic Obstructive Pulmonary Disease, Heart Failure, Secondary prevention of coronary heart disease, Peripheral Arterial Disease, Stroke and Transient Ischaemic Attack, Cancer, Rheumatoid Arthritis, Palliative Care, and Dementia) and 10-20% above the national rate in five areas (Asthma, Chronic Kidney Disease, Diabetes Mellitus, Epilepsy, and Hypertension).

There is a large amount of variation between practices (even when excluding extreme outliers). For example, hypertension prevalence ranges from 9.4% to 25.7%. Further variation can be identified by comparing observed to expected prevalence for several disease groups. For example, using 2013-14 registers, a comparison suggests that 66% of people with atrial fibrillation in Cumbria have been diagnosed (5,371 people with undiagnosed atrial fibrillation); however, this varies from less than 30% to over 90% at practice level. This is lower than national rates of diagnosis: the British Heart Foundation states that over 1.1 million people in the UK have been diagnosed with atrial fibrillation and estimates of undiagnosed cases are within the hundreds of thousands.

Figure 17: Variation in Primary Care Referral and Admissions *Source: Dr Foster PPM*



This variation continues into the care processes and treatment targets for long-term conditions. For example, of the 81,470 people diagnosed with hypertension in Cumbria in 2013/14, 15.5% (12,646 people) had blood pressure that was not < 150/90, but this ranges between GP practices from 6.4% to 42.9 %. If all practices were to achieve as well as the average of the best achieving

practices, then an additional 4,644 people would have their hypertension controlled. Similarly, it is estimated that there are 5,076 people with undiagnosed diabetes and the range of observed diabetes at GP practice level is from 3.9% to 9.9% (Cumbria average: 6.6%). Of the patients diagnosed with diabetes, there is large variation in the achievement of HbA1c, cholesterol and blood pressure targets at practice level, with 41.7% to 80.7% of people with diabetes that met the HbA1c target, 38.9% to 94.6% that met the cholesterol target, and between 50.9% and 89.9% that met the blood pressure target.

General practice workload is increasing. Data from the majority of practices in Cumbria show that practices carried out 15% more patient contacts in 2014/15 compared to 2009/10. The major causes of workload increases are the ageing profile of the Cumbrian population, more care being provided closer to home and the impact of unplanned work. The rural geography also means that some patients receive services in General Practice which would be normally provided in acute settings (e.g. routine tests) to avoid travelling long distances.

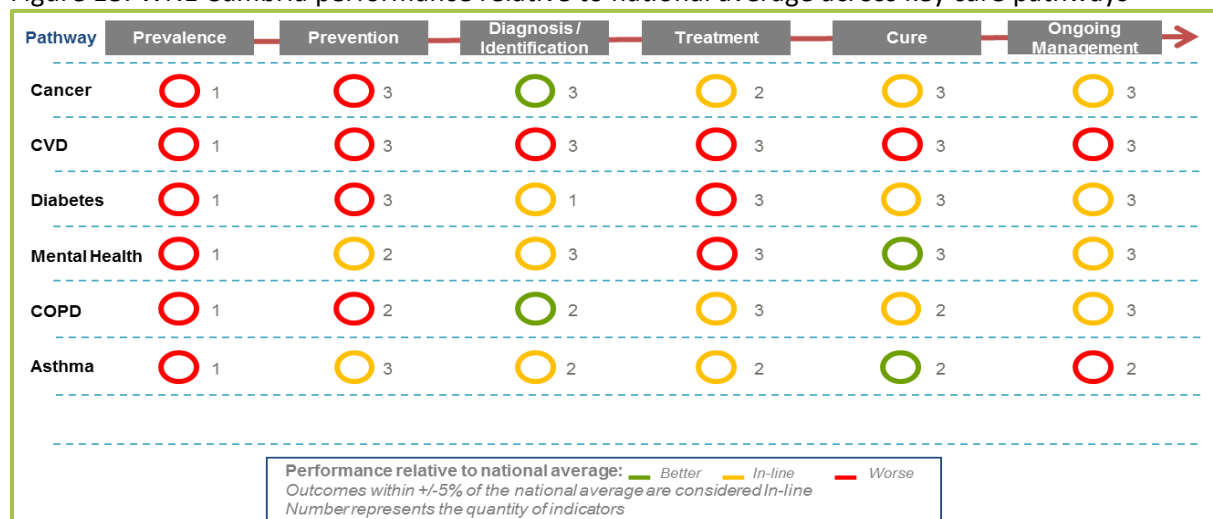
In relation to prescribing, we have a well-established and comprehensive prescribing support system currently hosted by the North England Commissioning Support Unit (NECS) including medicine optimisation pharmacists and practice based medicine managers. Despite this strong performance there is variation in individual practice performance not all of which can be attributed to the considerable differences in demographics and deprivation across WNE Cumbria. The forecast out turn cost per ASTRO-PU values differs by almost £30 ranging from £26 to £55.50. Similarly, the composite practice quality indicator scores as defined by national and local Quality, Innovation, Productivity and Prevention (QIPP) programmes range from 43 down to 16. Commissioning for Value analysis has identified almost £7m of potential savings across all of Cumbria, compared with the best five similar CCGs and £2.2m compared with the best 10 similar CCGs.

Cumbria Health on Call (CHOC) is Cumbria's Out-of-hours GP services which provides urgent primary care when GP surgeries are typically closed, from 6.30 pm to 8.00 am on weekdays and all day at weekends and on bank holidays. The Department of Health has set national quality requirements which establish minimum standards for all out-of-hours GP services. CHOC performs well against the standards and onwards referrals are better than national figures, feedback from users also shows a high satisfaction with the service.

### 2.3.6 Integrated Care Performance

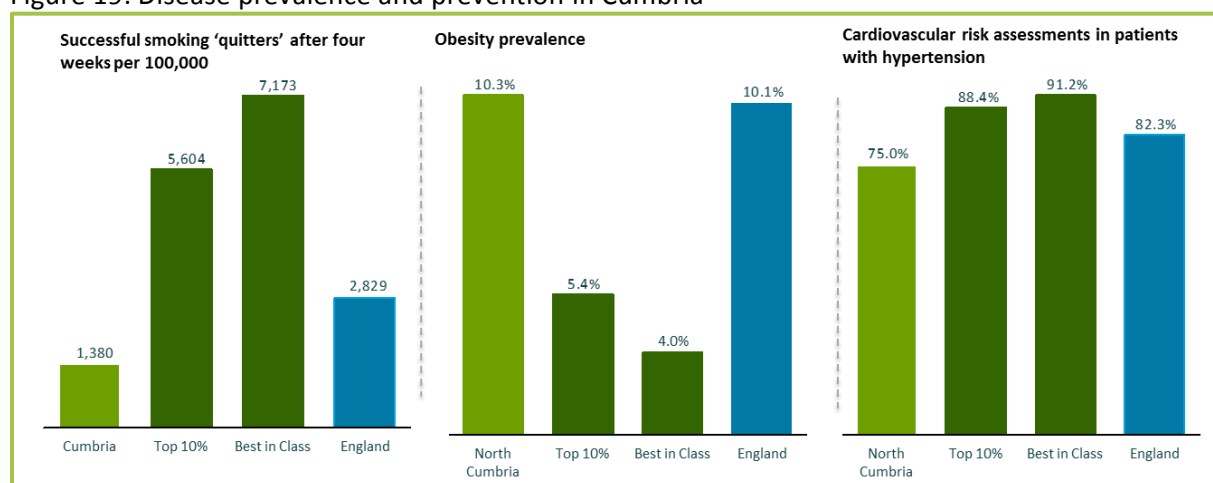
The high prevalence of preventable disease (compared to the English average) results in increased demands on health and social care services (see Figure 18 below).

Figure 18: WNE Cumbria performance relative to national average across key care pathways



Cumbria as a whole performs badly against national benchmarks for a number of disease prevalence and prevention indicators. For example, after a four-week programme, smokers in Cumbria were half as likely to quit compared to the average across England. Similarly, obesity prevalence is slightly higher than the English average, and cardiovascular risk assessments for patients with hypertension are lower than average, as set out in Figure 19 below.

Figure 19: Disease prevalence and prevention in Cumbria



Sources: QOF 2014/15, HSCIC 2012/13

There has been an increasing recognition of the need to more closely join up health and social care. For many years, health and social care professionals have been working more closely together, but this has often taken place on a fragmented basis. The way our health and social care system has been set up has often hindered rather than helped professionals to provide joined-up people-centred care. However, the understanding of the importance of joined up care is growing.

In 2013, the Better Care Fund (BCF) was established with the aim of increasing integration across health and social care services in England. Legislation including the Health and Social Care Act, 2012 and the Care Act, 2014 also directs the NHS and local authorities to provide more joined up care and the Government has pledged to deliver integrated health and social care across England by 2018.

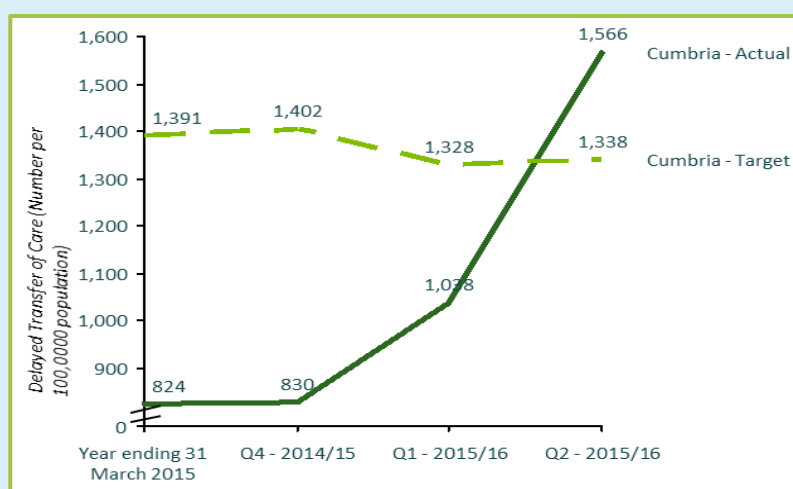
There is, however, currently limited integration and coordination across health and social care services in WNE Cumbria. Combined with aspects of health and wellbeing performance (such as high disease prevalence) Cumbria County Council has had to make significant savings during this period. Taken together, this is contributing to poorer outcomes and high utilisation of services as evidenced in the Oak Group audit report referenced earlier. For example:

- Emergency hospital admissions usually managed in primary care are approximately 3% higher for Cumbria as a whole – compared to the rest of England and approximately 27% higher than the national top quartile.
- Emergency admissions that do not usually require hospitalisation are also approximately 11% higher than the national average.
- WNE Cumbria also had a relatively consistent level of avoidable admissions between 2012 and 2014.
- An increasing number of people are experiencing a delay in accessing appropriate care in the right place and at the right time as evidenced by the increasing incidence of delayed discharges from acute and community hospital beds.

### Delayed Transfers of Care in WNE Cumbria

Across WNE Cumbria delayed transfers of care have been increasing, resulting in individuals not being able to move to the most appropriate setting for their ongoing care. While in 2014/15 WNE Cumbria was performing well in this area, with delayed transfers of care from acute and non-acute settings being c.5% lower than national benchmarks, there has been an 89% increase in overall delayed transfers across the system as demonstrated below. A key factor associated with the increase has been the timeliness of assessment and availability of social care support to enable safe discharge from hospital highlighting the important interface between health and social care. National evidence supports the view that inappropriate placement and long length of stay results in reduced functionality, loss of opportunity for maximising independence and poor outcomes. This practice puts patients at risk and is not cost-effective in delivering care. The rise in delayed discharges is ergo both a 'ways of working' issue and a resources issue (i.e. productivity).

Figure 20: Delayed Transfers of Care in WNE Cumbria



Source: WNE Cumbria Success Regime

### 2.3.7 Care and Quality – Case for Change Summary

We are determined to address the care and quality issues that endure across our health and social care services. Specifically, we want to:

- Reduce the current variation in outcomes across WNE Cumbria, by having more robust single pathways and teams co-located able to provide timely access to specialist staff.
- Provide the opportunity for clinicians to take ownership of patient pathways by working in a single team around the needs of the patient.
- Have co-located support services to help with patient flow, better management of the increasing acuity of demand and deteriorating patients.

While there are actions being taken to drive quality, efficiency and effectiveness of our services in WNE Cumbria, we believe that there must be more fundamental changes in order to consistently meet, and where possible surpass, national standards within the resources we have available to us. Without service change we will not have the capacity and concentration of expertise to maintain current service delivery let alone being able to offer a consistent seven days a week service. The case for change for patient safety and quality is closely linked with workforce and financial considerations. We are determined to take the opportunity to create safe and best practice care environments and pathways whilst supporting services to all patients and offering better and more consistent outcomes.

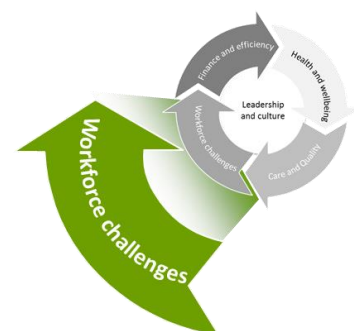
## 2.4 The Scale of the Challenge – Workforce

**Workforce is one of the key constraining factors driving the need to transform the way our services are planned and delivered.**

There have been issues around the recruitment and retention of staff across the Cumbrian health system for over 15 years.

It has been particularly difficult to attract and appoint to key medical roles. In part, this is due to national workforce issues, especially in relation to the availability of Paediatrics, Psychiatry, Neurology, Obstetrics and Gynaecology and Emergency Department specialties. Locally, this has manifested itself in workforce instability, significant financial difficulties at the acute Trust, who are in special measures and reputational damage including repetitive negative media coverage. There is difficulty attracting junior doctors to the acute Trust as the lack of substantively filled consultant posts inhibits a first class teaching/learning experience, especially in the West of the region. This is particularly the case following the withdrawal of Medical specialty training at WCH due to the lack of consultants available to train at Whitehaven, this has meant that the FY2 and Registrar roles in Acute Medicine are almost entirely provided through premium price locums. Geographical location is a hindrance, especially in the West. All the above has resulted in high demand rotas and professional isolation – which has made recruitment (and retention) more difficult. This has impacted on the continuity of clinical services, acknowledged increased risks around quality and safety of care, and high levels of additional costs incurred for locum and agency staff to cover vacancies.

Whilst some specialties are predicted to have adequate national training numbers coming through over the next five years (Obstetrics and Gynaecology, for example) to meet anticipated staffing needs, it still does not guarantee recruitment to Cumbria at all, or in a timely manner. Nor





is it reflected in all specialties. Health Education North East (HENE) has undertaken a forecast on the Medical and Dental workforce and likely CCT holders, on a specialty basis, over the next five years. While there is no comparable research for Cumbria, there is no reason to believe that the position is any better here and indeed may be worse due to the lower number of total trainees in Cumbria. The HENE research lists Psychiatry and Community Sexual Health as “red” risk rating (consultant workforce will not be delivered without additional recruitment outside of the North East). Emergency Medicine is amber (likely to require additional recruitment outside of the area).

**GP recruitment** – of last year’s 13 available places on the local GP training scheme, only one was filled. In Copeland, the GP vacancy rate is 23% and 47% of current GP partners across WNE Cumbria are planning to retire over the next 10 years. It is noted that local problems are exacerbated by the short supply of GPs nationally. The General Practice Forward View acknowledges that many practices face recruitment issues and are increasingly reliant on temporary staff, and a higher proportion of older GPs signalling that they are considering leaving the workforce early. The GP Forward View sets out ambitions for 5000 net more GPs by 2020/21, as well as minimum of 5000 other staff working in General Practice in the same timeframe. The local position is set out below.

Figure 21: GP vacancies by locality

Locality	Total list	Expected number of GPs (1800 patients/ GP)	Number of WTE vacancies	Vacancies as % of expected WTE
Allerdale	104,489	58	4	7%
Carlisle	103,852	58	5	9%
Copeland	61,905	34	7	21%
Eden	52,157	29	5	17%

*Source: WNE Cumbria Success Regime Primary Care Proposition (69% of practices responded)*

There is a shortage of **practice nurses** with many working part-time in multiple practices and specialising in particular illnesses such as COPD, heart failure and diabetes. Many practices have extended the clinical workforce with a range of nursing and support roles and also roles for pharmacists within the clinical team. However, recruitment of pharmacists is difficult in WNE Cumbria – and the expansion of the role of nurse practitioners is not matched by the availability of sufficient numbers of nurses trained for these roles.

NWAS is experiencing significant **paramedic** vacancies, with over 30 posts unfilled across Cumbria as a whole.

Recruitment, retention and vacancy challenges in **NCUHT**: there are high vacancy rates for both **medical and nursing staffing** with total consultant vacancies levels at 23% across CIC and WCH. Junior doctor staffing levels at WCH are particularly fragile, with 53 vacancies out of 80 for non-consultant staff. High vacancy rates are affecting the ability of the Trust to meet existing and future workforce standards, deliver adequate staffing levels across the Trust sites and provide necessary clinical supervision and training. There is an over-reliance on locums, particularly in medicine, with associated financial implications.

**Intense, fragile clinical rotas**: the provision of services at two acute sites and a significant number of staff vacancies has resulted in NCUHT operating a number of high-frequency clinical rotas. This places a considerable workload strain on staff and detracts from the resilience of services as a



whole. It is noted that there are no particular problems within Anaesthetics staffing at CIC. There are some shortages in middle grade doctors at WCH.

Figure 22: Medical staffing in the most pressured areas of NCUHT

Site	Specialty	Funded WTE		Contracted WTE		Vacancies		Combined vacancy	Combined vacancy total (%)
		Consultant	Non-consultant	Consultant	Non-consultant	Consultant	Non-consultant		
WCH	Emergency admissions unit	3	18	1	1	2	17	19	90%
WCH	General surgery	3	18	4.8	3	-1.8	15	13.2	63%
WCH	A&E	5	13.7	3	5.57	2	8.13	10.13	54%
CIC	A&E	5.8	19.5	2.9	14	2.9	5.5	8.4	33%
WCH	O&G	5	9	5	2	0	7	7	56%
CIC	O&G	5.7	17	4.7	15	1	2	3	13%
WCH	Paediatrics	5	5	3	3	2	2	4	40%
CIC	Paediatrics	6	7	5	5	1	2	3	23%

Source: WNE Cumbria Success Regime

There are also vacancy rates of over 40% in consultant posts in Emergency Care and Medicine and Pathology, and 26% in Radiology.

Figure 23: Nursing staffing by band and site

Site	Band	Contract WTE	Vacancy	Vacancy factor
CIC	5	424.2	52.73	12%
	6	232.92	9.52	4%
	7	139.1	0.45	0%
	8	33.47	1.8	5%
	<b>CIC TOTAL</b>	829.69	64.5	8%
WCH	5	198.21	26.65	13%
	6	136.92	7.97	6%
	7	94.11	2.1	2%
	8	6.2	0.6	10%
	<b>WCH TOTAL</b>	435.55	37.32	9%

Source: NCUHT, January 2016

Recruitment, retention and number of vacancies are also a challenge for **CPFT** (equating to 51.73 WTE vacancies across the Trust in January 2016). In addition, a number of issues related to workforce are affecting current and future standards:

- In **Old Age Psychiatry**, medical staffing levels are just adequate to meet current service demands despite service redesign.
- In **Child and Adolescent Psychiatry**, current children and adolescent mental health services (CAMHS) staffing levels are 4.5 WTE consultants of which two are locums. Plans to provide a county-wide 24-hour service would require a minimum of 6.0 WTE consultants in line with RCPsych guidance.
- The highest number of vacancies is within **nursing** and at the time of data collection amounted to 96.71 WTEs.
- There are issues maintaining safe staffing to support **small, isolated community hospitals** with four units currently run by a single nurse, responsible for their cohort of patients without any 24-hour medical cover. Over the last two years, a trend has emerged with difficulty recruiting staff to work in the Community hospitals; as at April 2016, there were 16% Registered Nurse vacancies, 4% Healthcare Assistant vacancies and 22% Ward Manager vacancies. Combined with a higher than average sickness level, beds have been closed at short notice to ensure safe staffing levels. This impacts on the quality of the patient experience and is not a sustainable method of managing a bed base. The CQC inspection in Autumn 2015 highlighted concerns re staffing, recruitment, sickness, isolation and the impact on patient safety.

Figure 24: Staffing vacancies at CPFT

Staff Group	WTE Vacancies
Medical and Dental	11.1
Additional Clinical Services	24.26
Additional Professional Scientific and Technical	48.1
Allied Health Professionals	28.32
Estates and Ancillary	5.43
Nursing and Midwifery	96.71
Admin and Clerical	18.04
<b>TOTAL</b>	<b>231.96</b>

*Source: CPFT, correct as of May 2016 vacancies for whole of CPFT (Cumbria-wide)*

- In relation to **sickness absence**, both Trusts report rates above the 4% target (4.8% average year to date at NCUHT and 4.4% at CPFT, in March 2016). The top two reasons for absence in both Trusts are defined in electronic staff records (ESR) as anxiety / stress / depression / other psychiatric illnesses and other musculoskeletal problems.

- Both Trusts rely considerably on **agency and locum staff** to cover gaps in the workforce. This represents a considerable financial pressure for the Trusts, with £21.4m agency locum expenditure for FY16 for NCUHT and £7m for CPFT. Both organisations are working towards applying the locum cap but this is likely to be difficult to apply fully, in part due to the proximity of Scotland, who do not have to apply the cap and the size of the locum requirement.

In summary, to ensure the long-term sustainability of services we investigating how we can effectively deliver services in the future – reflecting changing workforce demographics.

## 2.5 The Financial Case for Change

**This section summarises the current financial position of WNE Cumbria, and how this could develop if the system continues to operate in a similar way.**

In this section we set out:

1. The scale of the financial challenge across WNE Cumbria and key drivers.
2. The capacity baseline across WNE Cumbria.
3. The approach taken to estimate the financial challenge.
4. The scope for improved efficiency and use of resources.

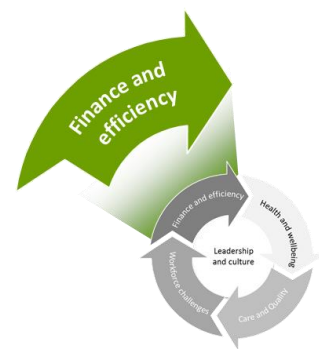
Across providers and commissioners, WNE Cumbria is currently spending c. £86m more than it receives in funding. Demand growth from an increasingly complex population and a range of cost pressures mean that, if the system were to continue functioning in a similar way, this gap could increase to c. £163m by 2020/21. It is clear that there are opportunities to drive further efficiency and better use of resources to significantly address the financial gap and mitigate the risks associated with an ageing population and demand growth. The efficiencies described below could address the financial challenge by c. £78m, reducing a projected shortfall of c. £163m in 2020/21 to c. £85m.

The financial analysis and modelling is described in greater detail in Appendices I and J.

### 2.5.1 The Scale of the Financial Challenge

In the Five Year Forward View, NHS England outlines a ‘Do Nothing’ national financial challenge of c. £30bn by 2020/21, based on demand growth, cost pressures and flat funding in real terms<sup>19</sup>. As a result, there is a national requirement for the NHS to deliver savings of c. 5% of spend per annum over the next five years. Of this challenge, c. £8bn is expected to be provided through real increases in funding, leaving a remaining challenge of c. £22bn by 2020/21. This would reduce the annual savings requirement to c. 3-4%.

WNE Cumbria is currently spending c. £86m more than it receives in funding under the system. High spend on agency workforce compared to peers; operating a number of services at relative

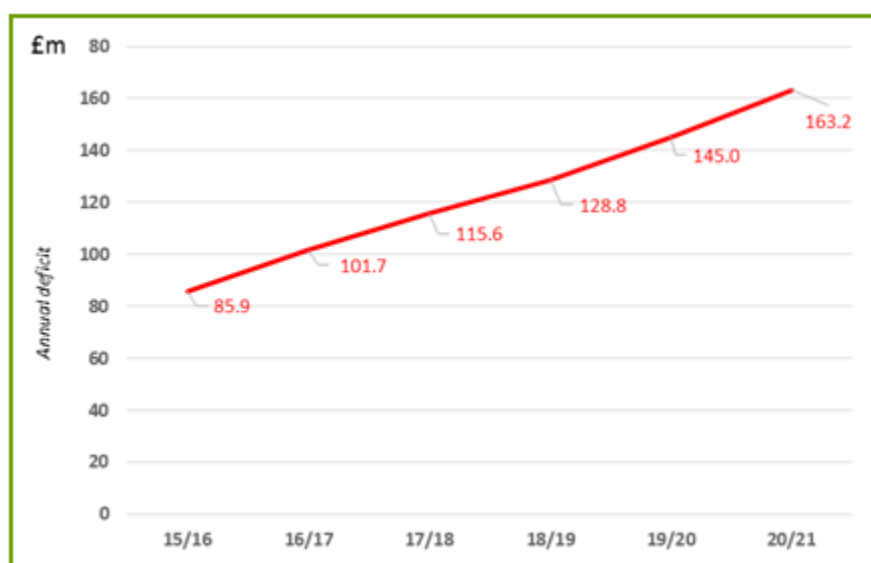


<sup>19</sup> Source: <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>

sub-scale; and other factors which could be linked to WNE Cumbria's rurality are likely to be contributory factors to this financial challenge. The financial challenge has increased significantly since 2013; investment undertaken potentially linked to recommendations from the Francis report around staffing level requirements could in part be driving this.<sup>20</sup>

Based on current services, by 2020/21, an estimated additional c. £163m of funding could be required above that which is likely to be available, in order to keep pace with expected increases in demand and cost pressures<sup>21</sup>. In particular, average increases in funding of c. 2.5% per annum are outstripped by demand growth of c. 2% per annum; cost inflation of c. 2.5%; and a c. 2% (c. £12m) cost uplift by 2020/21 to account for the cost of meeting national clinical standards such as 7 day services. Figure 25 summarises the financial challenge.

Figure 25: Do nothing financial challenge



Source: WNE Cumbria Success Regime

The £163m by 2020/21 reflects a savings requirement of approximately 6.5% per annum over the next five years to bridge the financial challenge, which is greater than the average national requirement of approximately 5%.<sup>22</sup> The main driver of this greater than average financial challenge, is the larger deficit in WNE Cumbria's 2015/16 starting position. The rate of growth in the financial challenge over five years is relatively consistent with the national trend.

Significant collaboration and joint working will be required to design the appropriate solutions to address the challenge.

The cost of delivering services in WNE Cumbria is higher than the national average as well as its peer group. For example, average reference costs for NUCHT are approximately 5% higher than the national average and approximately 15-20% higher compared to the upper quartile of acute trusts. There are a number of likely drivers of these higher costs, including:<sup>23</sup>

<sup>20</sup> Source: <https://www.england.nhs.uk/tag/francis-report/>

<sup>21</sup> For a detailed breakdown of assumptions used to estimate Cumbria's 2020/21 financial position see Appendices I and J

<sup>22</sup> Source: <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>

<sup>23</sup> Success Regime: Key challenges and baseline facts and figures (KCBFF) document.

1. Spending on agency staffing – which amounts to approximately 7% of total spend at NCUHT compared to approximately 2-3% for peers;
2. Running a number of services on a sub-scale basis; and
3. An ageing population which drives a more complex case mix.

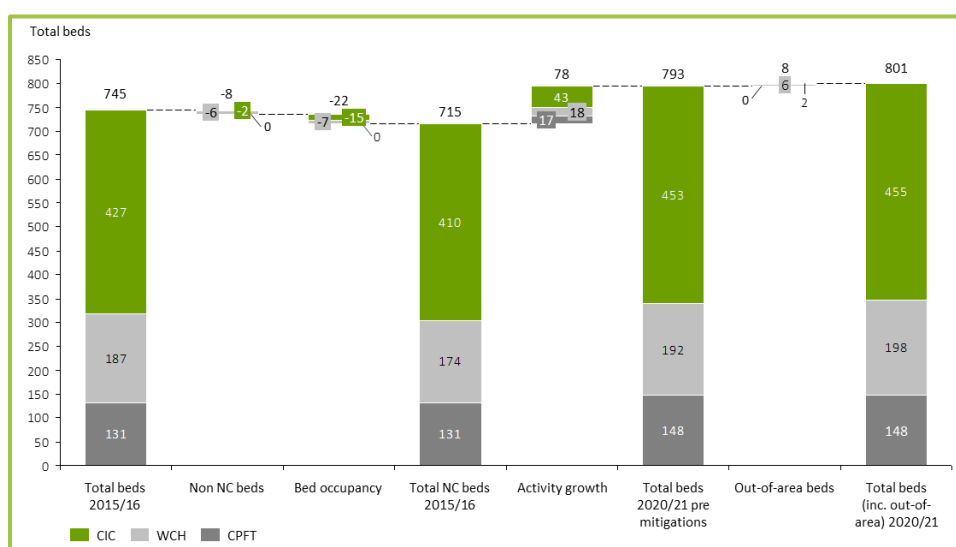
The higher costs identified suggest that there is some opportunity to provide services more efficiently within the same clinical model through cost improvement programmes, for example targeting reductions in agency spend. These opportunities are assessed as part of the mitigations to address the financial challenge. A number of these mitigations offset the growth in the cost base that would otherwise occur in the 'Do Nothing' scenario.

## 2.5.2 The Capacity Baseline Across WNE Cumbria

There are approximately 745 beds in WNE Cumbria: CIC (427); WCH (187); and CPFT (133)<sup>24</sup>. Adjusting for a target bed occupancy of 85%<sup>25</sup> and only including beds for patients in WNE Cumbria, the total demand is estimated to be approximately 715 beds in 2015/16.

If the system were to continue to function as is, based on 2% activity growth per annum over five years, 793 beds are likely to be required in WNE Cumbria by 2020/21 to meet the additional demand. This reflects an increase of 78 on the current bed base.

Figure 26: Do nothing bed base in WNE Cumbria



Source: WNE Cumbria Success Regime

National benchmarks indicate the potential for WNE Cumbria to reduce its activity – particularly non-elective activity – through demand management and providing more care in Out of Hospital settings. For example, 'Right Care' indicators<sup>26</sup> show an estimated potential savings opportunity of approximately £14m for WNE Cumbria through reduction in non-elective activity, see Appendices I

<sup>24</sup> Data received from Success Regime programme (NCUHT & CPFT).

<sup>25</sup> <http://www.nhs.uk/Scorecard/Pages/IndicatorFacts.aspx?MetricId=8120>

<sup>26</sup> See <http://www.rightcare.nhs.uk/index.php/2015/07/developing-outcomes-based-indicators/>

and J. Right Care and other indicators for opportunities to reduce activity are assessed in detail in section 2.5.4. These mitigations offset the growth in the bed base that would otherwise occur in the 'Do Nothing' scenario.

### 2.5.3 Approach to Estimating the Financial Challenge

The 'Do Nothing' 2020/21 financial challenge reflects the extent to which WNE Cumbria is expected to be spending beyond the level of funding it is likely to receive, if the current methods of delivering care continue. This is the financial position upon which the options to deliver change are evaluated from a financial perspective.

The financial modelling which underpins the estimates of the financial challenge has been overseen by the WNE Cumbria Finance Directors Group. This group includes representation from Cumbria CCG, NCUHT, CPFT, NHS England and Monitor. Key assumptions and outputs from the process have been agreed by all members of this Group, for the purpose of feeding in to this document.

Data from the financial year 2015/16 collected from Cumbria CCG, NCUHT and CPFT has been used as the starting point to estimate the financial challenge. The modelling process for the financial challenge has been undertaken in three stages:

1. **Data.** A number of adjustments have been made to the underlying financial data, including, removing non-recurrent items; adjusting for the share of the financial challenge related to WNE Cumbria; and excluding areas not considered part of the 'Do Nothing' perspective (such as cost improvement plans and quality innovation and productivity plans (QIPPs)). Further detail on the data used in this analysis is included in Appendices I and J.
2. **Assumptions.** Four types of assumptions are applied to the underlying data to estimate the 2020/21 'Do Nothing' financial challenge: funding assumptions for WNE Cumbria; tariffs and payments; demand pressures; and provider cost pressures.

Each of these assumptions have been agreed with the Finance Directors Group and aligned with the organisations involved. A breakdown of these assumptions is included in Appendix I.

To reflect that underlying provider costs do not decrease one for one with activity, a series of cost and activity relationships are estimated. In particular, costs are split into fixed, semi-fixed and variable, and the following relationships are applied:

- Variable costs (e.g. the drugs and consumables) change one for one with activity;
- Semi-fixed costs (workforce) change by 70% of the activity change, for example a 10% change in activity leads to a 7% change in semi-fixed costs<sup>27</sup>; and
- Fixed costs (e.g. cost of buildings and equipment) do not change with activity initially, and are estimated based on beds after all other impacts are applied.

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<sup>27</sup> Source: cross-referenced with Department of Health study on cost elasticities and other business cases e.g. Shaping a Healthier future PCBC (<https://www.healthiorthwestlondon.nhs.uk/documents/joint-committee-primary-care-trusts-nwl/jcpcts-meeting-papers-25062012/sahf-pre>)

These assumptions have been applied in a range of business cases to estimate cost and activity relationships.<sup>28</sup>

3. **Outputs.** Applying the range of assumptions to the underlying data provides an estimate of the 'Do Nothing' 2015/16 financial challenge; how this could develop by 2020/21; and the drivers of this change.

A full list of assumptions underpinning the financial challenge is included in Appendix I.

#### 2.5.3.1 Summary

As a result of this work, there is a shared understanding that, across providers and commissioners, **WNE Cumbria is currently spending approximately £86m more than it receives in funding.** Demand growth from an increasingly complex population and a range of cost pressures mean that, if the system were to continue functioning in a similar way, this gap could increase to c. £163m by 2020/21.

A suite of mitigations has been developed to reduce this financial challenge. These mitigations focus on radically improving efficiency through integrated and consolidated care with WNE Cumbria aiming to be in the top decile. The following sections discuss each of the mitigations in turn.

#### 2.5.4 Scope for Improved Efficiency and Use of Resources

Efficiency savings refer to delivering the same service at a lower cost. Given its high relative cost base compared to peers, there is significant opportunity for WNE Cumbria providers and commissioners to deliver efficiency savings.

There are three components to the efficiency analysis:

1. Provider efficiencies;
2. Shared organisational arrangements; and
3. CCG efficiencies.

The following subsections take each of these areas in turn.

#### 2.5.5 Provider Efficiencies

Provider efficiency savings refer to providers delivering the same service at a lower cost, for example through more effective deployment of workforce.

In defining efficiency, two components of provider efficiencies are considered:

1. **Catch-up component** – this captures the savings achieved from providers increasing efficiency in line with the most efficient providers in the sector. Examples include the

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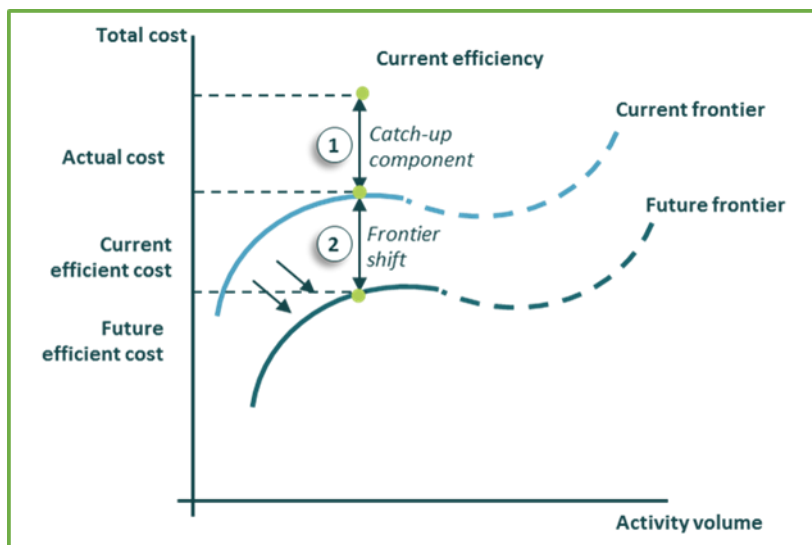
<sup>28</sup> See North West London PCBC for example, <https://www.healthiernorthwestlondon.nhs.uk/documents/joint-committee-primary-care-trusts-nwl/icpcts-meeting-papers-25062012/sahf-pre>

efficiency opportunities identified as part of the Carter Report Review opportunities, which are based on reference cost benchmarking.<sup>29</sup>

2. **Frontier shift** – this captures efficiency savings from the potential future sector wide productivity gains due to technological advances or service delivery optimisation. This is the forward looking component of the efficiency factors and aims to capture the dynamic nature of productivity change within healthcare services.

The sum of the two components provides an indication of the total efficiency opportunity. An illustration of these definitions is included in Figure 27.

Figure 27: Efficiency savings methodology



Source:

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/317572/Supporting\\_document\\_A\\_-\\_Deloitte\\_Efficiency\\_Factor\\_for\\_publication352b.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/317572/Supporting_document_A_-_Deloitte_Efficiency_Factor_for_publication352b.pdf)

The provider efficiency analysis focusses on triangulating a range of sources to understand the potential opportunity to reduce costs, including:

- **Top down reference cost benchmarking**, through comparing unit costs with peers;
- **Further benchmarking**, for example using econometrics to understand greater detail around cost drivers and netting out some factors which could be structural;
- **High level CIPs**, to understand individual schemes which are planned to underpin cost reduction opportunities;
- **Carter Report review**, using the independent NHS England report to understand the potential for cost reduction;<sup>30</sup> and
- **Frontier shift**, considering evidence of the frontier shift component of efficiency.

The potential to identify peers and undertake benchmarking for CPFT has been more limited and a greater emphasis has been placed on previous CIP delivery and current CIP plans. The overall

<sup>29</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/434202/carter-interim-report.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/434202/carter-interim-report.pdf)

<sup>30</sup> See Appendices I and J.



scenarios imply a greater opportunity for NCUHT compared to CPFT, given the greater relative spend on agency staffing at NCUHT.

Through these sources, as well as detailed discussions with Finance Directors Group, two scenarios were developed for NCUHT and CPFT around the total efficiency opportunity. These are summarised in Figure 28.

Figure 28: Summary table of efficiency savings scenarios

Efficiency assumptions: NCUHT			Efficiency assumptions: CPFT		
	Core	Stretch		Core	Stretch
Yearly average	2.6%	3.5%	Yearly average	2.0%	3.0%
Total over 5 years	13.0%	17.5%	Total over 5 years	10.0%	15.0%

Source: Success Regime analysis

### 1. Core scenario

The core scenario is intended to capture the potential cost reduction which is considered locally as relatively achievable. This scenario comprises of c. 13% by year 5 for NCUHT and c. 10% for CPFT and equates to c. £57m by 2020/21. Of this efficiency, 6.25% reflects the frontier shift for each organisation (1.25% per annum).<sup>31</sup>

### 2. Stretch scenario

The stretch scenario reflects a set of more ambitious efficiency targets, indicating top decile performance for WNE Cumbria providers. In particular, this scenario comprises of c. 17.5% cost reductions for NCUHT and 15% for CPFT by year 5. These targets have been identified as challenging to deliver, particularly in the context of historical cost improvements achieved. Of this efficiency, 6.25% reflects the frontier shift for each organisation (1.25% per annum).

Based on discussions with local providers and commissioners, it was identified that the more ambitious cost reductions implied in the stretch scenario would only be achievable if more significant transformation (through the roll-out of ICCs and the reconfiguration of services) is undertaken. This is particularly significant given that more of the structural challenges in WNE Cumbria, such as reliance on agency spend could be better addressed upon more significant transformation as part of the ICCs and consolidation of services. Based on this, the increased saving from the efficiency stretch assumptions has been linked to the level of transformation through the ICCs and hospital reconfiguration in Appendix I and Section 1.5. In particular, the total increase in cost savings associated with the stretch scenario is c. £17m; of this, c. £12m is linked to the transformation in the out of hospital model and the remaining c. £5m is linked to the hospital reconfiguration options, with a higher share of this value potentially being achievable with greater consolidation of services.

The efficiency analysis in this section reflects the cost reduction assumptions included in the core scenario.

<sup>31</sup> 1.25% has been identified as a reasonable assumption based on econometric analysis, based on Monitor, 'Methodology for efficiency factor estimation'. A range of other sources are also being considered.

Work is currently ongoing to underpin these top-down targets and a range of schemes have been identified to date for the individual organisations. Further detail on this work is contained in **Appendix I**.

### 2.5.6 Shared Organisational Arrangements

Literature highlights the potential for benefits that occur through having shared organisational arrangements.<sup>32</sup> Initial analysis indicates that c. £4.4m could be saved across WNE Cumbria by 2020/21 through streamlining resources including back office finance, HR and procurement. A more detailed analysis of shared organisational arrangements is in Appendix I.

### 2.5.7 CCG Efficiencies

There are two sources of specific CCG efficiencies:

1. **CCG cost efficiencies** - Cumbria CCG has identified a suite of actions that could mitigate its expenditure without impacting providers including improvements across running costs, continuing health care and high cost drugs spend, all of which would save an estimated £12m<sup>33</sup> by 2020/21.
2. **Out of area acute QIPP targets** - Part of the CCG's commissioned activity is to providers who deliver care outside of North Cumbria. As such, part of the financial challenge related to the CCG is likely to be linked to these providers. The CCG expects these providers to improve performance in line with QIPP requirements. On this basis, a total saving of £5.3m for the CCG has been estimated.

### 2.5.8 Efficiencies Summary

The estimated efficiency savings in 2020/21 from the mitigations outlined could reduce the challenge by £78m, from £163m to £85m based on the core provider efficiency assumptions, as illustrated in Figure 29. Appendix I and Appendix J provide greater detail on the efficiencies.

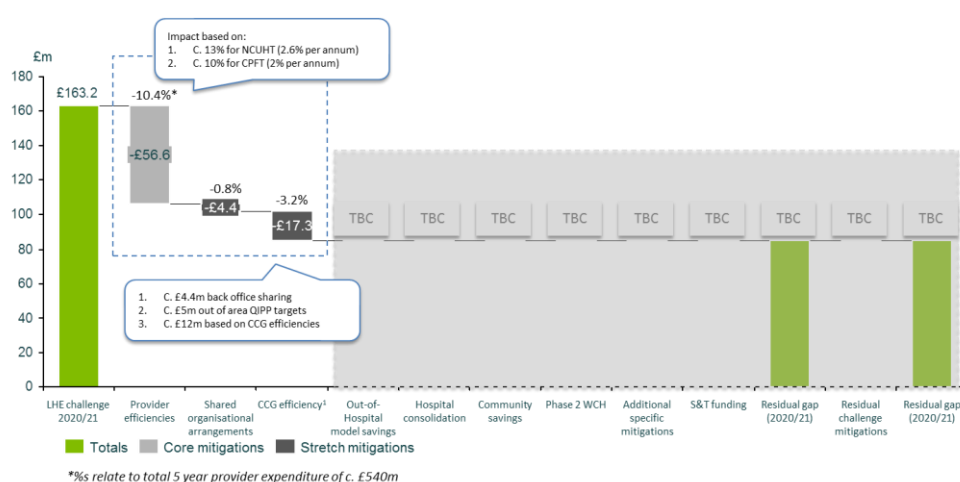


Figure 29:  
Efficiency  
savings

Source: WNE  
Cumbria Success  
Regime

<sup>32</sup> Source: Quality, Innovation, Productivity and Prevention QIPP national workstream: Shared Organisational Arrangements efficiency and management optimisation (November 2010).

<sup>33</sup> The £12m is broken down to £6m each in 2016/17 and 2017/18- 2020/21.

## 2.6 The Case for Change – Time to Act

Local organisations have, in the past few years, worked hard to improve the care and services they provide but progress has been too slow. Staff engagement and levels of confidence from the people who use our services remain low in general and the health and social care economy is both challenged and fragmented.



Our aim is to deliver more services within the community, protecting and enhancing primary care and strengthening out-of-hospital services, while also encouraging individuals to change their behaviour to prevent poor health and reduce overall demand. This will enable NCUHT to focus on delivering secure, safe, stable, and high-performing acute hospital services.

Our ambition is not new. Local organisations and the people who deliver care services have, over a number of years, worked hard to improve care and services in WNE Cumbria. Whilst there has been some success, we accept that the health and care economy remains significantly challenged and fragmented. Improvements to date have been smaller scale and focused on improving quality standards within organisations.

The scale of change required and set out in this document will only be achieved if national and local leaders work together with a shared sense of purpose and focus on improving outcomes both with and for our patients. We need to recognise where there has been a shortfall in the past and demonstrate the right leadership behaviours, developing the capability to learn and improve.

We believe that there is a compelling case for change and that it is time to act.

## 3 WHAT OUR ENGAGEMENT HAS TOLD US

*Chapter Three outlines the engagement with our staff, the public and other stakeholders that is informing and shaping plans for the future.*

### 3.1 Five Broad Themes

Engagement is the informative and conversational stage during which the NHS gathers information, listens to people's ideas and views, and considers the findings as it develops its thinking and ideas for service transformation.

Public comments from engagement for this PCBC can be grouped into five broad themes:

#### 1. Capacity constraints:

- While people understand the difficulties associated with recruiting, retaining and rostering staff in community hospitals, only a relatively small number of people support the idea of reducing the number of community hospital beds.
- There are calls from some quarters to increase inpatient beds at community hospitals to reduce 'bed blocking' and delays at A&Es.
- There are others who believe that more could and should be done to solve recruitment problems and this should be the focus of activity before any services are changed. There are, however, very few specific suggestions as to what recruitment measures could be explored.
- Some people argue that local recruitment challenges stem from uncertainty about services in West Cumbria and returning services to WCH will help solve this issue.

#### 2. West Cumberland Hospital:

- There are several options on the table with respect to maternity services and some confusion over these options. There is, however, little evidence of public support for any option that reduces the perceived level of service at WCH.
- The idea of removing any further services from WCH does not have a great deal of public support.
- There are mixed views about the degree to which we should take more elective surgery to WCH. Some see this as a good thing as it is returning or enhancing the range of services provided at the hospital, while others see this as turning WCH into a 'cold' site which only has relatively routine services, with Carlisle getting the more intensive, acute and/or complex services.
- A fully functioning WCH with services returned and A&E services protected is the objective of local campaigners.

### 3. Cost factors:

- The cost of the PFI for the acute trust remains a critical issue for local people, with many believing that removing this cost would help tackle the financial problems faced by the local healthcare system.
- There are some people who believe NCUHT should bear the burden of any cost reductions because its deficit makes up a large proportion of the overall health system overspend.

### 4. New services:

- There are mixed views about potential for a Heli Medicine service. Anything that aids service delivery in remote areas is broadly supported but some people seem to understand the proposed service as being a helicopter ambulance service for injured patients. Others feel the Heli Medicine option is something of a “gimmick” rather than a realistic proposal.

### 5. Factors specific to WNE Cumbria:

- The rurality and geography of WNE Cumbria – and its poor transport links – are matters of considerable local concern. There are concerns about expectant mothers and acutely ill patients not receiving adequate care during the so-called ‘golden hour’.
- The potential influx of new residents as a result of nuclear industry expansion – along with other projections of increased populations locally – remain a concern for local people.

## 3.2 Engagement Method and Approaches

The engagement programme for the WNE Cumbria Success Regime began in December 2015 (building on engagement activities and views captured in a number of previous development programmes). The programme of formal public engagement events is now complete, although we are receiving written responses from the public daily. Engagement activities from December 2015 up to and including 25 May 2016 include:

- **110 public or private stakeholder meetings** (including workshops and focus groups).
- **31 staff engagement meetings** and **161 responses to an online staff survey**.
- **165 written responses** (letters, emails, blogs, etc.).
- **237 online responses through the ‘Have Your Say’ form** on the WNE Cumbria Success Regime website.
- **86 location visits from a travelling engagement vehicle led by Healthwatch Cumbria** “the chatty van”, which has travelled to communities across WNE Cumbria, covering more than 3,500 miles and capturing the views of more than 4,200 people.

## 3.3 Views Captured Through Engagement Activities

The summary tables below show what have done and what people told us. To inform their work, all feedback has been shared with WNE Cumbria Success Regime clinical workstreams.



### 4x listening events

#### What we did:

- Four listening events were held in December 2015, led by Healthwatch, in locations across Cumbria early conversations about local health and social care services.

#### What people told us:

- Rurality, geography, infrastructure and travel implications must be taken into account when planning service provision.
- The public are unaware of how the NHS is addressing the recruitment and retention issue.
- There should be honest, open information between the NHS and the public and staff, including positive stories.
- The system needs more resources.
- There should be a focus on what should be provided at WCH.
- Appointments, access to appointments, waiting times and poor administration should be tackled.
- Access to, and equity of sustainable services, location of services (including mental health and dental services) are important.



### 2x focus groups

#### What we did:

- We held two focus groups with health campaigners in West Cumbria to discuss the key local challenges and possible solutions

#### What people told us:

- They want to see more, not less, services at WCH.
- They perceive there to be a need in West Cumbria for more generalist clinical support.
- They want to see a more integrated approach to health and social care.
- They want to see improved transport infrastructure in West Cumbria.
- That there is not currently enough information available to help people make informed decisions about the future...



## Social Media

### What we did:

- We established a Facebook page and twitter feed and monitored consensus of opinion and views expressed.

### What people told us:

- Local people want a fully functioning WCH with services returned to the hospital and A&E services protected.
- Travel to access services is a major concern with road issues.
- A potential influx of new residents due to nuclear expansion needs to be properly considered.
- More should/can be done to help solve the recruitment problem.



## Online form

### What we did:

- An online 'Have your Say' form was established on the Success Regime website to allow people to submit feedback and suggestions for how to improve healthcare services in Cumbria.

### What people told us:

- There is concern among some people that acutely ill patients are not receiving care during the 'golden hour' due to travel times to get to hospital.
- Poor public transport and road infrastructure (particularly the A595) should be considered before any more services are moved from WCH to CIC.
- Opposition to any 'downgrading' of maternity services at WCH was expressed.
- Some people expressed the view that services already moved from WCH to CIC should be returned and no other services should be transferred.
- Some people expressed the view that that community hospital beds should not be moved.



## Contact information

### What we did:

- A general Success Regime email address has been set up and both this, as well as a postal address, are detailed on the Contact Us page of the Success Regime website. More than 160 people have sent in comments through these routes.

### What people told us:

- A number of people have asked why we might remove services from a new hospital given recent investment.
- That there are concerns about transport difficulties and the road infrastructure of Cumbria when needing to reach and then take patients to hospital.
- There are people who are opposed to any 'downgrading' of maternity services.
- There is concern among some people that the uncertainty around the future of services and the transfer of some services from WCH to CIC has worsened the recruitment and retention problems that exist in the county.
- Community hospital beds are seen by some people to play an important part in easing the burden on A&E departments and help reduce 'bed blocking' and therefore no beds should be moved. There were views expressed that the Heli Medicine model would not be helpful during periods of bad weather and should not be seen as a panacea. It is not the real solution.
- The use of telemedicine is widely supported and should be explored as thoroughly as possible.



## Mobile engagement

### What we did:

- A mobile engagement 'chatty van' has visited communities across Cumbria. In total, 86 venues have been visited and over 4,200 people have been engaged face-to-face. The vehicle continues to visit more venues and engage with more people on a daily basis

### What people told us:

- There is concern associated with any reduction in community beds.
- Cumbrian transport links are not good and need to be taken into account.
- The rurality of the county needs to be factored into emerging ideas.
- Many people in West Cumbria expressed a view that no services should be moved from WCH to CIC.
- People want to understand more about the role of integrated care communities.
- There is concern among some about any reduction in the number of mental health service inpatient sites.





#### 4x public engagement

##### What we did:

- There have been 10 public engagement meetings spread across North, West and East Cumbria. These attracted approximately 1400 people in total y.

##### What people told us:

- There remains a view among some that the PFI costs have led to the financial deficit in WNE Cumbria
- There is a view held by some people that changes to community hospital services are being proposed to help the acute trust's deficit and this is not fully understood.
- There is a need to ensure that the third and voluntary sector are fully involved in the thinking of the Success Regime particularly with ICCs.
- Cuts to social care funding need to be factored in to the Success Regime's thinking as the vulnerable may end up being more isolated as a result.



#### Public workshops

##### What we did:

- The NHS has held a number of workshop events for key stakeholders including district, parish and town councillors, community and campaign groups and third sector organisations.
- One such meeting involved the whole of the West Cumberland Community Forum and a further two (organised by the Success Regime) attracted more than 100 key stakeholders.

##### What people told us:

- Helping people as much as possible to self-care should be a crucial part of the Success Regime's work.
- Tele-medicine should be utilised as much as possible in any new proposals.
- Communications must state some home truths about what needs to change in Cumbria's health system and why.
- The public need a more practical picture of what ICCs will look like and how they will work.
- Maternity recruitment is a real challenge at the moment.
- Community hospitals could be utilised to provide more holistic care.
- There was some disagreement over the Success Regime's proposed vision. Some said it was too ambitious ("international beacon") while others said it was not ambitious enough.

#### What we did:

- Our work streams have been holding various workshops in which lay representatives and patients have been involved. For example, in February and April 2016, we engaged stroke survivors and carers in two workshops to discuss current stroke early supported discharge and stroke rehabilitation services, and the development of a future vision to improve stroke services across North Cumbria. Ophthalmology and orthopaedic and musculoskeletal services (MSK) workshops have also been held.
- A steering group was set up to look at engagement with stakeholders interested by children's and family services. The CCG commissioned Healthwatch in partnership with the Maternity Services Liaison Committee to undertake engagement activity in November 2015, which included an online survey with more than 1,200 responses, workshops, drop-in events across the area and visits to places such as children's centres and playgroups.

#### What people told us:

- Stroke survivors and carers told us the experiences they had of the current services - what was important to them and what we needed to think about to improve services for the future.
- Issues such as eligibility criteria, signage, car parking are key transport concerns for patients.
- Staffing numbers of paediatrics and obstetrics is a concern.
- Faster access to appropriate ophthalmology services, MSK and orthopaedic services is needed.
- Several recurring themes arose from the children's and family services survey and engagement activity as being key areas that patients valued in a maternity service, including:
  - Continuity of care and carer
  - Consistency and quality of information and communication
  - Breast feeding support
  - Support and information for women to make informed decisions and choices
  - Accessible services and choice
- When asked what a good maternity service would look like, responses included:
  - All staff to be well trained medically and socially
  - No agency staff
  - Continuity of midwife support throughout pregnancy and labour
  - All healthcare staff to be respectful of women and their families and to be sensitive to their wishes and needs
  - Good communication between staff and between staff and their colleagues

The final engagement activity report will be independently peer reviewed once the programme of activity is complete and the engagement report is drafted.

## SECTION B

### Where do we want to be?

This section explains the changes we are proposing.

#### Section checklist

##### **The development of our plans**

Significant change is required  
Clinically-led plans

##### **Plans for social care services**

Greater resilience, less demand

##### **Healthcare services**

Public health, prevention, self-management  
Primary care  
Proactive and urgent care  
Integrated care communities  
Community hospitals  
Emergency and acute medical  
Women and children  
Mental health  
Planned elective care  
Specialised services  
Clinical informatics and technology  
Transport services  
Workforce  
Organisational Development  
Estates

## 4 THE CHANGES WE ARE PROPOSING

*Chapter Four outlines our proposals to achieve our vision (as outlined in Chapter One). It also highlights existing opportunities to improve the effectiveness and efficiency of our health and social care system and ensure optimal health outcomes. Some significant changes are proposed which, following discussion with the Cumbria Health Scrutiny Committee, require – and will benefit from – full public consultation.*

### 4.1 Significant Change is Required

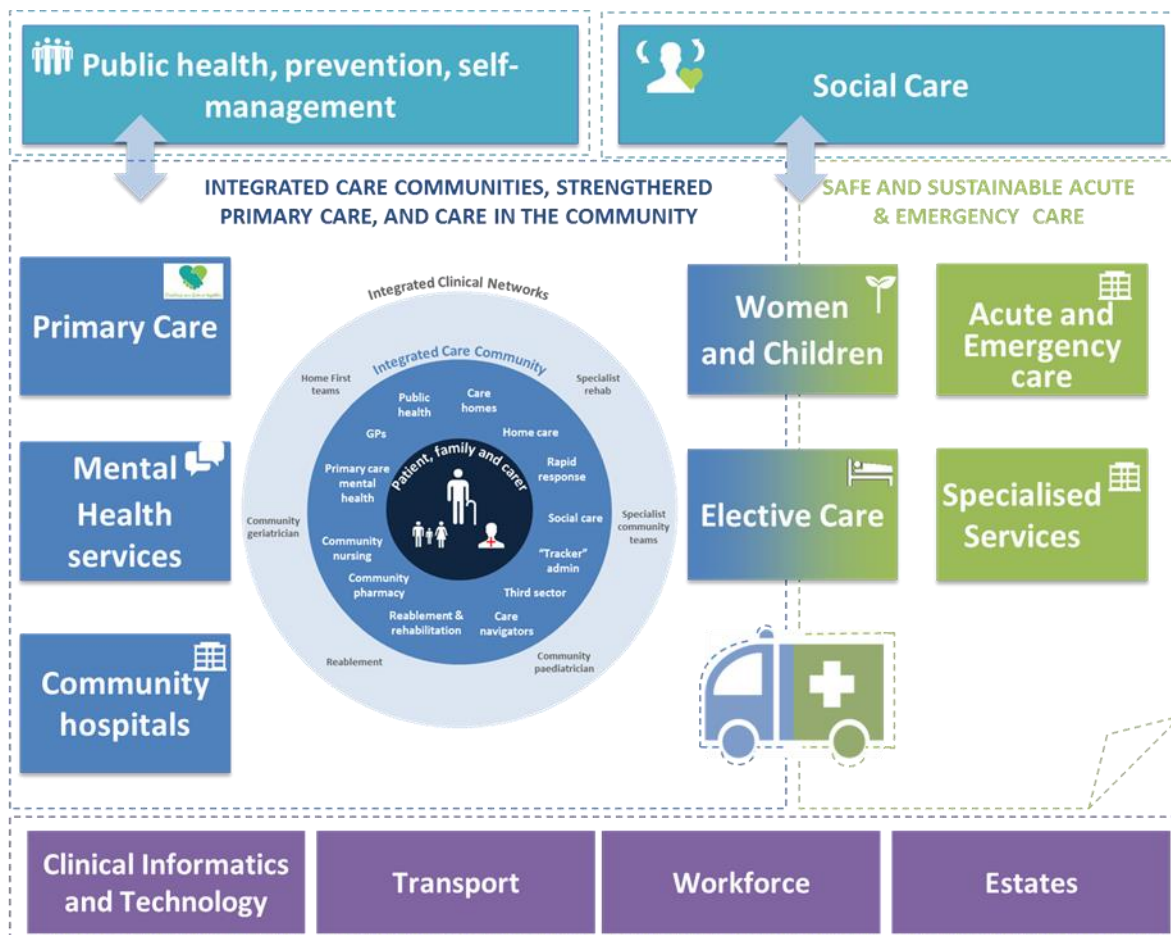
Many improvements are already in progress, while other proposals will require significant change in the way we deliver services. The latter will require formal public consultation in line with Section 242(1B) of the National Health Service Act 2006 (“2006 Act” as amended by the Local Government and Public Involvement Act 2007 (“2007 Act”). The areas where we will be seeking to undertake formal public consultation are set out in more detail in Chapter 5.

Specifically, formal public consultation will be required to consider the following proposed significant changes:

- **We propose to configure our acute hospital services to work as a single service across two sites (CIC and WCH).**
- **We proposed to strengthen the role of our community hospitals to work as part of new Integrated Care Communities focusing on admissions avoidance to support people in their own homes.**
- **We will ensure that an holistic approach is taken to improve the health and well-being of our population, with the interdependency between mental and physical health services being paramount. This will require essential improvements to our local mental health services for those with learning disabilities and enduring mental health conditions and associated co-morbidities; but also focus on preventative and social interventions e.g. Strengthening interventions to prevent the consequences of loneliness and isolation. ).**
- **We will deliver £57m in core efficiencies through transformation of services across WNE Cumbria – not least by: bringing care closer to home; reducing lengths of stay; cutting out unnecessary duplication; developing advanced telemedicine services; improving health outcomes and reducing repeat admissions.**

For reference, key components of our health and social care system are illustrated below.

Figure 30: Key Components of the WNE Cumbria Health and Social Care System



Source: WNE Cumbria Success Regime

## 4.2 Our Service Principles

The following service principles are essential prerequisites to help us achieve our vision:

- Development of **Integrated Care Communities (ICCs)** will be fundamental to the future model of care.
- Services must be maintained across **two acute hospital sites**, ensuring that both WCH and CIC provide safe, high-quality care. This will require a commitment to the concept of **single specialist clinical teams** that may cross organisational boundaries.
- **Strong partnerships** with our staff and our local communities will enable them to help shape the future.
- Specialised and specialist services should be provided through **strong network arrangements**.
- Realising the short-term improvements and longer-term changes necessary to improve health outcomes will require the highest levels of **leadership and commitment**.

### 4.3 Care Organised Around Citizens

We have a bold vision for health and care services for the next five years, based on our population needs and public and staff feedback about current services.

Whole-system integration of hospital, community, social and primary care is central to our vision because people tell us that services are currently too fragmented and difficult to navigate. We are building on our model of proactive care, to move more people from a reliance on reacting to their illnesses to one where we can intervene earlier in their care.

This will eliminate some hospital admissions as a default for people who are not acutely unwell but need help and support. Delays will be reduced significantly by changing the way that people work in partnership on a day-to-day basis and by removing barriers to cross-system working. Planned care will be delivered in a more effective and sustainable way, reducing the complexity for professionals and patients, whilst reinvigorating working relationships and dialogue between primary and secondary care clinicians.

The impact will be an improvement in the quality of care received and better outcomes for the patient: overall, an improved total patient experience.

Key elements of our new care model include:

- A proactive, co-ordinated multidisciplinary and properly resourced team based in the community to help maintain wellbeing – particularly for frail and elderly people;
- Support allowing people to return to their normal place of residence sooner and reduce the risk of losing the capability, support structures and confidence to live independently;
- Integrated urgent care services centred around the patient, with care professionals working seamlessly between acute, primary, community and social care – under a single structure;
- Care professionals able to access the right services at all times – with social, community and primary care as accessible and responsive as A&E;
- Elective care focused on those patients most likely to benefit from it, and provided where there are enough patients to run a high-quality, sustainable service; and
- Maternity and paediatric services that provide access to expert opinions earlier and only admit where necessary.

Patient stories at **Appendix B** illustrate the tangible benefits of the integrated health and social care system that we must achieve.

### 4.4 Clinically-led Development Plans

Clinical workstreams led by clinicians and professionals from within WNE Cumbria and supported by a project manager and financial adviser have led the development of propositions that were identified as being capable of delivering sustainable, high-quality care. The teams used best practice and clinical evidence as well insights gathered through engagement events and processes.

The focus was on areas that would reduce health inequalities, strengthen Out of Hospital services and improve our acute hospital services.

#### 4.5 Cumbria County Council Plans for Social Care services

Effective social care services are of course integral to successful integrated health and social care systems; indeed, the Care Act 2014<sup>34</sup> places responsibility on councils to promote prevention and wellbeing and, by 2020 they must have plans to integrate health and social care.

We have noted in Section 2.2. that the utilisation of long term residential and nursing care homes for older adults in social care is c25% higher for Cumbria County Council compared to its peer group. However, over the past few years, the number of older people receiving person-centred care in WNE Cumbria has increased more sharply than for the peer group and the national average (there was a 55% increase in care provided by Cumbria County Council between 2006 and 2010).

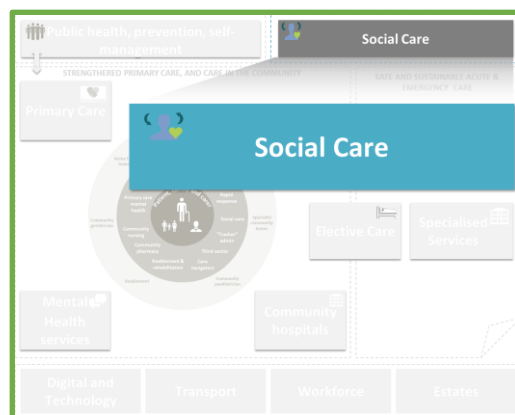
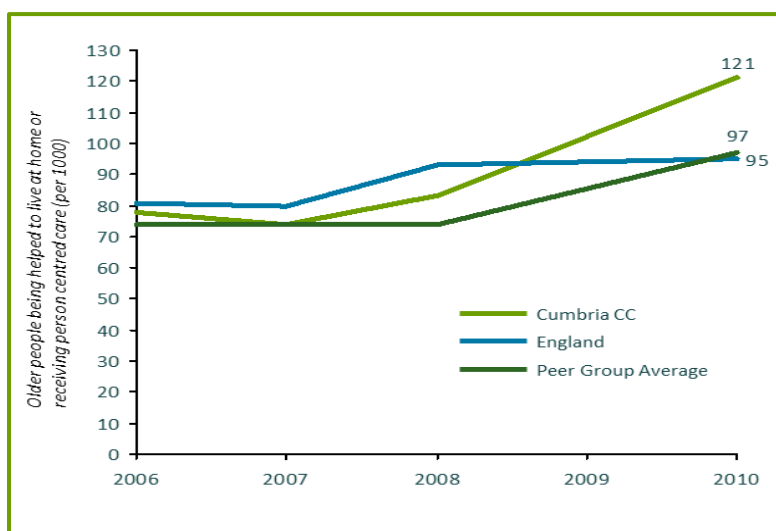


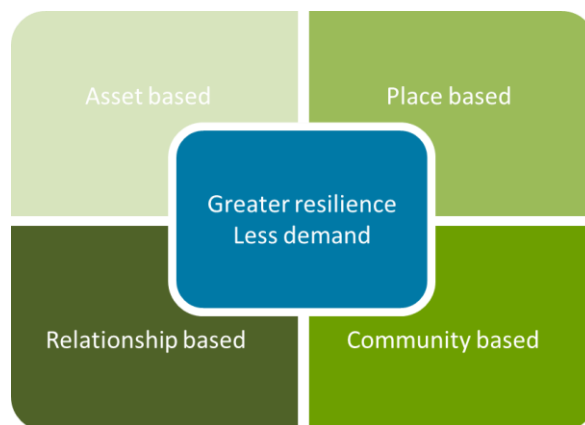
Figure 31: Figures for older people being helped to live at home or receiving person-centred care



Cumbria County Council has consulted on plans to support the proposed ICC, place-based model. It will be targeting investment in services which prevent, reduce or divert demand, enabling individuals and activating communities to become more resilient by providing more support themselves. Independence will be promoted through investment in rehabilitation, new technology and supportive Extra Care provision to reduce reliance in residential and nursing home services. Specifically, plans include:

<sup>34</sup> See <http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted>

- A single “front door” for information and advice, with a greater emphasis on accessing support and advice through digital routes and telephone services.
- The development of universal and targeted prevention services, enabled through “**health and well-being coaches**”, with the primary aim of coordinating public services and third sector agencies, to help enable people to take control of their own wellbeing.
- Encouraging and helping individuals to develop their own support plan, pulling on a wide range of resources, including family, friends, the third sector, and, if necessary, formal care settings.
- Supporting people with **complex needs and at the end of life**, collaborating across the health and social care system to provide care and support in advance of a crisis, to provide care as close to home as possible, and to minimise admissions, and reduce delays in discharge. This will include the arrangement of formal care, if needed.
- Redesigning the **reablement and intermediate care** pathway for people living with frailty to ensure there is a period of recovery before decisions are made about long term care. Those for whom long term care is being considered will first be offered access to reablement services, and technology and equipment to remain living independently at home.



#### 4.6 Our Proposals for Public Health, Prevention and Self-Management

Key indicators suggest that WNE Cumbria has an underlying health and wellbeing gap. Use of health and care services are higher than the national average. This suggests that refocusing our public health efforts and increasing the use of self-care and self-management will create opportunities to respond to and change patterns of demand. By refocusing use of our existing resources, we believe that there is the potential to contribute £2.7m savings across the health and care community through changing patterns of demand by 2020/21. Our proposals for public health and prevention, requiring formal public consultation, are as follows.



Establishing a **Health and Wellbeing Service for adults** is a priority, supported by an online ‘Wellbeing Cumbria’ platform that will enable wide ranging access to information, advice and digital support services that support self-care.

We are funding a team of **Health and Wellbeing Coaches** (HAWCs) who will provide individual and family support to vulnerable groups and those identified as most needing additional support to meet their individual goals. The third sector plays a key role in promoting health and wellbeing activities and offering opportunities for purposeful activity for the benefit of local communities through volunteering.



#### How will we know we are making an impact?

- Improved self-reported mental wellbeing and resilience
- Improved lifestyle behaviours, reduced loneliness and isolation
- Reduced use of statutory health and adult social care services

We will be working to increase uptake of the **Stop Smoking Service**. Currently the service is accessed via self-referral, GP signposting or county council call centre. 89 pharmacies are accredited across all of Cumbria to provide the service although only 60 are active.

#### How will we know we are making an impact?

- Reduced incidence of CHD, respiratory disorders, cancer, complicated pregnancy and births

We will be continuing the **cardiovascular disease** screening programme that targets adults aged 40-74 to proactively assess risk and aiming to improve the number of young people (aged 40-55) and especially men to engage. We will also be implementing the national **Diabetes Prevention Programme**, a behaviour modification programme for people at risk of diabetes. It is expected there will be 2,000 – 2,500 referrals in Cumbria per year.

#### How will we know we are making an impact?

- Reduced incidence/more rapid diagnosis of heart disease, stroke, diabetes, kidney disease (CKD) and vascular dementia

We will maintain a **Community Weight Management** programme for adults aged over 18 with a BMI greater than 28. Access to 12-week intervention is free of charge.

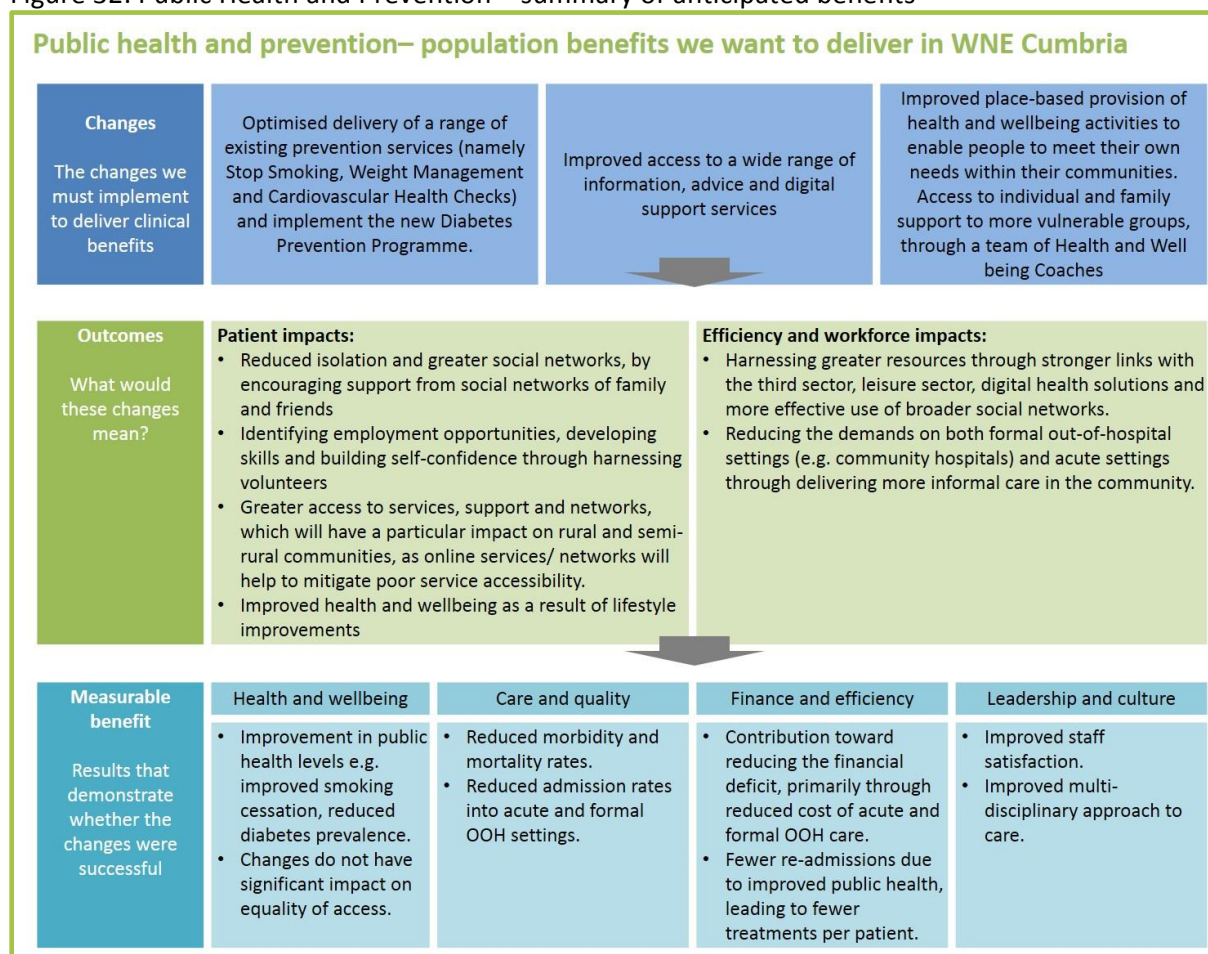
#### How will we know we are making an impact?

- Anticipated average weight loss around 10 lbs. in 12 weeks

An integrated health and wellbeing service for **children and young people** aged 0-19 is also being developed, bringing together the 0-5 Healthy Child Programme, 5-19 Healthy Child Programme, and the Early Help Services to ensure that as the Early Help Strategy evolves and develops, there is flexibility to build some of the universal delivery elements of public health services into Early Help. The integrated service will be able to respond more effectively to changing need, and this additional public health capacity will release clinical staff to focus on clinical activity. Priorities include childhood obesity, dental health, breastfeeding and emotional health and resilience.

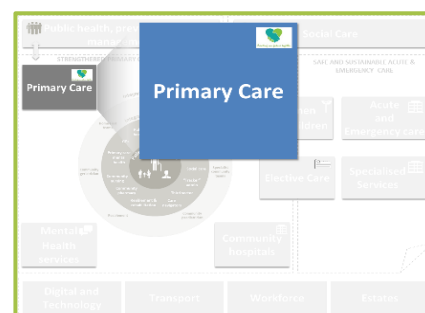
The figure below provides a summary of the population benefits we expect our proposals to achieve.

Figure 32: Public Health and Prevention – summary of anticipated benefits



#### 4.7 Our Proposals to Support Primary Care

Primary care services are the foundation upon which our health system operates. The major component of the primary care system is general medical practice. In addition, pharmacies, optometrists and dental services and non-statutory community services are playing an increasingly important role.



Maintaining high standards of general practice is a priority for us, as it will be fundamental to the success of the Integrated Care Community model (detailed in 4.6.1), and the sustainability of the health and social care system more generally. However, nationally and locally GP services are now increasingly fragile – for a great many reasons. Specifically, for WNE Cumbria:

- Over the last three years, UK-wide pressures on general practice have been felt particularly acutely in WNE Cumbria. One third of all practices in WNE Cumbria have applied for NHSE “vulnerable practices” **funding** as a result of national contract changes.

- **Workload** has increased significantly (for example, there were approximately 15% more patient contacts in 14/15 compared to 09/10). This has been exacerbated in WNE Cumbria by the pressures in our acute hospitals, resulting in significant unplanned work.
- There are major issues affecting GP and practice nurse **recruitment** – of last year's 13 available places on the local GP training scheme, only one was filled. In Copeland, the GP vacancy rate is 23% and 47% of current GP partners across WNE Cumbria are planning to retire over the next 10 years.
- Many practices are experiencing significant issues with their **premises**, which can also impact on recruitment.

Working with NHS England and Health Education England (HEE), we are progressing a number of short-term actions with the aim of boosting the number of GPs working in WNE Cumbria (see 4.13 for details).

Initiatives intended to support the wider recruitment and retention of the primary care workforce and to address workload pressures include:

- **Extending the role played by community pharmacies** enabling them to provide a wider range of enhanced services that increase patient accessibility, encourage patient self-care and therefore release capacity within general medical practice such as emergency contraception and the minor ailments scheme
- **Supporting practices to benefit from technology enablers** - by the summer of 2016, all GP practices will be using the same IT system enabling cross-Cumbria e-referrals and e-prescribing, allowing practices and patients to monitor pathway progress online.
- **Investing in infrastructure** to enable greater co-location of primary care services with the wider out of hospital services, and, where appropriate releasing practices from onerous premises related issues, potentially leading to financial savings from operational efficiencies. Key to this will be the finalisation of a case for investment through the Estates and Technology Transformation fund (primary care) (see Figure 33 below).
- **Enabling practices to collaborate** to deliver an enhanced range of services (see below for examples).

We recognise the specific challenges faced by small rural (isolated) practices. General practices are being supported to help them develop new ways of working:

- Practices are being supported to reduce unwarranted variation and increase clinical outcomes through a new **Quality Improvement Scheme** (April 2016) and the introduction of new tools to support them, including 'Map of Medicine' and electronic referrals.
- Development of collaborative services, with **practices working together** to deliver services to care home and housebound patients and to deliver enhanced services such as extended opening/access, including collaboration with CHOC.
- Practices joining together to form larger practices (**mergers**) enabling greater skill mix economies of scale.
- **Exploring new models for the future**, building on the care principles of general practice, ensuring that patients continue to receive personalised continuity of care. Realising greater efficiencies and creating more attractive models of employment, e.g. salaried GP services and integrated same-day demand services.

- Supporting all practices to continuously improve and innovate.

Figure 33: WNE Cumbria priorities for Estates and Technology Transformation Fund (Primary Care)

**WNE Cumbria proposals for the Estates and Technology Transformation Fund (Primary Care) to support primary care infrastructure development**

The CCG will be submitting proposals for the Estates and Technology Transformation Fund (Primary Care) programme in June 2016. In addition to the criteria set nationally for PCTF funding, the CCG prioritised schemes that will accelerate the implementation of our clinical strategies, particularly ICCs. The PCTF requires schemes to be at least revenue neutral to the health system. The schemes listed below are being developed with CPFT and Community Health Partnerships:

**Workington** - This scheme will bring together five practices and all community services based in Workington. The practices currently work from five independent bases and from Workington Hospital. Community services are based in a variety of locations. Co-location will accelerate the development of ICC services. Site options need to be considered and envisaged services (beds, outpatients) to be provided from Workington Community Hospital will be an important factor in the options appraisal.

**Carlisle** - Three practices are merging in Carlisle and will move from operating on three sites from the current five. The practices currently have two branch surgeries in the south of the city and the proposal is to build a new health facility to replace these, together with accommodation for community services, supporting the planned new models of care and the rapid development of the ICC. Site options are being reviewed with land currently owned by CPFT as one potential site.

**Seascale / Rural practices** - An application for funding to further develop proposals for a health bus is being developed. Primary Health buses are used across New Zealand, North America & Canada, but the only ones in England are for secondary care services (e.g. MRI) or in urban areas providing public health screening to homeless & vulnerable patients.

The figure below summarises the anticipated benefits that our primary care initiatives will create.

Figure 34: GP Development – Summary of the benefits we want for WNE Cumbria

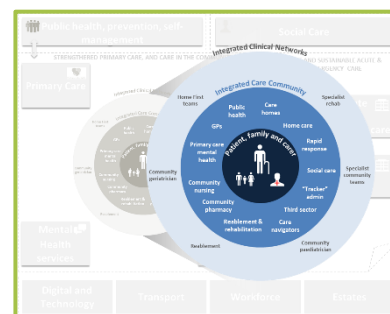
Changes				
The changes we must implement to deliver clinical benefits	Sustained, high quality General Practice available to communities, rural and urban, across WNE Cumbria	Increased clinical outcomes and reduce unexplained clinical variation	Integrated care through one common IT platform	Greater co-location of primary care services with the wider out of hospital services
Outcomes				
What would these changes mean?	<b>Patient impacts:</b> <ul style="list-style-type: none"> <li>Enabled self-management with patients able to monitor pathway progress online.</li> <li>Improved clinical outcomes with reduced unexplained variation</li> <li>Reduced variation in referrals</li> <li>Better access to primary care services, including extended access over 7 days.</li> <li>More services provided out of hospital and closer to home.</li> </ul>		<b>Efficiency and workforce impacts:</b> <ul style="list-style-type: none"> <li>Release practices from onerous premises related issues, potentially leading to financial savings from operational efficiencies</li> <li>More efficient patient management pathways (e-referrals)</li> <li>More efficient use of scarce resources through working collaboratively and at scale.</li> <li>Improved recruitment and retention by improving the range of training and job s roles on offer and supporting people in their work.</li> </ul>	
Measurable benefit	Health and wellbeing	Care and quality	Finance and efficiency	Leadership and culture
Results that demonstrate whether the changes were successful	Care and quality <ul style="list-style-type: none"> <li>Improved patient experience and satisfaction</li> <li>Improved access</li> </ul>	<ul style="list-style-type: none"> <li>Reduced admission rates into acute settings</li> <li>Improved outcomes in key targets</li> </ul>	<ul style="list-style-type: none"> <li>Contribution toward reducing the financial deficit, primarily through reduced cost of acute care</li> <li>Sustainable General Practice through efficiency and shift in investment in General Practice.</li> </ul>	<ul style="list-style-type: none"> <li>Improved staff satisfaction</li> <li>Improved multi-disciplinary approach to care</li> </ul>

## 4.8 Our Proposals for Proactive and Urgent Care

Our clinical strategy for Proactive and Urgent Care services has a number of core inter-related components, focusing on developing clinically and financially sustainable service models and configurations for:

- **Emergency and acute medicine services** on the WCH and CIC hospital sites which satisfactorily reduce risks of current provision, thus improving the safety and quality of care provided.
- Services that **maximise admission avoidance** and improve management of patients in a community setting.
- Services that ensure **timely discharge** from hospital to settings as close as possible to home.

These proposals comprise discrete elements relating to developing effective, integrated Out of Hospital service and establishing Integrated Care Communities. We must also redefine the role of our nine community hospitals – with specific reference to the provision of community inpatient beds and the provision of safe and sustainable emergency and acute medicine. An overview of the





approach taken to modelling the financial impacts of out-of-hospital interventions is set out in Appendix I.

#### 4.8.1 Integrated Care Communities (ICCs)

NHS Organisations in West, North and East Cumbria and Adult Social Care are working to integrate services and Integrated Care Communities (ICCs) are one of the key developments that will help improve the care we provide to the population.

The establishment of ICCs is core to our future model of care. Based on best practice from other parts of the country, particularly NHS England Vanguard programme New Care Models<sup>35</sup>, as well as our local experiences, ICCs will bring together public health, general practice, social care, community services, mental health services and community assets, including community hospitals. A full explanation of our plans and the role of ICCs is set out in **Appendix C**, in addition further detailed information on the financial, activity and workforce impact of the model is provided in **Addendum I**.

Of note, the development of integrated care nearer to home will be most effective if it is done alongside other key elements of our plans set out within this PCBC, specifically:

- The development of system wide care pathways for key conditions and needs such as Stroke, Frailty, end of life and Respiratory illnesses.
- Integrated work to improve health and well-being and prevent ill health, dealing with lifestyles and social and economic challenges.
- A new model of integrated services for professionals working in and around acute hospitals to reduce admissions and lengths of stay and return people home as soon as possible.
- New models of support commissioned by the NHS and Councils working together to invest in Extra Care Housing, high quality dementia and nursing care, assistive technologies and support from the community sector. Investment in digital solutions to support self-help, telecare and telemedicine and improve choice and control for the public.
- New approaches to co-production of services with individuals, families and communities to achieve a truly fully engaged community.
- The sharing of learning across sectors as well as the integrating of pathways, for example, the experience of Direct Payments in the Council can help develop Direct Payments for Health Services while the experience of risk stratification in the NHS may help the Council improve its 'case-spotting capability'.

Three ICCs were mobilised in April 2016 (early adopters), with a further three planned in October 2016, with complete roll-out by the end of 2016/17. The three early adopter sites proposed are Workington, Maryport & Cockermouth and Eden, two of which will also benefit from being part of the national Primary Care Home<sup>36</sup> initiative.

<sup>35</sup> See <https://www.england.nhs.uk/ourwork/futurenhs/new-care-models/>

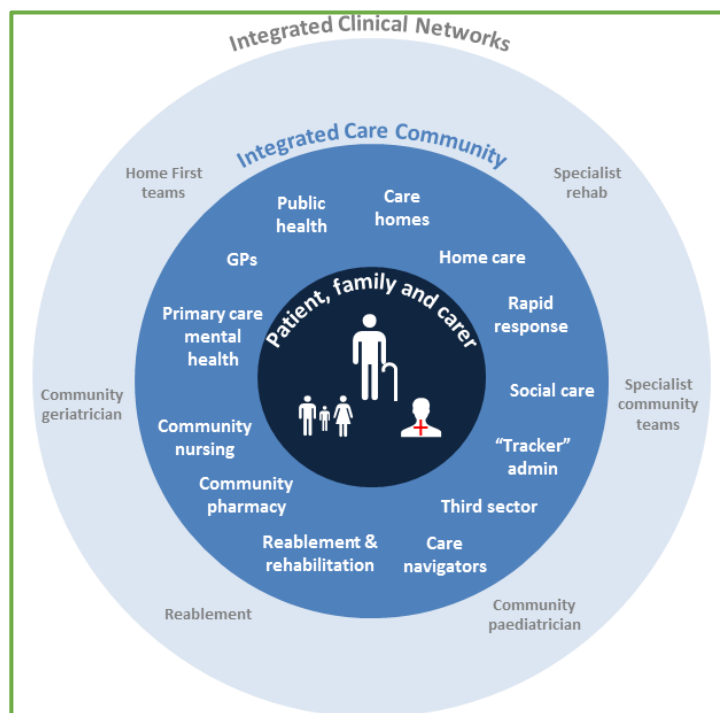
<sup>36</sup> See <http://www.napc.co.uk/primary-care-home>

Based on natural communities of between 20,000 and 70,000 people, the ICCs will form an extended primary health and care team, where GPs, Social Workers, Nurses, Therapists, Support Workers and the Voluntary sector work together in teams to wrap themselves around individuals, families and communities, providing both person centred co-ordinated care and an organised approach to improving the population health. They will have local budgets, enabling them to flexibly respond to local population need to deliver and arrange services. They will be able to draw on the range of services which are commissioned at a county or STP footprint level and on the existing frameworks for domiciliary, residential and other services. However, they will also have a key role in reducing dependence on such services and in working with commissioners to develop services to meet local needs.

Where services are of a more specialist nature or cover a wide geographical footprint, they will sit at a clinical network level, where the interactions with ICCs will be fundamental to the wider system efficacy. Provision such as specialist respiratory or heart failure or respiratory medicine will out-reach into the ICCs and ICCs teams will in-reach into acute settings to expedite discharge.

ICCs will be most successful in delivering seamless care to our citizens only if clinicians and care professionals work together in networks across primary and community and secondary care (and tertiary services if necessary). We will invest time in creating the culture and conditions that encourage the new ways of working, and fully engage our primary care and hospital doctors together in shaping the new care model. The benefits will include appropriate and effective care, and also an increased level of formal and informal contact between clinicians will contribute to the sense of a single team that will be imperative in future careers. Our model for ICCs is set out in Figure 35 below.

Figure 35: Our model for Integrated Care Communities in WNE Cumbria



Source: Cumbria CCG

Anticipated benefits of ICCs include:

- Ensuring that people are treated and supported at the **right time** and in the most **appropriate setting**.
- Ensuring an increased focus on **prevention**, encouraging individuals and mobilising the population to take personal responsibility for their own health and wellbeing.
- Greater use of **community assets** to support wider individual wellbeing.
- Focus on **self-care / support** for citizens and their carers.
- Embedding **person-centred care** and **shared decision-making**.
- Providing more **care close to home**.
- Better care planning / **risk stratification** across the health and social care system.
- **Reduced clinical variation**.
- More **efficient** services with **less waste**.
- Positive patient experience that feels joined up and **seamless**.

This will translate to:

- **Reductions in attendance and use of hospitals**, reducing unplanned admissions, length of stay and movements across the system.
- **Reductions in the use of residential and nursing care**, aiming to reduce admissions and overall length of stay.
- **Increases in people receiving rehabilitation and reablement at home** to maximise independence.
- **Increased numbers of people being able to die in their own home rather than in hospital**.
- **Increases in people being able to take control of their own health and care** by use of expert patient programmes, digital access, telehealth and telecare.
- **Increased engagement of local organisations** such as schools, employers, third sector groups in promoting health choices and communities.

Each ICC will have a dedicated manager, and control of an integrated health and social care budget. The role of the early adopters will be to:

- Test how best to integrate community nursing teams, community therapy teams and social care to create a single point of access for patients.
- Improve patient care by developing new evidence-based and best practice pathways, e.g. frailty, discharge to assess.
- Improve use of resources by developing greater insight in to current spend with the aim of reducing duplication and establishing a shared understanding, pooling knowledge and resources.
- Start integrating services in shadow form, to inform future organisational arrangements.
- Work together to develop solutions for enabling areas i.e. governance, financial delegation, information sharing, interoperability, estates, workforce.

While we expect all ICCs to be delivering the same outcomes we also recognise that they will need to have the ability to respond to local needs in a way that reflects local needs.

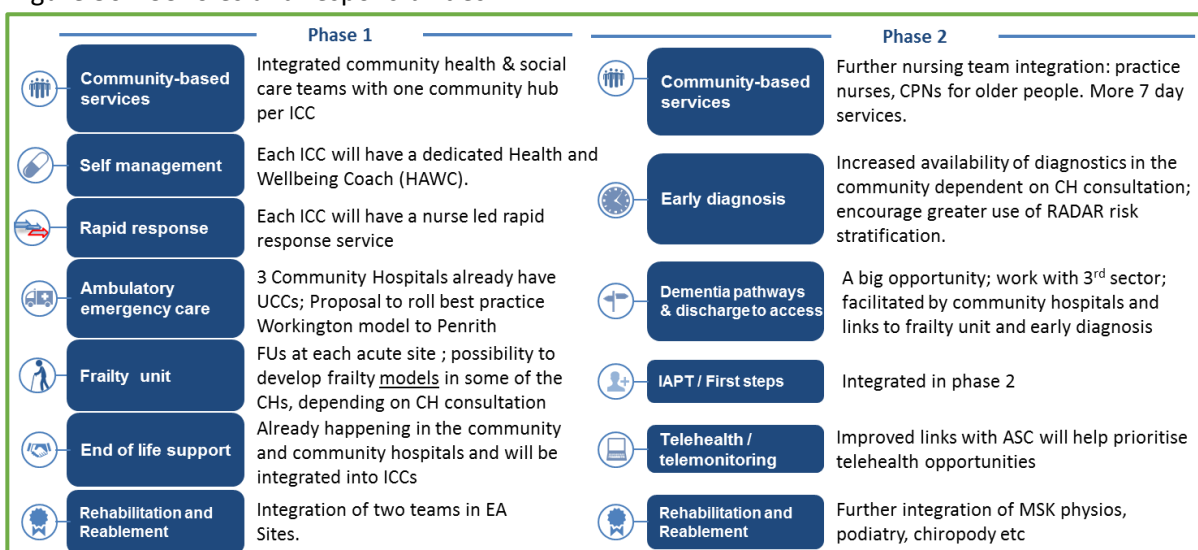


As a minimum we will expect all ICCS to have a core operating model:

- There will be regular multi-disciplinary team meetings, to discuss and share intelligence regarding the ICC population.
- The ICC will be the focus for local care co-ordination. The ICC Hub will be the 'heartbeat' of each ICC. Shared information systems will ensure that each resident will receive more proactive person centred care. The Hub will know when a patient is in hospital and who their key worker is when they return home. Each cohort of patients depending on their needs will have different types of key workers. As interoperability increases, ICC hubs will be able to co-ordinate virtual outpatient consultations with acute consultants, reducing the need for either patient or consultant to travel unnecessary distances.
- Each ICC will co-ordinate a multi-agency co-ordinated Rapid Response function that focuses on preventing avoidable admissions and enabling effective discharge. The most appropriate team member will respond to keep someone safe. An integrated rehabilitation and reablement function will maximise someone's independence with a recognition that the best place to do this is within someone's own home.
- Each ICC will support end of life care, linking to specialist teams at Clinical Network Level.
- Each ICC will have a standardised approach to care co-ordination and care and support planning, including a personal care plan that is visible to all relevant providers of health & care.
- ICCs will be required to implement standardised evidenced based pathways e.g. frailty, respiratory, dementia
- ICCs will be required to implement a standardised approach to self-management, linking with local employees & educational establishments to ensure the same messages are heard at every level of the community.

We also anticipate that as ICCs develop, further integration of community teams will be progressed, to include: community-based mental health services; other therapeutics services (such as musculoskeletal physiotherapists, podiatrists and chiropodists). Each ICC will have a dedicated Health and Wellbeing Coach (HAWC) to strengthen prevention services. This is set out in Figure 36 below.

Figure 36: ICC roles and responsibilities



The ICCs will be supported by systems-wide approaches to IT, records management and information management.

There will also be a system-wide implementation plan for support via digital systems covering the spectrum from digital/app based advice and self-help, telecare, to support vulnerable people be safer at home and in the community, including people with physical frailty as well as those with Learning Disabilities and Dementia, telehealth and telemedicine to help people manage their own LTC, support reduced hospital admission and shared care arrangements and enable remote medicine, for example models similar to the remote fracture services provided at NCHUT.

The re-negotiation of contracts with care homes will build in a requirement to collaborate with ICCs on the use of telecare/telehealth and also to collaborate on how to meet local needs in a timely way. The provision of domiciliary care will be organised to ensure that ICCs can build a relationship with local providers and work together to understand capacity and demand.

In summary, by working seamlessly with strengthened ambulatory care, frailty services and rapid access clinics, ICCs will enable a significant reduction in admissions of frail elderly patients and reduce length of stay. Our initial estimates suggest that we can achieve a 12% reduction in admissions of people living with frailty, and a reduction in length of stay of at least 3 days on average. This equates to an overall reduction in bed usage of around 10%. We believe that there is scope to further reduce reliance on inpatient beds beyond this over the next five years. We have had early successes which provide the evidence that ICCs can deliver these ambitious objectives. (For example, in the last 12 months we have reduced the number of emergency bed days spent by Millom patients in the acute hospital by 29%. This compares well with other areas some of which increased over the same period.) We will work to ensure that these improved outcomes are generalizable across WNE Cumbria. We will develop metrics against which we will continuously evaluate improvements. Two local case studies detailing the achievements to date are set out in **Appendix D**.

The following table confirms the key performance indicators we will be using to monitor the impact of the ICCs.

Outcomes	Measured by	Indicator
<b>Improved patient/service user experience</b>	<ul style="list-style-type: none"> <li>Improvement in people's experience of receiving care</li> <li>Proportion of people dying in their place of choice</li> <li>Social Care Satisfaction Survey</li> </ul>	Patient and carer experience feedback GP survey Locally defined ICC indicators tbc Practice data Advocacy and Healthwatch feedback.
<b>Improved staff experience</b>	<ul style="list-style-type: none"> <li>Increased recruitment and retention rates</li> <li>Reduced staff sickness rates</li> <li>Improvement of staff experience of delivering care and support reported.</li> <li>Progression routes between roles.</li> </ul>	Organisational data Organisational data Staff questionnaire
<b>Improved outcomes</b> Patient /service user supported to maintain their independence in their place of choosing	<ul style="list-style-type: none"> <li>Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation</li> </ul>	Adult Social Care Outcomes Framework

Patients/service users are supported to manage their long term condition	<ul style="list-style-type: none"> <li>services</li> <li>• Readmissions within 28 days for selected patient types</li> <li>• Proportion of people feeling supported to manage their long term condition</li> <li>• Proportion of Primary Care Interventions to avoid unnecessary ambulance conveyances</li> <li>• Improving one-year cancer survival rates</li> <li>• Reduction in potentially avoidable admissions for high risk groups</li> </ul>	<p>Inpatient Data</p> <p>GP survey data</p> <p>NWAS data</p> <p>NHS outcomes data</p> <p>Inpatient data</p>
<b>Healthier Communities</b>  Promotion of healthier behaviour	<ul style="list-style-type: none"> <li>• Improvement in the public health indices tables for the ICC population.</li> <li>• Increased number of smoking quitters</li> <li>• Increased number achieving weight management goals</li> <li>• Increased number achieving physical activity goals</li> <li>• Reduction in social isolation.</li> <li>• Increase in numbers of people receiving support from community groups and social networks.</li> </ul>	<p>Public Health Data</p> <p>Acorn Data</p> <p>QOF data</p> <p>Acorn data</p> <p>Public health data.</p> <p>Public health data.</p>
<b>Better use of resource</b>	<ul style="list-style-type: none"> <li>• Reduction in inappropriate emergency admissions</li> <li>• Reduction in overall Delayed Transfers of Care across all hospital sites</li> <li>• Reduction in admissions to residential &amp; nursing home placements.</li> <li>• Reduction in readmission rates</li> <li>• Reduction in A&amp;E attendances</li> <li>• Reduction in unnecessary ambulance conveyances</li> <li>• Reduction in bed days in both an acute &amp; community hospital setting</li> <li>• Reduced high intensity packages</li> <li>• Increased take up of assistive technology</li> </ul>	<p>Inpatient data</p> <p>Inpatient data</p> <p>ASC/NHS dataset</p> <p>Inpatient data</p> <p>In patient data</p> <p>NWAS data</p> <p>Inpatient data</p> <p>ASC/NHS data.</p> <p>GP/ASC survey data</p>

#### 4.8.2 Additional Planned Improvements to Proactive and Urgent Care Services

We propose to:

- Redesign the respiratory care pathway to provide a consistent, best practice service model across WNE Cumbria.
- Develop supported early discharge services for patients who have had strokes.
- Redesign our urgent care access pathways through the development of an urgent care hub (see below).

## Urgent Care Hub Development

There is agreement between key partners (including the CCG, NHS 111 Lead Commissioners, NWAS and CHOC) that we should review and revise how CHOC and NWAS work together.

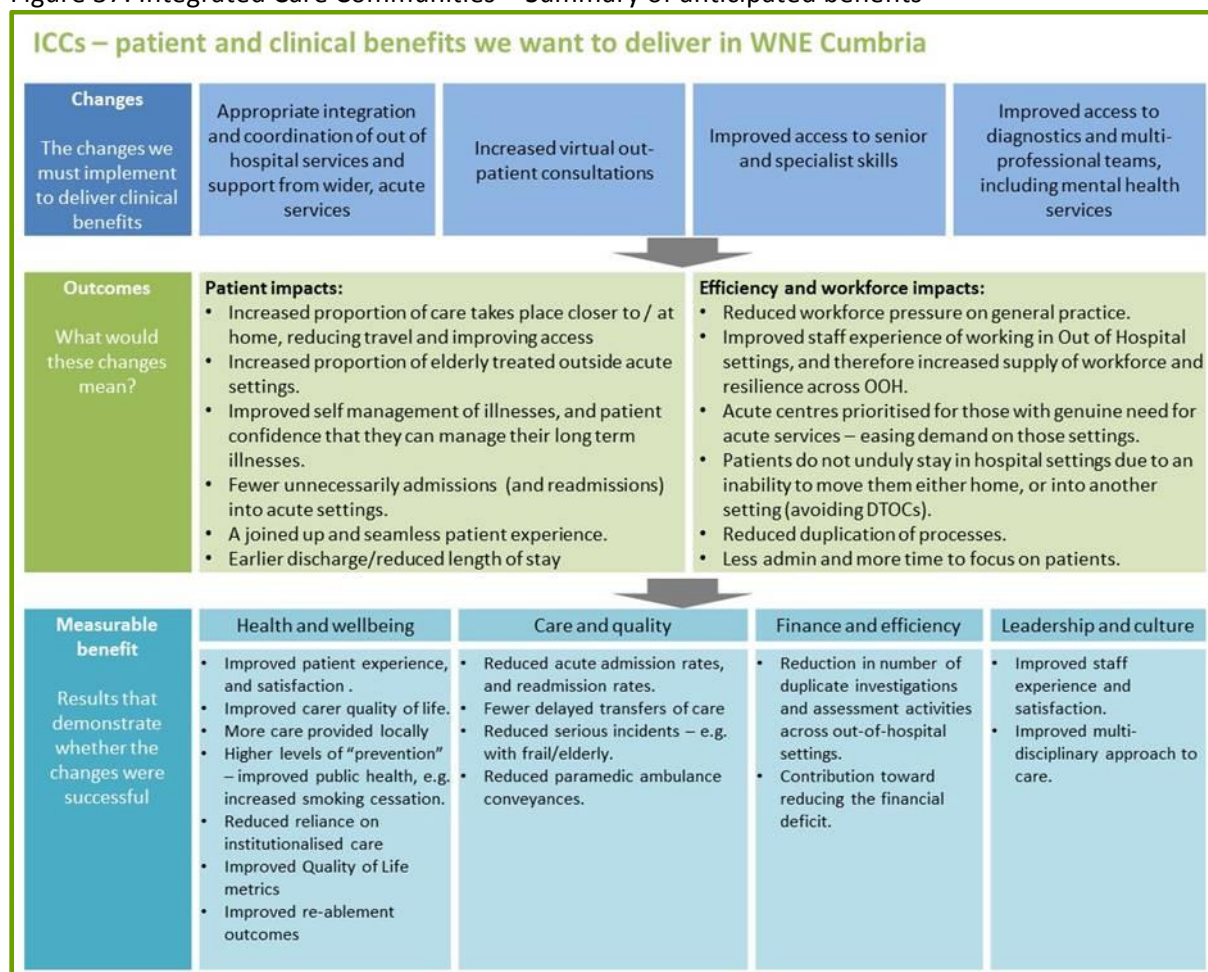
The aim is to establish a clinical hub that reduces duplication and improves outcomes for patients seeking urgent care advice and treatment. Initially this will focus on:

- Out of hours calls assessed by NHS 111 as complex and which require senior clinical input.
- Calls where the assessment outcome suggests the patient should attend A&E
- Calls to NHS 111 or 999 assessed as requiring a low-priority ambulance response.

There will an evaluation of the impact of the work programme enabling decisions to be taken about extending this to cover the in-hours period. As part of agreed collaborative commissioning arrangements, a strong clinical and corporate governance framework is in place to monitor and oversee implementation, evaluation and shared learning.

Our proposals are summarised in Figure 37 below.

Figure 37: Integrated Care Communities – Summary of anticipated benefits



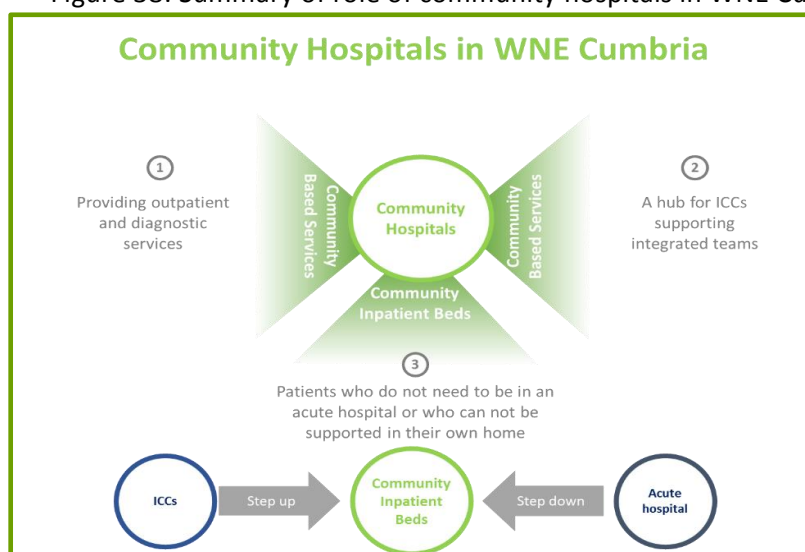
### 4.8.3 Our Proposals for Community Hospital Beds

Community hospitals will be a significant asset in the delivery of integrated out-of-hospital care particularly in the context of the development of ICCs.

Engagement involving a wide range of health and social care stakeholders makes it clear that thriving, sustainable community hospitals can support rural communities and provide centres for the delivery of integrated health and social care with facilities for diagnostics and ambulatory care. (See Figure 38.)



Figure 38: Summary of role of community hospitals in WNE Cumbria



Source: WNE Cumbria Success Regime

There are currently eight community hospitals in WNE Cumbria and an inpatient unit on the WCH site, which are operated by CPFT. The geographical position of the hospitals has, to a large extent, grown up based upon historical development rather than population health needs. See Figure 39 below.



Figure 39 Locations of WNE community hospitals



There is also significant variation in size and scope of services provided – for example:

- The number of commissioned inpatient beds in each hospital ranges from six to twenty-eight. Some community hospitals host minor injury and/or primary care assessment services as well as a range of outpatient and therapy services.
- As referenced in the Oak Group report, performance of inpatient beds in community hospitals is also variable across sites.
- Where community hospitals have a small number of beds, there have been significant challenges associated with recruitment and safe staffing levels. Some of our units are very small and often only have 1 registered nurse on duty, recruitment and sickness issues in small units can lead to crisis situations where no registered staff are available to work which results in unplanned bed closures putting pressure on the whole system. This can lead to existing staff working long hours, double shifts and for prolonged periods of time. The CQC report in autumn 2015 highlighted that staff often felt isolated and vulnerable.
- The cost of community hospital inpatient beds is comparatively high, with significant variation between sites ranging from £288- £454 per bed night (correct August 2015).
- Admission criteria is variable across sites, and there have been a number of quality and safety issues – which are a concern given the increased pressure on a depleted workforce who may not always have the most appropriate skill sets to provide optimum care (depending on the complexity of need).

- There is considerable variation in the condition of community hospital estates and the ongoing ability to meet national standards.
- The increase in the number of delayed transfers of care is also of concern – a proportion of our patients are spending too long in hospital. The majority of patients want to be at home or their normal place of residence but patients are spending time in hospital because we do not have the services in the community to care for them. Apart from the inconvenience and distress this can cause emotionally, there are significant physical effects for the elderly on unnecessary and prolonged hospital stay such as loss of functionality, susceptibility to infection, muscle wastage and skin problems.

Community hospitals have a long history in WNE Cumbria and are strongly supported by their local communities and active League of Friends that contribute significant funds. Overall they deliver a high standard of nursing care and excellent patient experience.

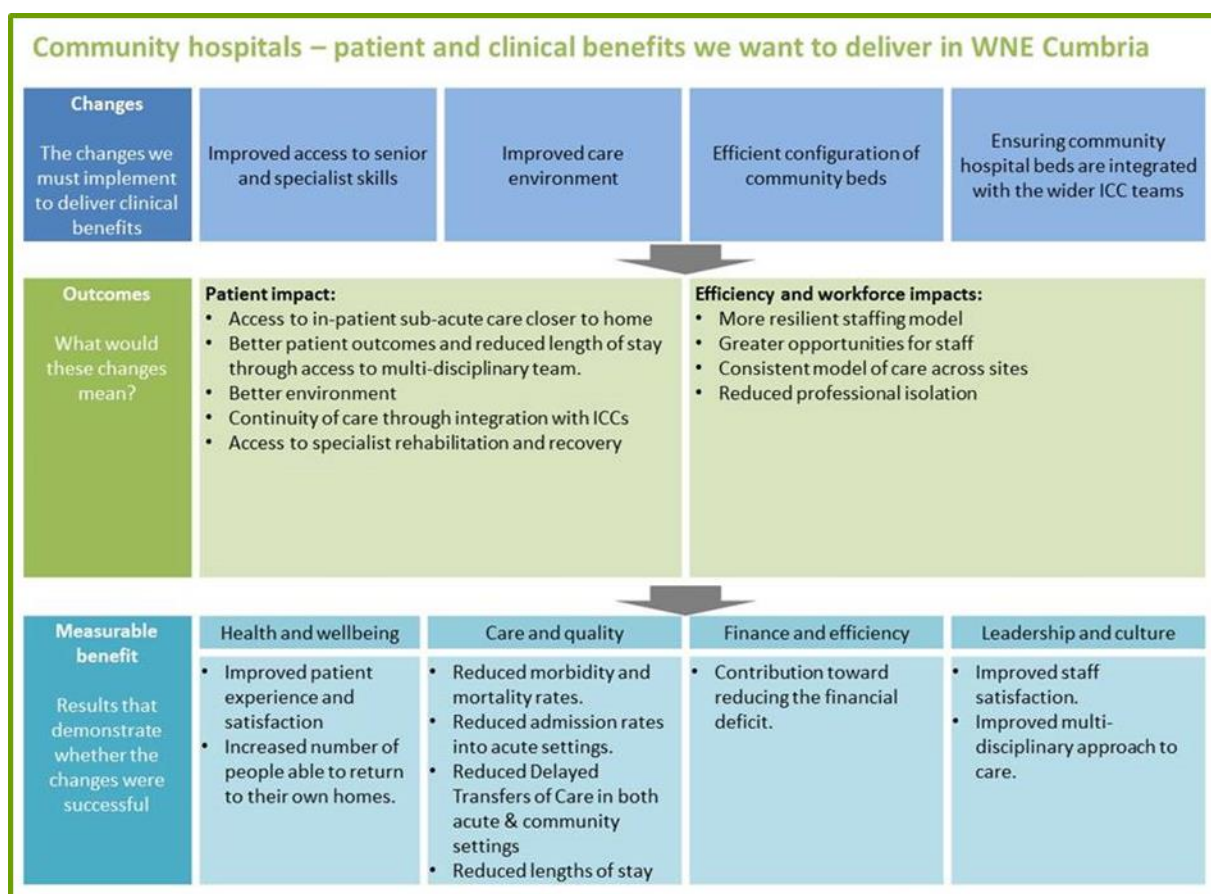
However, medical cover presents a challenge and nurse recruitment is becoming a critical issue. These units have grown organically and have not been part of a designed system. They are closely connected to primary care which is a strength but the connection to specialist elderly care is variable and they do not form a coherent bed base for step down care with the elderly care wards. There is also a view that many people who use the hospitals could go directly home had the appropriate community care been available with many professionals expressing concern that patients decompensate whilst in hospital and this may mean that ultimately their ongoing care costs more emotionally physically and financially.

These are exceptional times with the health and care economy in WNE Cumbria facing extreme financial pressures. The direction of travel nationally is to deliver far more care outside acute hospitals. There is general agreement that we have to build a stronger intermediate care tier that sits between primary care and secondary care. This should mainly be delivered to people in a bed in their own home and as a result our Community Hospitals should be used as assets in support of community care but not as beds to fill.

To address these issues, we have recognised the importance of allowing the new ICCs to develop and shape the future role of our community hospitals as part of a place-based model of care.

**There are, however, some aspects where there are options for more substantial change. These relate to the configuration of, and future need for, community hospital inpatient beds to support high-quality, efficient and effective care. We believe that these aspects should be tested through full formal public consultation, they are explored in Chapter 5.**

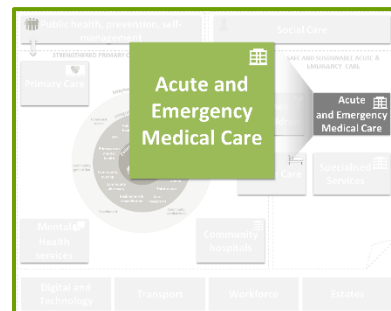
Figure 40: Community hospitals – Summary of Anticipated Benefits





#### 4.8.4 Our Proposals for Emergency and Acute Medical Care

While many aspects of our work to improve emergency and acute medical care are being progressed as part of our commitment to continuous improvement, we must consider options for more substantial change which should be **tested through full public consultation** (and are therefore set out in more detail in Chapter 5).



As noted in Section 1.3.4 a number of changes have been made to develop a single-service model across the two acute sites with the aim of improving outcomes for patients. There remain, however considerable challenges within emergency and acute medical services across in NCUHT and therefore, in addition to the changes already made, it is believed that there are some additional groups of patients who are also likely to benefit from access to more specialised services which can only be delivered on one site. This includes the management of patients presenting with suspected stroke but will include also small numbers of seriously ill patients where clinical assessment identifies that for a particular individual, additional support/intervention would improve outcomes. We also wish to provide improved access for minor trauma surgery at WCH, where this can be provided safely and effectively.

While recognising the need to address pathways for specific groups, there are more general issues with regard to securing the right workforce to support emergency and acute medical care across the two hospital sites. Non-consultant rotas at WCH are particularly fragile, with 53 vacancies out of 80 for these staff. On the withdrawal of medical training at WCH, the Trust invested in development of a cohort of 28 WTE Nurse Practitioners (plus nine support staff) to cover all WCH F1 and F2 roles, working alongside an acute medicine establishment of 18 Junior (FY3 / CT2) and Middle grade (ST3) doctors.

The recent significant decline in GP trainees in West Cumbria, and an inability to recruit substantively, has meant that the Junior & Middle Grade roles in acute medicine are almost entirely provided through premium price locum services, with projected full-year locum junior, middle grade and consultant overspend in medicine running at £3.0m as of February 2016 (£1.4m for junior and middle grade; £1.6m for consultants).

We need to strengthen daytime ambulatory and 'anticipatory care' services to ensure that patients and professionals can swiftly access specialist opinion and diagnostics to prevent unnecessary admission to hospital and/or deterioration in condition that would result in eventual emergency admission. This should include the development of frailty assessment services (aligned to ICC frailty pathway work), hot clinics/slots and increased opportunities for telephone/email advice.

Following public consultation (undertaken since June 2013), the majority of operative trauma provision has been provided at CIC. Although the major stimulus for that change was associated with improved outcomes, an important local factor was the lack of resources to provide a robust service on both sites.

At that time NCUHT retained some trauma service at the WCH site to minimise travelling as well as the burden on the ambulance service and the infrastructure at Carlisle. This comprised an on-call rota, two trauma lists per week for minor trauma procedures, new patient fracture clinics for minor injuries and local admission of patients requiring conservative management. On 25<sup>th</sup> February 2014 the NCUHT Trust Board made a number of changes to the service at WCH on safety grounds. These changes reflected a clinical audit of activity undertaken between July 2013 and

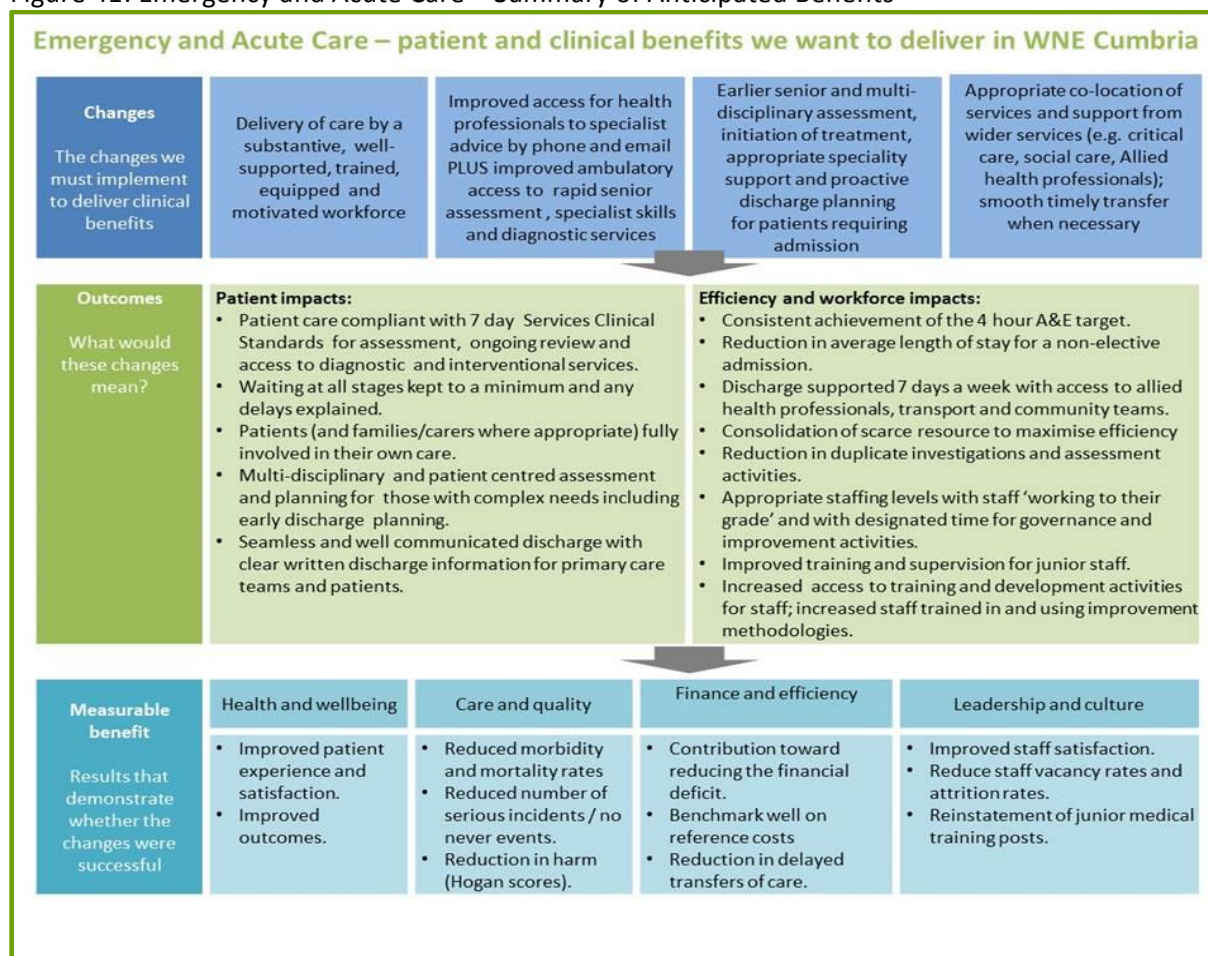
February 2014. This showed an average of 0.3 admissions to WCH per day, with an average of 1.6 inpatients at any one time. An average of 1.5 operations were undertaken per week over the period (capacity for 6 per week). The audit also revealed significant issues with governance, cost, clarity of pathways and workforce. The changes resulted in the cessation of on call and inpatient trauma care at WCH. It also included a reorganisation of consultant input to fracture clinics, revised protocols in A&E. In June 2014, the Trust Board took a decision to cease minor trauma operations at WCH due to extremely low numbers (1-2 per week) and consequent inefficiency.

We continually review this position, and believe that new facilities at WCH would have the potential to provide three minor trauma slots to enable West Cumbria patients to be treated closer to home and still maintain elective activity. The costs of this proposal are comparatively modest at £65.5k.

In addition to the above we have also reviewed the high-risk surgical pathways that were transferred as part of the wider changes to emergency surgery. There are three pathways that could be treated effectively and efficiently at WCH within the new WCH facility. These relate to gallbladder, abscess, and right iliac fossa pain including diagnostic laparoscopy. As well as providing care closer to home for some lower risk patients, removing some low-risk cases from the 'CEPOD' list at CIC will allow more efficient use of lists for CIC inpatient emergencies and will improve patient flow.

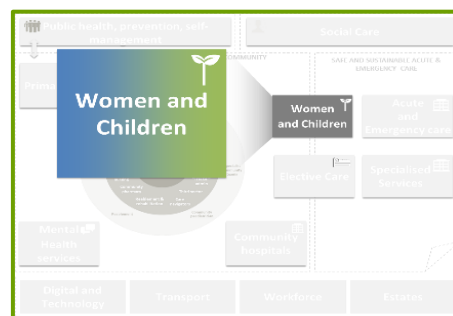
The figure below summarises the patient and clinical benefits we want to achieve.

Figure 41: Emergency and Acute Care – Summary of Anticipated Benefits



## 4.9 Our Proposals for Services for Women and Children

Services provided for women and children in WNE Cumbria have been subject to far-reaching review, focusing on potential opportunities to develop a more integrated model of care that is better able to respond to the needs of children and their families. The scope of review includes the role and configuration of hospital-based children's and maternity services. National and international models of care have been investigated and advice from a range of clinical experts has been sought.



The recruitment and retention pressures facing the UK paediatric and obstetric workforce are being felt acutely in Cumbria and the need to provide safe and sustainable staffing to deliver high-quality services underpins the case for change.

The provision of a consultant-led maternity service is co-dependent on a range of services being in place including Paediatric and Anaesthetics.

While many aspects of our work to improve services for children and their families are being progressed as part of our commitment to continuous improvement, options for more substantial change should be **tested through full public consultation** (and are therefore set out in more detail in Chapter 5).

### 4.9.1 Integrated Children's Services

We aim to create an evidence-based, sustainable, one-team model focused on integrated services across all professions, to improve health outcomes and patient experience for children, young people and their families.

Traditionally the services have been provided by both the Acute and Community Trusts which leads to fragmentation in delivery. Our plan is to have integrated provision centred on the needs of the child and family which will improve patient experience and be better for professional teams. The changing nature of childhood illness means that fewer children require an inpatient hospital stay and those that do need to be admitted tend to have a shorter length of stay than in the past. Changing epidemiology also means there has been an increase in children with complex long term conditions and technological developments have enabled a children's health service delivery model that is much more community-based and multidisciplinary.

Our engagement has confirmed that expectations and behaviours have changed over recent years. Parents are more likely to present to NHS services, particularly with children under two years, however the pattern of childhood illness means that fewer children require an inpatient hospital stay and those that do tend to have a shorter length of stay than in the past. Taken together this means that children are in general likely to be less unwell, but more likely to be in the health system.

Currently NCUHT provides paediatric assessment and inpatient services at both CIC and WCH, with 39 beds across the two sites (24 beds at CIC and 14 bed at WCH) operating as 16 inpatient beds and eight assessment beds from 08.00 to 20.00 hours. The 14 beds in WCH operate as seven

inpatient beds and seven assessment beds from 08.00 to 21.00 hours; they function as a 14-bed area overnight.

The proposed new model reflects the fact that 37% of children admitted to hospital stay less than 12 hours and 83% stay just one day. (Nationally the evidence shows that up to 97% of children referred as emergencies can be safely managed through a SSPAU without needing an inpatient admission)

HDU care is available within its bed resource. Both hospitals are able to manage Continuous Positive Airway Pressure (CPAP) treatment in neonates, with adult HDU beds used at WCH for critically ill children. Special Care Baby Unit cots are supported on both hospital sites – associated with the maternity units but requiring paediatrician management. While both units are staffed at Level One, they are required to manage ventilation and intubation for up eight hours, pending transfer to a tertiary unit.

There may be significant scope to change patterns of demand for urgent and emergency care through improved integrated community children's services and encouraging and supporting self-care. During 2014/15 there were over 16,000 A&E attendances by children aged 0-18 years at WNE Cumbria hospitals, or 45 children per day (60% at CIC and 40% at WCH). The rate of attendance varies considerably across localities: 780 attendances for children on practice lists in Eden; 3975 for those in Copeland; 3995 for those in Allerdale; and 6108 in Carlisle. This suggests that those living closest to an acute hospital have the highest attendance rate. 86% of children attending A&E are discharged home without admission.

A number of children will need to be admitted to hospital for planned procedures. In 2014/15, 1307 children were admitted to North Cumbria hospitals for planned care. In order to reduce the time that children are away from their families and home setting, as much planned care as possible takes place as a day case. The number of children admitted for elective care to North Cumbria University Hospitals has been gradually declining, from 1566 in 2011/12 to 1307 in 2014/15. Of these, just over 1000 were day case admissions.

A number of children will need to be admitted to a more specialist tertiary centre, for example to ensure the right expertise is available in giving anaesthetics to very small children. Tertiary care is provided across a range of centres in the north east and north west of England, the main centre in the north east being The Great North Children's Hospital, at The Newcastle Upon Tyne Hospitals NHS Foundation Trust.

In 2014/15, there were 1284 planned admissions to The Newcastle Upon Tyne Hospitals NHS Foundation Trust, almost as many as to NCUH. The numbers being admitted to Newcastle have increased by 27% over the past two years, from only 1012 in 2011/12.

Cumbria Partnership NHS Foundation Trust (CPFT) provides children's community services (led by a very small community paediatric workforce), which are being compromised by an historic inability to recruit to vacant sessions (now fully recruited). This is putting severe pressure on the provision of services to key groups of children with complex needs, including those with autism. As a result, the system is failing to hit RTT times - an integrated larger medical team, service redesign and successful recruitment would address this issue. The community paediatricians are also the key workforce in the delivery of initial health assessments for children looked after and for adoption medicals, in partnership with Cumbria County Council.

Our proposals focus on supporting our staff to work as a single team. Specifically:

- Support children and young people to be healthy and safe by working with partners to strengthen prevention and early help.
- Standardise quality and provide better health outcomes, providing integrated services, with easy access, including for children with long term conditions and complex needs.
- Developing the interface with ICCs and networks within a place based approach – ensuring that children can get care they need as close to their home as possible. This will be achieved via consultants outreaching into the community , better care coordination and integrating the nursing teams.
- Provision of short stay paediatric assessment Units (SSPAU) at Cumberland Infirmary Carlisle and West Cumberland Hospital, Whitehaven, delivering rapid and appropriate assessment and treatment an reducing unnecessary hospital attendance, admission and length of stay.
- Changes to in patient care with low acuity beds at WCH.
- The Development of a new, integrated and coordinated children’s nursing service that will deliver acute care and community-based, multidisciplinary care as close to home as possible including working with Jigsaw children’s hospice as part of the integrated nursing team.
- Working collaboratively at a regional level to deliver more specialist services and improving the sustainability of services locally
- Develop a whole-system approach to promoting emotional resilience and good mental health.

To do this the health economy has worked on a plan to make things better for Sam. Sam is fictitious and represents any child or young person and family – any age, gender, ethnicity with any condition or illness and helps us all to renew our focus on the child and family.

The underlying premise is that hospital is not the best place for the majority of children and young people. The majority want to stay at home and only wish to be in the hospital system if absolutely necessary. If they do go into hospital it should be for effective assessment and treatment in line with their needs and most health input should be provided as close to home as possible. Therefore it is desirable to provide integrated and coordinated community support and rapid and appropriate assessment and treatment.

The current system has blocks, delays and duplication in the system particularly – redesigning the model will address these issues.

The redesigned service model lends itself to working a several different levels including:

- Improving the interface with GPs as part of integrated care communities.
- Providing an integrated clinical team.
- Working collaboratively at a regional level to deliver more specialist services.

All elements of service need to link up around Sam’s needs. This model is illustrated in Sam’s House which has been developed to support the communication of the Strategy.

We believe that this model has the potential to support new configurations of inpatient care across the two hospital sites, and will deliver the RCPCH Standards.



Additional investment (detail to be expanded and confirmed once shortlisting of options is completed) will be required to deliver the expanded integrated workforce required to enable the delivery of a place based approach, providing more responsive and community focussed healthcare – where paediatricians and integrated nursing teams have a relationship with ICCs or practices; seeing children closer to home and upskilling the primary care workforce. This new integrated model will provide the benefits of a bigger team and should lead to more successful recruitment.

This model of integration will extend to include Child and Adolescent Mental Health Services (CAMHS) to ensure all needs are identified and addressed. Emotional Wellbeing and Mental Health services are subject to substantial development as a ‘whole system’ model is embedded across the multi-agency partnership that includes not only health and care services but also education and justice services.

Cumbria Transformation Plan: Transforming services for children and young people’s emotional wellbeing and mental health sets out a number of priorities for service development that will directly affect paediatric health services including the development of:

- Children and young people’s community eating disorder services that will require paediatric expertise.
- CAMHS crisis service that will divert admissions from paediatric wards for some patients who are currently admitted and improve care for those who continue to be admitted but require this type of support.
- Working with Commissioners and Providers of specialist in patient CAMHS to ensure pathways to and from these services are effective.
- With partners in the local authority options for providing alternative places of safety are being explored in order to limit the use of in-patient beds to those children and young people whose physical health needs warrant such a service.
- The integration of physical and mental health services will enable the children and young people who are most vulnerable, and those with complex needs (including those with developmental and behavioural needs) to receive comprehensive care from one team.

We believe that this model has the potential to support new configurations of inpatient care across the two hospital sites, and will deliver the RCPCH Standards.

Additional investment (detail to be expanded and confirmed once shortlisting of options is completed) will be required to deliver the expanded integrated workforce required to enable the delivery of a place based approach, providing more responsive and community focussed healthcare – where paediatricians and integrated nursing teams have a relationship with ICCs or practices; seeing children closer to home and upskilling the primary care workforce. This new integrated model will provide the benefits of a bigger team and should lead to more successful recruitment.

It is important to recognise that any future models for paediatric services will need to be considered alongside the future model of maternity services, with any changes being subject to formal public consultation.

In looking to the future, Figure 42 below summarises the patient and clinical benefits we want to achieve as we look to improve our services such that all our children and their families have access to safe and sustainable care.

Figure 42: Integrated Children's Services – Summary of Anticipated Benefits

Changes				
The changes we must implement to deliver clinical benefits	Improved access to senior and specialist skills	The development of one team for children – integrating services and workforce around the needs of the child	Appropriate co-location of services and support from wider services in the community	
Outcomes	Patient impacts:		Efficiency and workforce impacts:	
What would these changes mean?	<ul style="list-style-type: none"> <li>All emergency admissions seen and assessed by the responsible consultant within 12 hours of admission or 14 hours of time of arrival.</li> <li>Rapid and appropriate assessment and treatment in short stay paediatric assessment units (SSPAU).</li> <li>Reduced variation in outcomes.</li> <li>Transition to adult services managed on a case by case basis.</li> <li>Improved convenience, appropriateness and quality of care.</li> <li>Reduced need for hospital based care</li> <li>Reduced waiting times</li> </ul>		<ul style="list-style-type: none"> <li>Integrated teams provide greater resilience</li> <li>Staffing levels will reflect varying levels of patient acuity and dependence in accordance with national guidance.</li> <li>Removal of duplication as teams integrate.</li> <li>One team for children providing more attractive working conditions and more resilient workforce.</li> <li>Better co-ordination of care.</li> </ul>	
Measurable benefit	Health and wellbeing	Care and quality	Finance and efficiency	Leadership and culture
Results that demonstrate whether the changes were successful	<ul style="list-style-type: none"> <li>Reduced safeguarding incidents</li> <li>More children supported in community settings.</li> <li>Improved patient experience and satisfaction</li> <li>Reduced waiting times</li> </ul>	<ul style="list-style-type: none"> <li>Reduced admission rates</li> <li>Reduced duplication within services</li> <li>Reduction in handoffs of care</li> <li>Reduced number of paediatric serious incidents.</li> </ul>	<ul style="list-style-type: none"> <li>Reduction in number of duplicate investigations and assessment activities</li> <li>Contribution toward reducing the financial deficit.</li> </ul>	<ul style="list-style-type: none"> <li>Improved staff satisfaction.</li> <li>Improved multi-disciplinary approach to care.</li> <li>Improved emphasis on training and skills development.</li> </ul>

#### 4.9.2 Improving Maternity Services

In Autumn 2014 we commissioned a review of Maternity Services, by the Royal College of Obstetricians and Gynaecologists (RCOG). The purpose of the review was to provide independent and expert advice on the best way to arrange high-quality, safe and sustainable maternity services in the future. The review took place in November 2014 and reported in March 2015.

The report made a number of recommendations and identified six options to address the ongoing issues. Of the six options only three were recommended to be taken forward subject to a detailed feasibility report exploring the cost, viability and risk associated with each one, considering working in very different ways to try and improve long term safety through different configurations and working practices of staff.

**The RCOG Report (March 2015) proposed the following options:**

- **Option 1** - Consultant-led maternity units at CIC and WCH with the immediate development of an 'alongside' midwifery-led unit at CIC; and, in the longer term, evaluation of potential development of an 'alongside' midwifery-led unit at Whitehaven.
- **Option 2a** – A consultant-led unit at CIC and development of an 'alongside' midwifery-led unit at CIC. This is the assessors' second-favoured option should it not be possible to achieve Option 1. It would mean the closure of the consultant-led unit at WCH.
- **Option 2b** - A consultant-led unit at CIC, developing an 'alongside' midwifery-led unit at CIC and converting the consultant-led unit at WCH to become a 'free-standing' midwifery-led unit.

There is increasing evidence about how services should be designed to maximise safety whilst being realistic about the availability of skilled staff and the feasibility of managing very small units with expert staff close by. There is clear guidance from Medical Royal Colleges and NICE, which define levels of care to provide an acceptable safe service for pregnancy and childbirth, postnatal and neonatal care, and these standards are used by CQC when reviewing local services.

In April 2015 the CQC highlighted that the midwife to birth ratio of 1 to 25 at Cumberland infirmary and 1 to 24 at West Cumberland hospital was better than the England average which was 1 to 28. In addition, 100% of patients had one to one care from a midwife during labour. In their report the CQC concluded that while the maternity service was delivered by committed and compassionate staff who treated patients with dignity and respect, there were areas identified by the CQC as requiring improvement.

The CQC inspection at WCH found that the maternity service had made insufficient improvement to provide high risk patients with an effective service. Historically, there have also been major gaps identified in the provision of anaesthetic services for women in labour, reducing choice and potentially raising risks for women.

While many aspects of our work to improve maternity services are being progressed as part of our commitment to continuous improvement, options for more substantial change have been identified that should be tested through full public consultation. These are set out in more detail in Chapter 5.

In 2014/15 there were 3036 births in NCHUT (1,703 deliveries in CIC, 1264 in WCH and 69 in the birthing centre in Penrith). A small number of women (1.5%) require very specialist tertiary services outside Cumbria and there are strong links with Newcastle Upon Tyne Hospitals NHS FT for tertiary and Level 3 neonatal facilities to support these women.

Improving maternity services is recognised as a key priority in the NCUHT Quality Improvement Plan. A number of actions have already been taken:

- A programme of work has been progressed to improve midwifery leadership and develop the midwife-led patient pathway.
- An audit has been completed to review the theatre model at WCH, which has confirmed that current arrangements are appropriate.



- High-quality consultant candidates have been appointed in obstetrics and gynaecology (however, non-consultant specialist appointments at WCH remain a major challenge).
- The Trust has worked with consultant obstetricians to develop underpinning principles for their roles, expressly focusing on: a cross-site approach to governance; clinical guidelines; and continuing professional development.
- The maternity dashboard has been standardised across Cumbria, providing a consistent suite of high-quality metrics to monitor. The Trust Board has received regular progress reports via the Safety and Quality Committee.
- Since October 2015, epidural anaesthetics have been made available at both CIC and WCH.
- There is a new foetal telemedicine link between WCH and Newcastle. This is being rolled out at CIC.

Reconfiguration of maternity services poses different problems for different populations. In urban populations, centralisation of acute services may be appropriate, but in rural communities such arrangements can pose major challenges for the dispersed populations. In addition, much of the professional advice about service specification, staffing requirements and skill mix for CLUs is aimed at larger units, operating within large conurbations.

The need to provide safe, high quality, sustainable maternity services across North Cumbria underpins the case for change. The RCOG review team has worked closely with Trust managers, clinicians and members of the Maternity Services Liaison Committee (MSLC) to explore innovative approaches to the delivery of maternity services. A number of challenge sessions have been held with clinicians and external consultants including the Strategic Clinical Network.

The publication of the National Maternity Review Five Year Forward View<sup>37</sup> informs our thinking, and it is helpful in recognising the particular challenges in providing safe and sustainable maternity services in remote and rural areas as summarised below.

#### **Key findings of the NHS Five Year Forward View for maternity care services for rural and remote areas**

For remote and rural areas, where there can be particular challenges in commissioning safe and sustainable services, commissioners and providers need to take into account the above considerations in thinking innovatively about how to cater for the needs of their communities. They will also wish to take into account the following:

- There is no clinical reason why an obstetric unit cannot operate safely in a remote and rural area with a relatively low number of births each year, providing that it has sufficient staff and access to 24/7 support services, clear pathways and transfer guidelines for specialist care, and support across a local maternity system (e.g., to aid staff deployment and professional development). However, there are not, nor are there likely to be, nor would it be desirable for there to be, enough obstetricians in the NHS to support a large number of such units. Therefore, there are only likely to be a small handful of such units in the most remote areas of England.

<sup>37</sup> National Maternity Review – Better Births Improving Outcomes of Maternity Services in England, A Five Year Forward View, NHS England February 2016

- They should not be restrained by what might be perceived to be gold standard service models – whilst these might provide best care in some places, they may not provide sufficient clinical benefits to justify the investment everywhere. For example, the NPEU evidence review finds insufficient evidence to support a model of 24-hour resident consultant presence on the labour ward, which is only recommended for large urban units.
- Remote and rural areas should think about how they can use their workforce innovatively, for example:
  - Sharing staff across multiple sites or providers within a local maternity system.
  - Making use of on-call systems in place of 24-hour medical staff residency, which are able to respond in a timely manner to provide safe care:
    - Upskilling generalist medical staff in remote areas to provide specialty services.
    - Enhancing the consultant workforce with a view to reducing reliance on other grades of doctors.
- Remote and rural areas can introduce innovative working practices such as:
  - Robust triage and transferring the care of women with more serious complications at an appropriate time in the pregnancy to a more specialised unit.
  - Defining which types of women should be advised to give birth at which units across the local maternity system.
  - Providing transport facilities for women needing to travel to more specialist units and enhanced transfer services for women or their babies experiencing unexpected serious complications.
  - Making use of technology, e.g., consultations by video link between the centre and smaller unit.

National and international models of care have been investigated and advice from a range of clinical experts has been sought, including the Hywel Dda University Health Board in South Wales highlighted below.

#### **The Hywel Dda University Health Board Model**

The reconfiguration of maternity, neonatal and paediatric services in South Wales was undertaken as a result of significant recruitment difficulties at consultant level. This led to the development of a stand-alone midwifery led unit and a paediatric assessment unit at Withybush Hospital. These services were previously consultant-led.

An evaluation of the reconfigured services was carried out by the Royal College of Paediatrics and Child Health (RCPCH). Their report was published in November 2015. The high-level findings supported the original reconfiguration and saw no clinical reason to reverse the decision. The evaluation found services to be safe with improving outcomes and better compliance with professional standards.

The Welsh model includes a Dedicated Ambulance Vehicle (DAV) commissioned by the Health Board from the Welsh Ambulance Service Trust (WAST) to transport urgent maternal, neonatal and paediatric transfers from Withybush to Glangwili – a journey of just over 33 miles.

The DAV is staffed by a 10-strong team of paramedics and emergency technicians who provide 24/7 cover. Following a review of activity data, the RCPCH review concluded that there had been “no measurable deterioration in clinical outcomes” as a result of this service development.

The service was modelled and designed to handle around nine transfers daily, but in practice, at the time of the review had made 636 journeys in eleven months, averaging around two per day, including provision of some transfers of women or children from home when the 999 service was unavailable. For the Welsh model, this dedicated retrieval service is a key means of mitigating the potential negative impacts of decreasing access to maternity care. In order to mitigate the same risk, the options for consolidating maternity services in Cumbria (6.4) take into account the need for a dedicated retrieval service.

Within the HDUHB, Aberystwyth continues to function as a low-risk CLU delivering approx. 500 babies p.a. to a remote population

We must take into account key interdependencies with other services, especially paediatrics and anaesthetics (both of which are experiencing significant pressures associated with the recruitment and retention of workforce).

The work following the RCOG review has demonstrated that new models of working can be defined and issues arising from small numbers can be mitigated but models are entirely dependent on recruitment which remains a major challenge.

In February 2016, a Healthwatch Cumbria report, Maternity Matters, was commissioned to understand what women felt was most important to them from maternity services

Key issues highlighted in the Healthwatch Cumbria Maternity Matters report<sup>38</sup> include:

- The rural environment.
- High service costs in relation to relatively low volumes of care provided.
- Recruitment challenges for consultant and middle grade staff.
- Lengthy journey time between CIC and WCH sites, which could add up to 45 minutes to current journey times.
- A strong desire to continue service provision as locally as possible.

#### **Maternity Matters Healthwatch Cumbria Report Key Findings**

The report, based upon a survey of 1,234 respondents and 70 face to face sessions across Cumbria and North Lancashire, highlights that while there were generally high levels of satisfaction with the care across the maternity pathway, there are significant areas that require development. Survey responses showed considerable consistency and stressed the issues that were important to women in Cumbria. The key themes that emerged from the engagement include:

<sup>38</sup> See <http://healthwatchcumbria.co.uk/wp-content/uploads/HW-Maternity-Matters-FINAL.pdf>

- Continuity of care and carer throughout pregnancy, labour, and the post-natal period.
- Consistency and quality of information and communication.
- Breast feeding support.
- Support and information for women to make informed decisions and choices.
- Accessible services and provision of choice.

When asked what a good maternity service would look like, responses included:

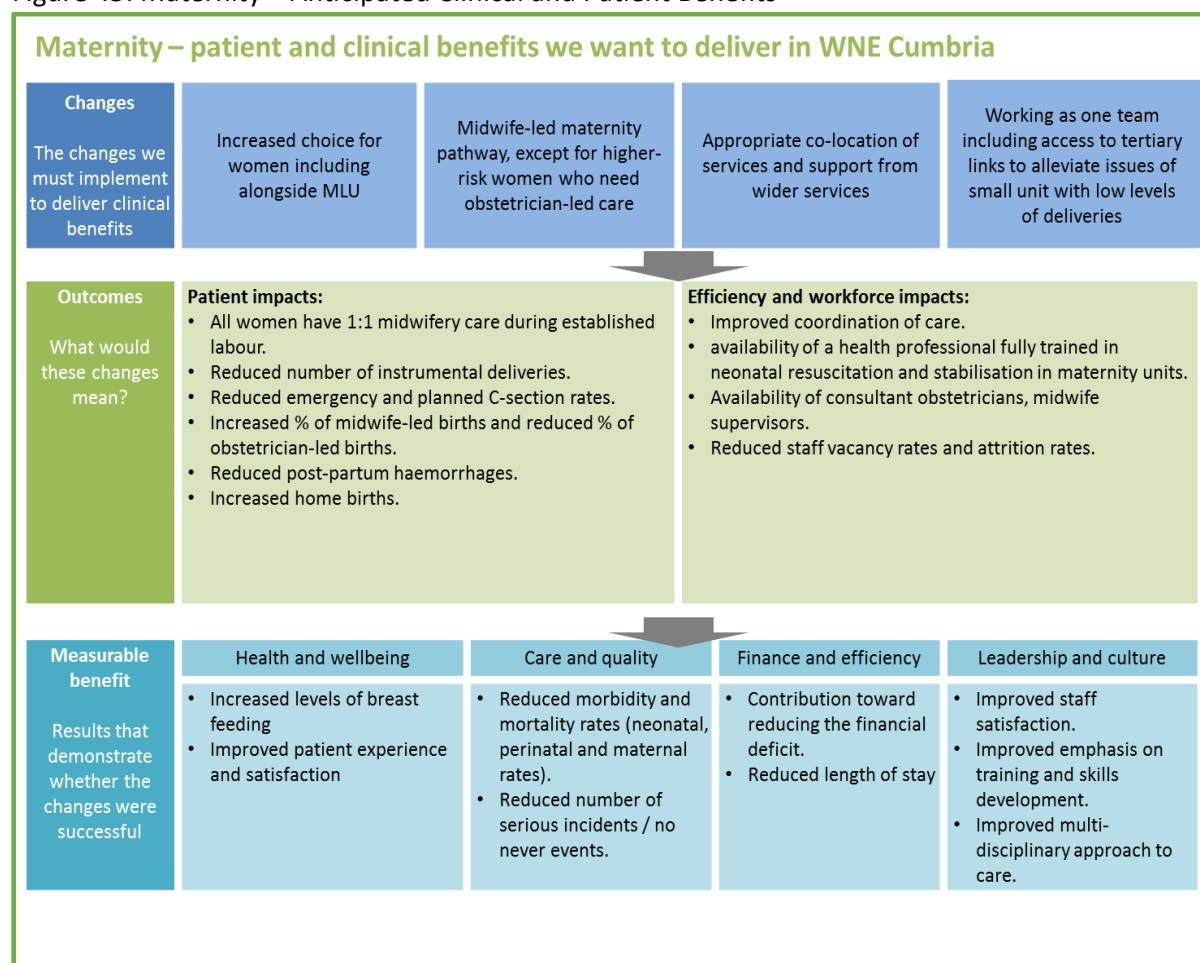
- All staff to be well trained medically and socially.
- No agency staff.
- Continuity of midwife support throughout pregnancy and labour.
- All healthcare staff to be respectful of women and their families and to be sensitive to their wishes and needs.
- Good communication between staff and between staff and their colleagues.

Important considerations in maternity service design include patient choice, convenience and proximity of facilities for women and their families (but not at the expense of quality and safety). The particular challenges of providing high-quality maternity healthcare for WNE Cumbria include:

- Geographical isolation and viability of secondary care units.
- Ease of patient access to services.
- Ensuring excellent patient safety.
- Opportunity to maintain clinical skills.
- Recruiting and retaining a high-calibre workforce.

Providing sustainable access to high-quality care will provide the benefits described in Figure 43 below.

Figure 43: Maternity – Anticipated Clinical and Patient Benefits



While many aspects of our work to improve maternity services are being progressed as part of our commitment to continuous improvement, options for more substantial change have been identified that should be tested through full public consultation. These are set out in more detail in Chapter 5.

## 4.10 Improving Mental Health Services

An engagement process led by the Cumbria Mental Health Partnership Group (a multi-agency body that oversees the development and delivery of a mental health strategic vision for Cumbria) informs the development of mental health services in Cumbria and development of evidence-based models of care. It confirms the need to improve prevention and the quality of primary care services, while recognising the need to develop our specialist offer for users of services with complex and enduring mental health needs.



In developing strengthened community based services, we need to review the optimal configuration of mental health inpatient beds across Cumbria using an independent bed-modelling process. Outputs will inform proposals for reconfiguration of location and function of mental health inpatient services, which operate as a network across the county. Consultation about proposed changes will be progressed on a county-wide basis, aligning with both the WNE Cumbria Success Regime and Better Care Together Vanguard programme in the south of the county.

Mental health and mental health services are an area of priority within the WNE Cumbria Success Regime. The key statutory partners (Local Authority, CCG, Police, Secondary Care Provider, etc.) are all county-based organisations and so a county-wide approach to the planning, consulting and implementation of improvements in this area is being taken forward positively.

In Cumbria, mental health issues of note include: high levels of dementia associated with above-average elderly populations; young people's emotional health associated with contemporary issues affecting this population; and commitment overall to reduce suicide in the county through increased resilience-building, broader prevention and improved services.

Taking these issues into account we have set out our vision for mental health to include:

- Recovery-focused & resilience-building services.
- Person-centred care, delivered as close to home as possible.
- Parity of esteem for mental health with other health issues:
  - Urgent and emergency mental health care.
  - Mental health and physical health:
    - ✓ Long term conditions.
    - ✓ Reducing inequalities.
- Improved quality and sustainability of services overall.

We have considered the key aspects of achieving this vision and identified that we need to finalise and consult upon changes to services in order to progress. We have identified that this will commence with consideration of changes to our acute mental health and dementia assessment inpatient services and their associated specialist community teams. We have designed an approach in line with the Success Regimes' other workstreams as follows.

### Indicative Process to Identify Preferred Options

May	Long List Formed and Options Defined, Project Plan and Resources Identified.
June:	Further engagement to apply Long List Hurdle Criteria
July:	Short List Appraisal, Detailed Consultation Plan, Pre Consultation Business Case
August:	NHS England Assurance, Consultation document and Plan
Sept:	Consultation Begins
Nov:	Consultation Ends
Dec:	Full Consideration of outcomes and implementation.

To achieve this process, we have established a number of governance mechanisms:

- Mental Health Partnership Board – a Partnership Board to consider all aspects of our plans as they are formed and the consultation feedback received.
- NHS Cumbria CCG and Cumbria Partnership NHS FT formal statutory Boards.
- NHS England and External Clinical Review Process.
- Cumbria Health Scrutiny Committee Processes.
- Success Regime, Better Care Together, STPs arrangements.
- Senior Responsible Officer(s) and Project Groups.

Our intention is during June and July to prepare a Pre Consultation Business Case (PCBC) as a basis for the Statutory Boards to initiate the NHS England Assurance Review process leading on to consultation taking place in the Autumn. The PCBC will include details of:

- Case for Change.
- Engagement.
- The Proposed Changes and Options.
- Appraisal of Options.
- Impact of Preferred Options.

We intend to apply four evaluation criteria entirely consistent with the Success Regime PCBC process with equal weighting:

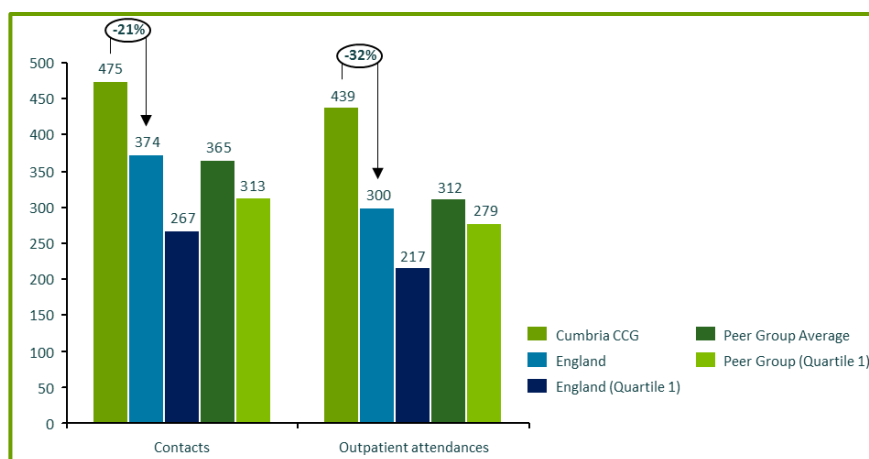
1. Health Gap: Population Health, Health Inequalities.
2. Care Gap: Quality – Outcomes, Safety, Experience.
3. Efficiency Gap: Capital and Revenue.

#### 4. Deliverability: Workforce, Managing Change.

We have engaged Mental Health Strategies to undertake more detailed service modelling and early outcomes of this suggest the following themes:

- If we significantly enhance community services, we appear to have the right number of beds for managing future demand.
- CPFT productivity appears to benchmark well against other mental health providers for length of stay (in-hospital services) and flow (between community and hospital services).
- We may not have the right 'mix' of beds, e.g., early signs indicate we need more Psychiatric Intensive Care capacity.
- Service utilisation, attendances and contact with CPFT mental health services performance are higher than average benchmarks, in part because CPFT provides high-volume Improving Access to Psychological Therapies (IAPT) services ('talking therapy'). However, the move from traditional clinical models of service for people with enduring and severe mental illness to more recovery-focused services is not as advanced in Cumbria as compared to other areas of England (see Figure 44 below).

Figure 44: Mental health attendances and contacts



Source: Health and Social Care Information Centre (HSCIC) (2014/15)

There is potential, therefore, to develop services so that they are more focused on prevention and on helping people to successfully recover from episodes of ill-health – ensuring that they can live more independently, enjoy full lives with have greater resilience. This approach will enable appropriate reductions in attendances and contacts with secondary mental health services and an increase in proactive and lifestyle appropriate alternatives.

The principles of Implementing Recovery through Organisational Change (ImROC)<sup>39</sup> are being implemented to support a movement away from pathology, illness and symptoms towards a focus on health, strengths and wellbeing. This will improve our ability to recruit and employ service

<sup>39</sup> See <http://www.imroc.org/>



users in meaningful roles to support other's recovery journey. The implementation of ImROC principles will also drive service change across patient pathways and identify opportunities for further improvement. Service users and carers have highlighted the need to prioritise the improvement of mental health crisis assessment and support services.

Cumbria CCG invested £1.4m in 2015/16 through the Better Care Fund initiative. This was used to improve the psychiatric liaison service across Cumbria. The service is based within the Access and Liaison Integration Service (ALIS), with additional resource focused on acute care, for people suffering acute mental health distress, and older adults.

Clinical leads provide daily leadership support to the teams, senior clinical support to the wards/A&E Departments, and clinical and operational management advice via Memory & Later Life Services to ensure continuity of care pathways for older adults.

Work to improve services has been prioritised, for all people experiencing mental health crises regardless of age – recognising the need for strong inter-agency working. We have agreed plans to introduce an alternative A&E front door for mental health urgent care by establishing a multi-agency crisis assessment centre at CIC. It is anticipated that this model will be rolled out to support community-integrated care outside of inpatient facilities, closer to home. The proposed third phase of our multi-agency assessment and crisis centre will test the impact of alternative approaches, such as third sector-provided short-stay crisis beds, safe havens and sanctuary cafes.

### ***Multi-agency Mental Health Hub Development***

The Cumbria Police and Crime Commissioner has recently secured funding (£3.3m over two years) from the Home Office Innovation Fund for a multi-agency mental health hub.

The hub will enable the police to direct all calls that involve mental health issues to a multi-agency team, which is expected to deal with on average 30-40 cases each day across Cumbria.

Work is progressing to improve and develop support and services for people living with and caring for people with dementia. The prevalence of people suffering from dementia in WNE Cumbria is approximately 12% above the national average. The Cumbria Dementia Strategy, *Implementing the National Dementia Strategy – Working Together to Improve Life with Dementia in Cumbria*, was published in 2011. The focus is on improving early diagnosis and enhancing support to care homes. Good progress has been made in terms of early diagnosis, which in October 2015 was at 67.8%, exceeding the national ambition for 66% by March 2015<sup>40</sup>.

The implementation of the Cumbria Dementia Pathway is resulting in transformational changes in memory services. Working with the Alzheimer's Society and Age UK, CPFT is remodelling memory services – developing more integrated, proactive, community-based models, benefitting from open referral, carer interventions and the implementation of common screening tools. This will improve access to individualised, specialist comprehensive assessments and signpost community-based support, including a range of "living well" initiatives and technology-enabled care.

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<sup>40</sup> Prime Minister's Challenge on Dementia 2020, February 2015, Department of Health

### ***Care Home Education and Support Service***

CHESS, launched in 2013, provides a rolling programme of mental health education combined with an outreach service working alongside care home staff and inpatient services.

The programme has reduced inpatient admissions from care homes from 52% to 5% (2013), with a reduction in readmissions from 20% to 3%.

## **4.11 Improving Planned Elective Care**

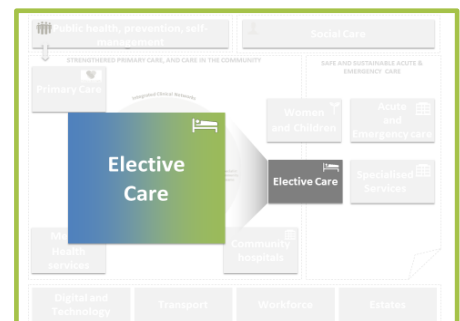
A multi-agency group has been looking at how we can ensure that elective care pathways can become more patient-focused – alongside improved access to services, efficiency and effectiveness.

Since the completion of the new hospital development at WCH, plans focus on further planned surgical activity, including associated outpatient and ambulatory care. The new facilities at WCH provide a purpose-built day case area, seven first class theatres and new diagnostic services including MRI.

The basis for much of the thinking about redesign looks at the need for a more integrated approach to patient pathways. Priority areas of work recognise that Cumbrian providers are failing to achieve three important elective care performance measures: the referral to treatment 18-week performance metric; the six-week diagnostic metric; and the 62-day wait cancer metric. They include:

- Redesign of MSK pathways (hip & knee, spine, foot & ankle, upper limb, paediatrics).
- Redesign of ophthalmology pathways (cataracts, glaucoma, AMD, Minor Eye Conditions, and Paediatrics).
- Consolidation of certain high-volume, low-risk surgery at the WCH Site, creating capacity at CIC for unplanned and higher risk surgery.
- Repatriation of elective work currently undertaken outside the county.
- General surgery improvements that will ensure that the right person sees the right patient at the right time.

At WCH progress has been made to increase breast surgery, introduce thyroid surgery and increase the number of upper GI laparoscopic surgical lists. There are also well-developed plans to increase gynaecology, orthodontic and ENT surgical activity at WCH. To position WCH as a centre of excellence, there are plans to consolidate cystoscopic laser lithotripsy (to treat bladder stones) and trans-nasal oesophagoscopy and oesophageal manometry/ph monitoring (the latter service currently requiring patients to travel out of area).



Work is also being undertaken to review high-volume elective pathways, such as musculoskeletal and orthopaedics (currently 30% of WNE Cumbria orthopaedic activity is provided by Trusts outside the area).

There are also proposals to develop a Clinical Assessment and Treatment Service (CATS). The aim of this multi-disciplinary service will be to maximise independence through development of evidence-based patient pathways, including alternatives to surgery (as summarised in Figure 45 below).

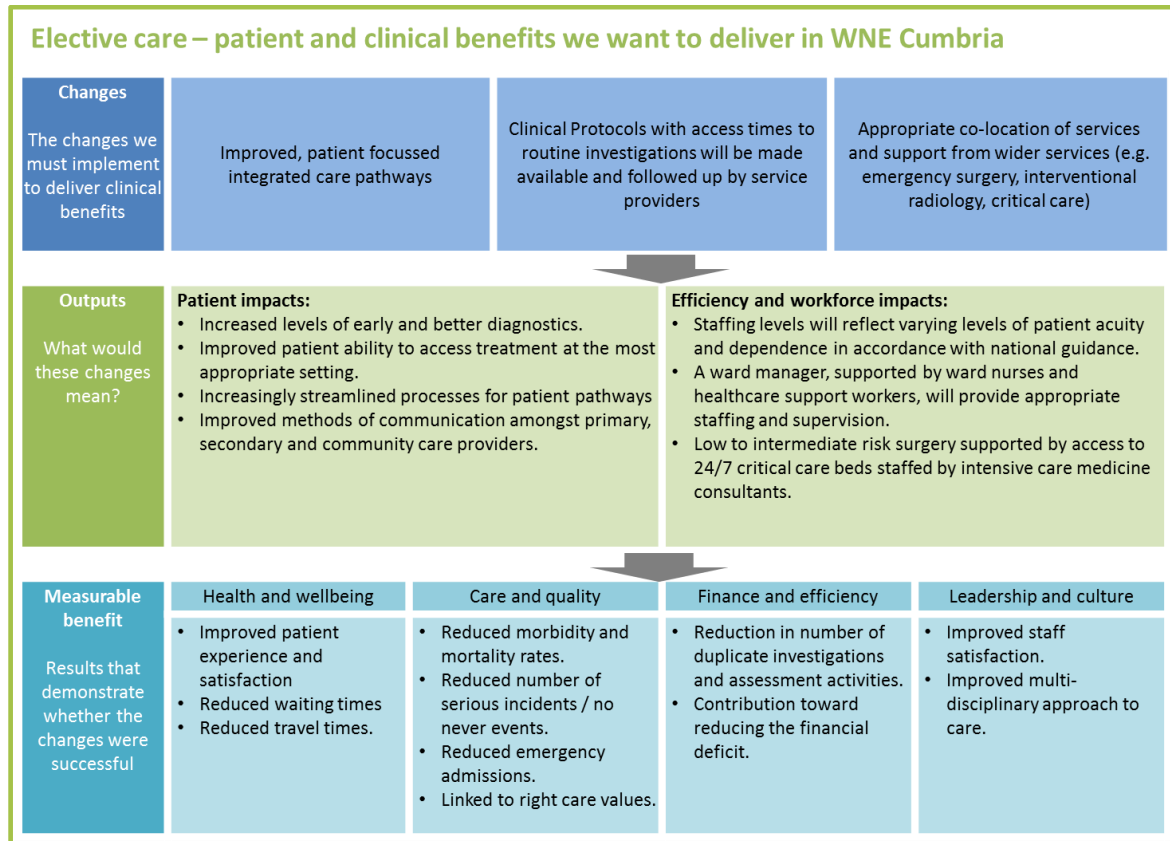
Figure 45: Planned elective services today and in the future

Figure 15: Planned elective services today and in the future

Elective	Today		In the future	
	WCH	CIC	WCH	CIC
	Limited low risk elective	Full elective service	Extended range of low risk elective service for West Cumbria residents	Full elective surgical services
What this means for ICCs	<ul style="list-style-type: none"> <li>Limited range of access to outpatient services in local settings.</li> </ul>		<ul style="list-style-type: none"> <li>Increased range of access to outpatient services In local settings (community hospitals and GP practices).</li> <li>Increase in community based services working in conjunction with consultant support including telephone advice, referral, management schemes, primary care services.</li> </ul>	
What this means for CIC	<ul style="list-style-type: none"> <li>Day case and elective surgery.</li> <li>Specialty outpatient clinics.</li> <li>Pressures on capacity access and flow.</li> <li>Sub-optimal use of available capacity.</li> </ul>		<ul style="list-style-type: none"> <li>Full outpatient service, with increased use of technology enabled care.</li> <li>Continued provision of full range of elective care for local catchment population, and high risk elective care for WNE Cumbria.</li> <li>Maximised theatre &amp; outpatient utilisation .</li> </ul>	
What this means for WCH	<ul style="list-style-type: none"> <li>Day case and elective surgery.</li> <li>Specialty outpatient clinics - limited slot availability.</li> <li>Sub optimal use of available capacity.</li> <li>Patients having to travel to CIC for outpatient and low risk procedures.</li> </ul>		<ul style="list-style-type: none"> <li>Full outpatient service, with increased use of technology enabled care.</li> <li>Increase in low risk elective care across all key specialties to meet needs of catchment population and offering choice to those further afield.</li> <li>Development of WCH as centre of excellence offering greater choice of WNE Cumbria sophisticated operating techniques for fit patients needing brief or day case admission.</li> <li>Maximised theatre &amp; outpatient utilisation .</li> </ul>	
Other / Specialist	<ul style="list-style-type: none"> <li>Tertiary and highly specialist networks with Newcastle</li> </ul>			

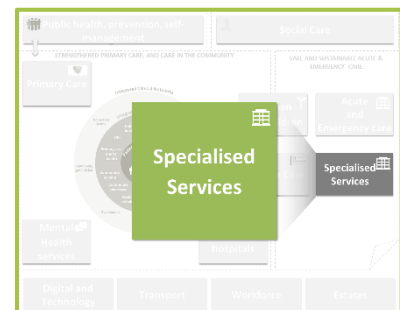
Source: WNE Cumbria Success Regime

Figure 46: Planned Elective Care – Summary of Anticipated Benefits



#### 4.12 Improving Specialised Services

Specialised services are extremely complex and mutually dependent with high-quality local services. Clinical networks are playing an increasing role in ensuring that appropriate pathways are developed to meet necessary interdependencies across all specialities. This is particularly important for WNE Cumbria, recognising the geography and access challenges.



It is recognised that new models for the delivery will be needed to ensure that the population of WNE Cumbria have equality of access to safe and sustainable specialised services. Equality Impact Assessments will be carried out to ensure we achieve this. These may be provided via links with a specialised tertiary centre (such as the Newcastle Upon Tyne Hospitals NHS Foundation Trust) using technology where possible and developing good clinical networks. This will not only enhance service provision by giving clinicians the opportunity to develop and maintain a broader range of skills at the specialised end of the spectrum, but should also help recruitment and retention of staff.

Lead provider models are part of the strategic direction for specialised services: discussions are progressing to explore potential opportunities to work with Newcastle Upon Tyne Hospitals NHS Foundation Trust to improve diagnostic pathways, efficiency and quality in chemotherapy delivery. Subject to procurement of new equipment, this approach could support advanced radiotherapy therapies and techniques to provide safe and sustainable services. This can only be achieved

through specialist networks working closely across primary care, community and acute hospitals to offer the right pathways and interventions, ensuring that local diagnostics, outpatients and post-surgical care are all provided closer to home.

### **Proposals for Chemotherapy and Radiotherapy Provision in WNE Cumbria**

Recent external peer reviews have highlighted some immediate risks and serious concerns in particular around procedural aspects of the chemotherapy service, along with ageing equipment, poor accommodation and the lack of suitable consultant oncology provision.

Demand for radiotherapy provision in Cumbria is steadily growing and this is expected to continue due to the ageing population and the increased number of people being diagnosed with cancer.

Currently there are a number of WNE Cumbria residents having to travel to Newcastle because of the complexities of their treatments which cannot be supported locally (45 patients travelling for Chemotherapy and 20 patients for radiotherapy accounting for over 850 visits per year). These patients could be treated in WNE Cumbria at CIC if there was access to the appropriate equipment, accommodation and staffing.

It is proposed to address these issues through the development of a lead provider model working with the Newcastle Hospitals Foundation NHS Trust.

The benefits anticipated through this approach include:

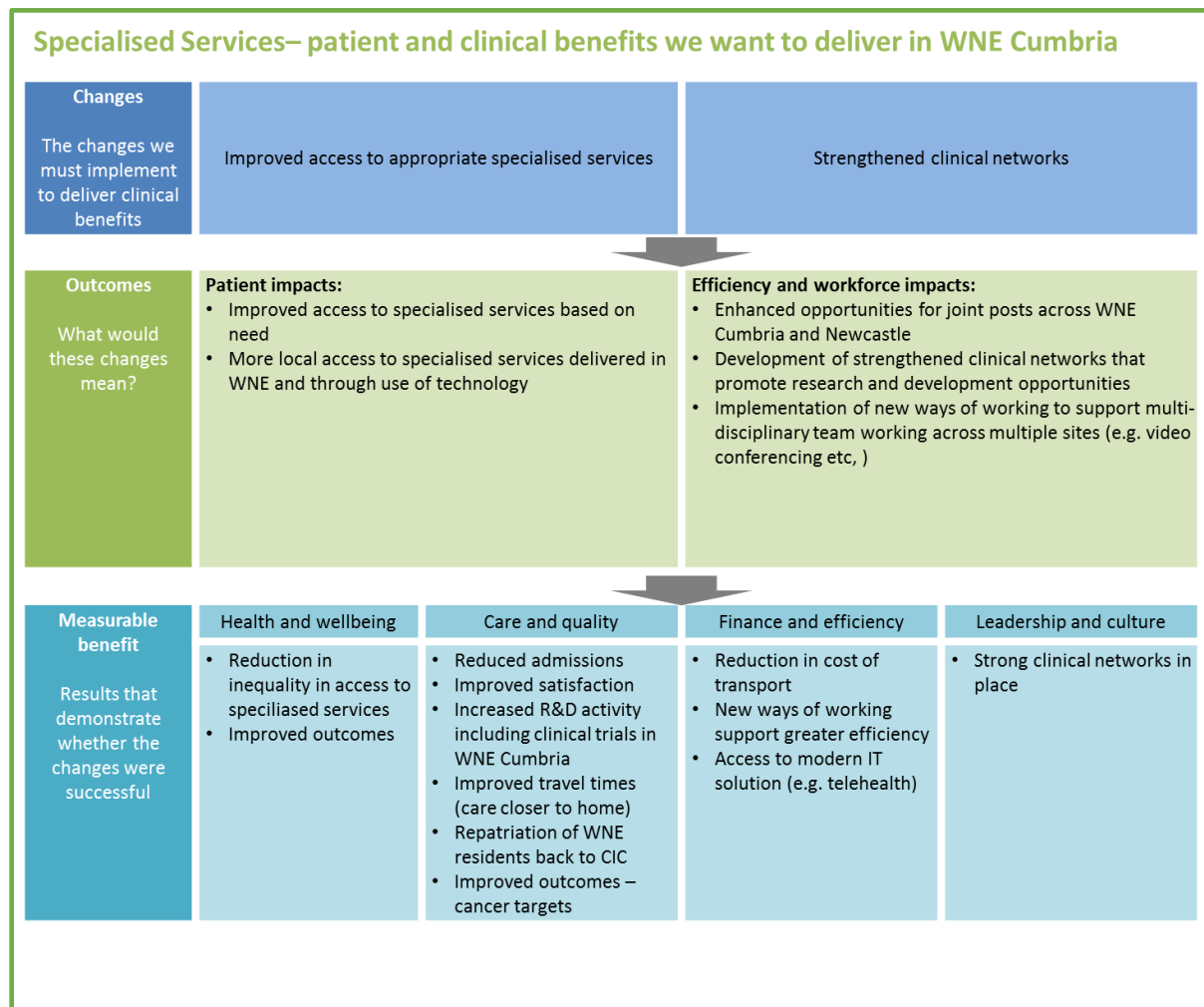
- Achieving national cancer standards and access standards (radiotherapy, chemotherapy and oncology)
- Improved access to specialised services, delivered in WNE Cumbria
- Reduction in inequity of access to modern treatments enabled by new technology
- Workforce opportunities; networked with a territory centre
- Improved in recruitment and retention of the medical oncology workforce
- Opportunity for staff to part of modern clinical trials and R&D linking with specialised tertiary centres

These changes will require significant capital investment (summarised below\*).

Summary of estimated costings	Estimated cost (£000)
IT non-recurrent cost	355.1
Interim service improvements (including new Linear Accelerator)	3,073.5
Demolition costs	1,080.0
Construct and furnish new centre	26,111.5
Fully commission new centre	3,875.6
Option to replace Brachytherapy and SXT equipment	384.8
<b>Grand total</b>	<b>34,880.6</b>

NUTH have developed a clear plan to support the delivery of chemotherapy and radiotherapy in WNE Cumbria. They have confirmed that this is deliverable subject to the provision of necessary capital and local tariff.

Figure 47: Specialised Services – Anticipated Patient and Clinical Benefits

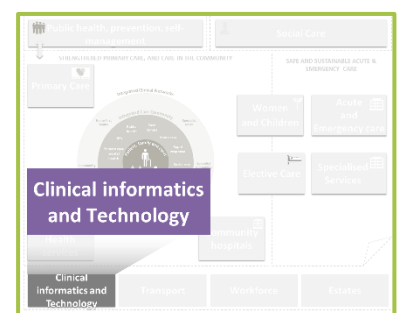


#### 4.13 Improving Clinical Informatics and Technology

Clinical informatics and use of technology will be major enablers of our vision for WNE Cumbria as a centre of excellence in the delivery of health and social care for rural and dispersed communities. Indeed, Cumbria is already recognised nationally for certain aspects of clinical informatics and technology. There is an opportunity to build on this platform to support integrated models of health and social care provision. We will ensure that the right information is available to patients, clinicians, carers and those governing services to improve quality and performance overall. To achieve this, we have agreed seven system-level principles:

##### Our Seven Principles

1. All providers will move from paper-based record-keeping to interoperable electronic records.
2. As a foundation for integrated care, electronic patient record (EPR) systems will be interoperable and accessible to clinicians in both primary and secondary care settings.



3. Interoperability will be extended to care homes, hospices and other providers as appropriate.
4. A single electronic tool for transfers of care between teams, services and organisations will be used to ensure e-referrals and resource matching is seamless for people accessing services or following pathways of care.
5. Social care will be supported through use of the NHS number in its electronic systems.
6. ICC models of care will be exemplars in the use of technology-enabled care.
7. Use of mobile technology will be the norm for our workforce and people using our services.

Our ambition is that a person's relevant health and care information will be available in well-designed information-sharing arrangements. This will underpin improvements in the quality of care (safety, outcomes and experience) and provide the foundation for the development of truly integrated care. Our plans will be supported by Cumbria's roll-out of superfast broadband, allied to investment in patient-facing technology by the NHS and local authorities. Technology-enabled care will be facilitated through the use of mobile devices that will access health and social care records. These will enable the expanded use of telecare, assistive technologies, text messaging/prompts and vital signs monitoring. Utilisation of video conferencing for remote consultations and/or multi-disciplinary team meetings will improve productivity and accessibility. Our workforce will have access to evidence and information on their caseloads, ensuring that patient contacts are as productive as possible.

People in WNE Cumbria will:	Staff working in health and social care services in WNE Cumbria will:
<ul style="list-style-type: none"> <li>• View their information through online access to their records, supporting them to make better decisions about their health and social care and take more control of their well-being.</li> <li>• Add to their information and their records, feeding in details they may have gathered from apps and wearable devices.</li> <li>• Routinely use digital apps, wearable devices and online resources to be well-informed, active participants in their care, making informed decisions and lifestyle choices.</li> <li>• Connect online with health and social care services; appointments online, order repeat prescriptions, check test results, access their medical record, secure email and video conferencing with clinicians and care professionals in a way that suits them, improving access for themselves to services.</li> <li>• Use digitally-enabled services to monitor long-term conditions and daily tasks to support independent living.</li> </ul>	<ul style="list-style-type: none"> <li>• Capture information electronically at the point of care delivery.</li> <li>• Use information and electronic care to deliver co-produced, co-ordinated care around the personalised needs of the patient and their carer.</li> <li>• Have access to online decision support, to advice and guidance, supporting knowledge development enabling effective clinical networks to thrive.</li> <li>• Foster a 'digital first' philosophy to designing and delivering new services, to promote mobile, flexible, digitally-enabled service and workforce models.</li> <li>• Have the skills to work effectively in a digitally-enabled environment</li> </ul>



In particular, we will:

- Support each provider move from paper to **electronic clinical records** before 2018 as an enabler of improved clinical care and greater efficiency and productivity.
- Renew our key infrastructure as a platform for our staff to be a **technology-enabled** workforce to help them delivery better care more efficiently.
- Implement **Wi-Fi** for public and staff across all our healthcare sites to improve access to information.
- **Share information** effectively and appropriately – leading the way to do this efficiency and with good governance.
- Ensure that by summer 2016 all GP practices will be utilising a **common patient record system**, this being a common system in community and hospice/palliative care services also – a key enabler for our ICCs.
- Lead the way in the use of **electronic referrals** and resource matching for transfers of care with all referrals to adult social care from acute and community services being sent electronically. (Our “air traffic control” system for patients has streamlined the process in some cases from over two hours of forms and time spent to 15 minutes. It was shortlisted for a HSJ award in 2015.<sup>41</sup>)
- Work with local authorities to align our emerging **telehealth and telemedicine** strategies with their well-established telecare programme.
- Invest in IM&T across all settings of care, giving priority to the areas of acute service **EPR and ICC** mobile working solutions.

#### **Enabling an integrated patient record by digitising record-keeping**

We have formed a joint health and care informatics governance group to take forward our shared ambition to ensure clinical records are electronic, interoperable and shared so that patients and clinicians have access to the right information, in the right place at the right time to provide the most effective care. This will increase the quality of care by improving the experience, safety and outcomes for patients.

A high-level programme has been developed and business cases for investment prepared. We envisage that by enabling our clinical workforce to utilise technology effectively we can create benefits for both quality and efficiency well into the future. Our initial case outlines an investment requirement of approx. £7.7m over two years and significant work to implement improved working practices associated with adopting more modern recording, sharing and use of clinical information.

We are building on good foundations and have made early progress in the following key areas:

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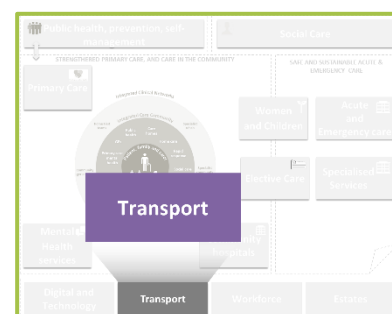
<sup>41</sup> See <http://www.cumbriaccg.nhs.uk/news/2015/november/cumbrian-e-health-scheme-shortlisted-for-national-award.aspx>

- A well-established and high-performing community of Interest network for all GPs<sup>42</sup>, clinics and hospitals so that we have superfast and secure IT links to transfer data between each other and enable our workforce to be agile and utilise technology with confidence.
- Comprehensive WiFi for all sites for both staff and public so that applications relevant to patients and practitioners are able to connect and be used with ease.
- Ensuring that by summer 2016 all GP practices, community services, hospices and palliative care services will be utilising a common product as their electronic patient record system. This provides potential for maximum interoperability with ease for increasingly integrated services in future.
- We are breaking new ground in the roll out of electronic referrals and resource matching software so that transfers of care between teams (both health and social care) are coordinated and managed electronically. This enables a streamlining of the process and significantly increased safety and effectiveness. The roll-out of this system is sponsored and lead by Cumbria CCG for all providers across the whole Cumbria digital roadmap footprint.
- Standardisation of referral forms to ensure high quality information capture and improved pathways for patients between primary and secondary care.
- As part of the Cumbria Rural Health Forum, we are growing a network of professionals across health and social care to take a collaborative and high impact approach adopting technology to support effective service delivery. This includes consideration of the telecare, telehealth and telemedicine solutions that will support the transformation of our services to serve the rural and dispersed communities in WNE Cumbria.

#### 4.14 Improving Transport

Transport is a critical enabler for patients and service users to access services when needed and be supported by families during care. The importance of appropriate transport in WNE Cumbria as part of overall health care delivery and patient experience cannot be overstated. The region presents significant challenges in relation to distance from home to (and between) health and care sites (including tertiary centres). In addition, there is poor road infrastructure, and unusually high reliance on public transport in some areas (particularly in West Cumbria).

Patient and carer consideration of transport issues is much broader than emergency services, with public transport, car parking and patient transport services as much a priority as paramedic ambulance provision. Indeed, transport is cited by public, patients and staff alike as an area of high concern in relation to both current and future health and social care services.



<sup>42</sup> <sup>42</sup> See <http://n3.nhs.uk/News/CumbriahealthorganisationsgetthebenefitsofanewCommunityofInterestNetwork.cfm>

#### 4.14.1 Our Vision for Transport and Access

WNE Cumbria Success Regime work has enabled engagement with a wide range of professionals and lay people so that fundamental issues of transport, physical access and associated requirements are being considered. The focus is on making sure that adequate transport provision is built into service proposals. Efforts must be made to address significant transport challenges currently experienced by patients (and to a lesser extent our staff).

The following key issues have been identified:

- Emergency transport and staffing capacity: demand outstrips capacity, but there are opportunities to reduce this through new ways of working.
- Concerns regarding emergency transfers between sites – experience and perceived safety.
- Parking difficulties – patients, carers and staff.
- Perceived gaps in public transport provision, patient transport services and information to support patients and carers in accessing health and social care sites.
- Impact on staff of greater cross-system working.
- Changes to clinical service configuration with potential significant transport impact.

Proposals therefore seek to address both the challenges of the ‘here and now’ as well as to ensure appropriate adjustments can be made to current provision to take account of possible new service models. Irrespective of eventual choices in relation to options for change, improvements to transport and access can be divided into three main categories:

1. Actions to improve ways of working and allow a high-quality integrated approach across the system for transport-related issues.
2. Actions to meet capacity in **current** health-provided transport-related services and/or improve efficiency.
3. Development of new transport-related services that further enhance quality and efficiency in the system.

Below we provide brief examples of our work to improve patient experience associated with transport. While these do not represent major service change in themselves, they will complement and support options for change in other areas.

The table below summarises the key issues around transport and access identified through engagement – and our vision for the future.

Transport and access now	Our vision for the future
<ol style="list-style-type: none"> <li>1. Patients can wait for long periods in emergencies to receive the care they need</li> <li>2. Patients transported away from their local hospital in an emergency do not always understand why this is being proposed</li> <li>3. Patients and their accompanying family members may experience uncomfortable lengthy journeys to or between hospitals</li> <li>4. Patients can find it difficult to reach their GP surgery, health centre or hospital if reliant on public transport</li> <li>5. Public transport users can face lengthy journeys, and transport is not always available at convenient times or places</li> <li>6. Appointment times offered often do not take into account the journey difficulties faced by often unwell or frail patients</li> <li>7. On arrival for clinics/procedures/day cases it may be difficult to access the drop-off points or get from car park/bus stop</li> <li>8. Clinic visits (hospital or community) can sometimes be very protracted, often far exceeding patient expectation and impacting on their travel/parking arrangements and overall experience</li> <li>9. Patients/carers arriving in hospital in their own/carers transport can experience significant difficulties parking</li> <li>10. Patients may experience long waits for transport home from hospital particularly later in the day, weekends or out of hours</li> <li>11. It is difficult to find user-friendly and up to date information about transport and related services to help access healthcare including financial support and eligibility criteria</li> <li>12. Staff are not always aware of patient transport needs and what is available to support them, and do not always communicate well with patients about transport aspects of their health experience.</li> </ol>	<ol style="list-style-type: none"> <li>1. Patients are able to access health and social care services, whether in community settings or in a hospital in a way that is: <ul style="list-style-type: none"> <li>- as comfortable as possible</li> <li>- an enabler to their management and health outcomes</li> <li>- as convenient as possible.</li> </ul> </li> <li>2. The need to travel to access healthcare is minimised as far as possible</li> <li>3. In an emergency, patients are confident that they will be able to receive timely, safe assistance from skilled workers, so that they are not disadvantaged by virtue of where they live /present</li> <li>4. Where it is in the best interests of patients to receive care at some distance from home, the reasons for this are understood, the transport arrangements are of high quality and do not result in delays to care which adversely impact on patient outcomes</li> <li>5. The experience of family members and carers supporting patients is enhanced by convenient public transport and parking facilities</li> <li>6. Patients and families are supported to make their own travel arrangements, and health-funded transport is only used when essential</li> <li>7. Patients and families can readily access information to help them plan their journeys to and from health and social care services</li> <li>8. Patients and staff are able to make best use of health and other technologies which may prevent their need to travel</li> <li>9. Staff members whose roles require them to work across a range of settings in West, North and East Cumbria, are supported in journeys which make best use of their valuable time, and which do not result in unreasonable stress in their working lives</li> <li>10. Funded transport is delivered as cost effectively as possible across and beyond the county, pooling resources where appropriate.</li> </ol>

### What we are doing to respond to transport challenges

- We will have a comprehensive, system-wide *Health and Care Transport & Access Plan* for WNE Cumbria by August 2016 – this will be based on thorough demand and capacity analysis, benchmarking and evidence based best practice.
- A publicity campaign will back up new leaflets, ‘Travel Cards’, and website material.
- A *Code of Professional Practice* is proposed alongside training for booking, outpatient and ward staff to take better account of transport needs, with work to smooth patient flows and improve experience.
- Plans are progressing for two new car parks at CIC, which will provide a further 395 spaces by Christmas 2016.
- Further development of alternatives to hospital when an ambulance is called, such as ‘hear and treat’ ‘see and treat’, ‘see and convey’, acute visiting schemes and telemedicine opportunities, as well as further development of community first responder schemes.
- A number of clinical pathways being developed by NCUHT and NWAS clinicians will enable direct transport of patients from community settings to the most appropriate hospital rather than necessarily the closest to reduce delays in initiation of treatment.
- The new Patient Transport Service (PTS) contract for Cumbria (recently re-awarded to NWAS) incorporates a number of quality improvements following engagement with hospitals, patients and commissioners, including:
  - Text-ahead service, to inform patients when their transport will arrive.
  - Streamlined quality standards, particularly around the journey arrival and collection times.
  - Revised process for applying the eligibility criteria to ensure equitable access to the service.
- The potential ways to extend services into weekends and evenings to assist in timely discharge, including complementary community transport provision to support patient journeys both to and from hospital.
- The development of a business case for Wi-Fi enabled hopper buses to operate between sites – to improve access for patients/families, and enable much more efficient cross-site working by staff.
- There is national support for the development of proposals for an emergency medical air retrieval service to support and complement delivery of acute services – see below.

Detailed modelling work has been undertaken to ensure that the transport implications of all clinical options for service configuration have been understood, including the degree to which potential increases in requirements in one area can be offset by reductions in other areas (for instance, reduction in site to site transfers, by increasing direct diversion to the best hospital to manage an individual patient). This work includes activity, workforce, and revenue consequences along with lead-in times and capital and training requirements, and applies to both emergency ambulance and post-initial treatment and discharge requirements.

The work achieved to date, with clear articulation of a vision for health-related transport by considering what ‘excellent’ looks like from a patient perspective, and with identification of early and longer-term actions and requirements, has established a good foundation from which to build this critical work. Importantly, our proposals for change have been significantly shaped by lay colleagues working constructively with multi-agency professionals, and in their breadth offer an exciting and ambitious programme for change.

#### 4.14.2 The Potential Role of Heli Medicine

WNE Cumbria has challenges driven by the rural geography, isolation of the local populations, and isolation of acute hospitals. Together, these add up to low patient volumes and workforce challenges, which pose serious challenges to the sustainability of the acute sites. One of the key solutions to these challenges – the centralisation of certain services – faces serious challenges around the increase in travel times. A dedicated national project has been established to determine whether a helicopter retrieval service may enable clinically and financially sustainable services in the North of England, focusing initially on WNE Cumbria.

We are considering a radical proposal to establish a helicopter-based Emergency Medical Retrieval Service. This service, based at WCH, would provide patients in remote and rural areas of the North of England with rapid access to an emergency medicine or intensive care consultant, equipped to provide lifesaving, specialist, and critical care.

Helicopters have a role in providing emergency cover over large and remote geographical areas and situations inaccessible to land ambulances. Planning of this model of response and investment in infrastructure is necessary if this is to provide a robust and sustainable response.

A review of the benefits of helicopter emergency and ambulance services (HEAS) for the Department of Health (2003) set out the following findings:

- In 2003, 16 HEAS covering the whole country reported average response times of 17 minutes, and transfer times of 10 minutes.
- Assuming there is a benefit, the estimated number of lives saved by HEAS was approximately 2-3 patients per 100 patients transported. The studies examined suggest that the main benefit arises in blunt trauma patients, particularly those injured in Road Traffic Accidents (RTAs), with severe injuries.
- Assuming 2-3 lives could be saved per 100 serious blunt trauma patients transported by HEAS, the 2003 study estimated that HEAS in England and Wales could generate 43-136 quality-adjusted life years (QALYs) per year.

A robust analysis of the benefits of helicopter transport is given in a study done for Northern Ireland in 2003. (Booze, Hamilton et al, 2003). In essence this report says “Effective HEAS (in any response role) require an integrated (as opposed to fragmented) pre-hospital emergency care system and the development of a significant amount of (usually new) ‘institutional’ mechanisms including a system of clinical coordination, and implementation of an effective operational and clinical audit regime.”

As distance and time increases with rurality and remoteness so there is a greater need for an integrated pre-hospital emergency care system that is evidence-based and works within robust clinical governance structures.

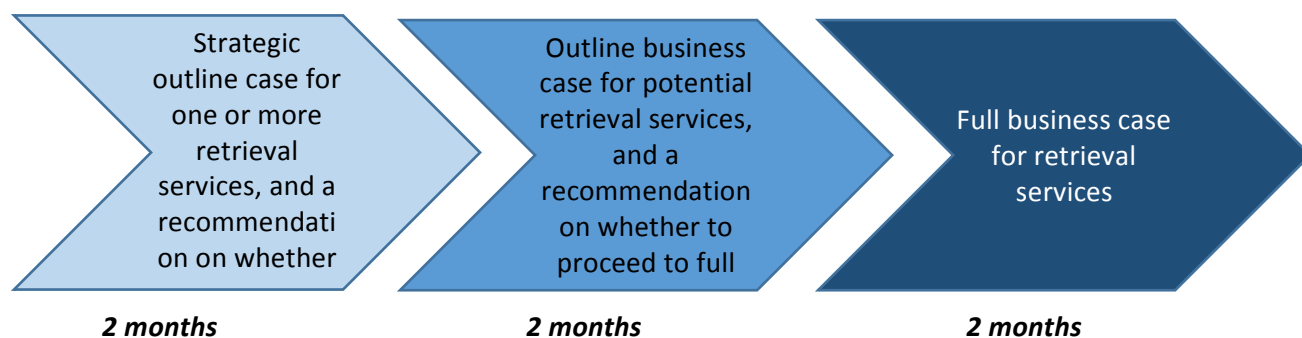
The project will aim to establish the extent of the role that Heli Medicine can play in making WNE Cumbria's health system clinically and financially sustainable, and determining whether a retrieval service is a viable solution for ensuring critically unwell patients have access to timely, safe and effective care, by providing:

- Safe and effective transfers for seriously ill adult patients.
- A bed location for transferred patients at a site of definitive care.

The national project (which will have a dedicated project director) will:

- Review the evidence for different models of retrieval services in relation to improving health outcomes and improving the value of health services.
- Consider which, if any, model of retrieval service might meet the needs of the wider health and social care system in the context of broader strategic plans for the area, i.e. can it enable service configurations that might otherwise not be possible.
- Model the costs of different retrieval services.
- Quantify the contribution, in each of these geographies, that various models of retrieval services could make to improving health outcomes and financial sustainability

Key outputs:



The proposal has support from Keith Willetts, NHS England's Director of Acute Care.

#### 4.14.3 The Potential Role of Telemedicine to Support Heli Medicine

The supporting infrastructure for Heli Medicine would necessarily involve significantly scaling up the use of Telemedicine (which would underpin development of more distributed care models, with home as the default setting wherever possible, and with an increased "see and treat" capability).

Telemedicine provides health services at a distance using a range of digital technologies (e.g. video consultations to support diagnosis and management, clinical networks and health professional education). Remote and enhanced delivery of care services to people in their own home or a community setting by means of telecommunications and computerised services can refer to sensors and alerts which provide continuous, automatic and remote monitoring of care needs, emergencies and lifestyle changes, using ICT to trigger human responses, or shut down equipment to prevent hazards. See section 4.11 'Improving Clinical Informatics and Technology'.

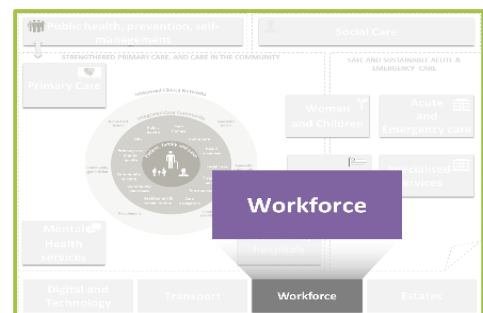


A technology-enabled and integrated approach to the delivery of effective, high-quality health and care services offers particular benefits for remote and rural communities, with a range of care options available remotely by telephone, mobile, broadband and videoconferencing. Telemedicine can improve access to a wide range of care options for patients in remote and rural areas and can reduce waiting times for specialist opinions.

To overcome barriers to development, there is a need for training and awareness raising – and to identify enthusiasts at each site. Teaching establishments should introduce telemedicine techniques into curricula and prepare doctors and nurses and AHPs for working in a rural community. Telemedicine equipment is not extremely costly and the potential savings in reduced travel costs and time can produce significant savings and improved efficiencies.

#### 4.15 Workforce Improvements

Emerging thinking on new models of care requires us to be ambitious in our plans to develop new ways of working, maximising opportunities for existing staff and attracting people to work with us. We are doing this against the background of arguably some of the most difficult recruitment and retention challenges across health and social care.



Across the country, there is an estimated 9% vacancy rate for nurses and 7% for doctors, compared to an average UK economy vacancy rate of 2.7% (Source: BBC FOI). These figures highlight the national difficulties with medical recruitment and retention, which compound the local challenges. Currently, WNE Cumbria reports an over-reliance on locums due to the high levels of vacancies. For example, estimated 12-month data for NCUHT provided in February 2016 shows that by business unit the number of locums are:

- Medicine: 18.2
- Surgery: 14.7
- Clinical Services & Cancer Services: 5.1
- Child Health: 3.0

The high vacancy rate not only impacts on finances (annual estimated locum spend across CIC and WCH was over £18m), but also reduced continuity for patients and other medical staff.

All organisations within the WNE Cumbria have tried to improve recruitment in particular over the years, and invested in new roles, with varying degrees of success. The solution needs to be across the health and social care economy in order to deliver the scale of change needed.

To drive this work forward, we have developed a “ten-point plan”, which is summarised in Figure 48 below.

Figure 48: Our Ten Point Plan for Workforce Improvements

	Action	16/17 Actions
1	Produce a workforce and investment plan in support of the clinical strategy	<ul style="list-style-type: none"> <li>- Workforce modelling for each clinical option – May 2016</li> <li>- Investment plan developed – Sept 2016</li> <li>- Produce 5 year STP plan – Sept 2016</li> <li>- Embedding Trusts WRaPT capability – Sept 2016</li> </ul>
2	Establish a new national clinical taskforce to be piloted in the CSR (NB now called Doctors in Partnership)	<ul style="list-style-type: none"> <li>- Implement national scheme in Cumbria in key groups (Paeds, Obstetrics, Emergency Medicine/A&amp;E) – Sept 2016</li> <li>- Undertake evaluation with view to extending pilot group – end March 2017</li> </ul>
3	Accelerate the development of extended and new roles / skills / behaviours	<ul style="list-style-type: none"> <li>- Identify accelerator roles for each clinical workstream – end of June 2016</li> <li>- CPD investment plans for 2016/17 – June 2016</li> <li>- Identify new roles for 2017/18 onwards – Sept 2016</li> </ul>
4	Focus on “Growing Our Own” workforce locally through a new Centre for Excellence	<ul style="list-style-type: none"> <li>- Identify recruitment champions for each clinical workstream – from April 2016</li> <li>- Establish local register of schools/colleges/careers advisors – End May 2016</li> <li>- Agree a work experience programme for potential doctors – End June 2016</li> <li>- Establish rolling programme of engagement with schools/colleges – Sept 2016</li> <li>- Primary Care Development Plan scoped – June 2016</li> <li>- Undertake baseline self-assessments against Talent for Care/Widening Participation – end June 2016</li> <li>- Integrated Nursing Development Group (INDG) to develop strategic recommendations for integrated nursing posts/teams etc. – Sept 2016</li> </ul>
5	Devise a prioritised ‘NHS in Cumbria’ reward and recognition strategy	<ul style="list-style-type: none"> <li>- Suite of options launched – April 2016</li> <li>- Identify further work and groups that would benefit from the “offer” – end June 2016</li> <li>- Review and evaluate impact – end Sept 2016</li> </ul>
6	Develop the first national teaching system accredited by local education and national partners	<ul style="list-style-type: none"> <li>- Establish a “System of Excellence” for education, training and development for all staff, between Trusts and UCLAN – Sept 2016</li> </ul>

7	Develop a recruitment hub (improving the quality of the recruitment experience)	<p>Phase 1 – Sept 2016</p> <ul style="list-style-type: none"> <li>- Develop proposals for GP recruitment collaborative</li> <li>- Repatriate medical recruitment from Northumbria – September 2016</li> <li>- Harmonise processes across Trusts</li> </ul> <p>Phase 2 – March 2017</p> <ul style="list-style-type: none"> <li>- Consider further integrated working opportunities</li> </ul>
8	Promote Cumbria through an NHS covenant and Local Enterprise Partnership (LEP) commitment	<p>Phase 1 – June 2016</p> <ul style="list-style-type: none"> <li>- Develop propositions/ options paper</li> <li>- Meet with patrons/sponsors (CCC, LEP, other large employers)</li> </ul> <p>Phase 2 – Sept 2016</p> <ul style="list-style-type: none"> <li>- Achieve sign-up from sponsors</li> <li>- Launch covenant</li> </ul>
9	Enhance the employer brand / employer of choice initiative, to support employee engagement and wellbeing	<ul style="list-style-type: none"> <li>- Consider utilisation of NHS Employers staff survey analysis toolkit – End May 2016</li> <li>- Undertake collective work on shared approach across 2 Trusts and key staff satisfaction indicators June 2016</li> </ul>
10	Invest in leaders and talent	<ul style="list-style-type: none"> <li>- Maintain current CLIC leadership programme offers – May 2016 onwards</li> <li>- Establish leadership subgroup for OD work area – end of June 2016</li> <li>- Appointment of OD Facilitators to support clinical workstreams – end July 2016</li> <li>- Subgroup to review current and future leadership development programme offer – end Sept 2016</li> <li>- Offer Systems Leadership training across (CSR and BCT) - end of August 2016</li> </ul>

Our workforce recruitment and retention will benefit from strengthened partnership working with the University of Central Lancashire:

#### **Strengthening our partnership with the University of Central Lancashire (UCLan)**

The University of Central Lancashire Medical School is committed to the development of medical education in Cumbria and is keen to establish further training opportunities out of their West Lakes Campus in support of senior and junior medical staff training and recruitment, and the development of a rural/mountain centre of excellence. The following represent some of the progress and plans to date:

- UCLan medical school has already been approved for MBBS training;
- Of the 30 place course for physician assistants, 12 will be undertaking their hospital placements in WCH.
- UCLan is promoting an 'earn as you learn' concept for training aimed at paramedics,

pharmacists, and AHP who would like to medically train whilst working part-time.

- A 'Summer School' being held in July for overseas qualified doctors, which will include placement at WCH with the aim of generating increased interest in opportunities in WNE West Cumbria.

A number of clinical and academic opportunities for the development of rural healthcare have been agreed, including:

- Professor of Medicine – to be in post by October 2016.
- Senior Lecturer and Honorary Consultant in General Medicine - to be in post by February 2017.
- Professor of Primary Care - to be in post by February 2017.
- 6 academic fellows spread depending on applicants between primary and secondary care.

Working with NHS England and Health Education England (HEE), we are progressing a number of short-term actions with the aim of boosting the number of GPs working in WNE Cumbria. These include:

- Introducing a new approach to **advertising and recruitment** using a web-based recruitment hub.
- Hosting a **recruitment fair** in June 2016.
- Establishing a scheme to **support and mentor** GPs, focusing initially on doctors who have been granted asylum and have refugee status, ex-Forces GPs, and GPs in their first five years of qualification.
- Development of a **GP Career Start** programme.
- Providing a **bursary** of £20,000 for trainees joining the Cumbrian GP training scheme.
- Extending GP training in association with NCUHT, offering **specialist training** and different career opportunities.
- Recruiting the first cohort of **physician associates**, with six to commence their training in WNE Cumbria.
- Extending the number of GP surgeries with **pharmacists within the clinical team**.
- Creating a **General Practice Recruitment Hub**, led jointly by CHOC (our GP out of hours provider) and CPFT, working in collaboration with our GP practices and key stakeholders. The recruitment hub will work at scale for GP practices:
  - Proactive, professional recruitment support, including HR, marketing and promotion.
  - Developing new streams of supply for key staff, with GPs being attracted to train and work in Cumbria (for example, through a career start programme, F3 schemes and nurse practitioner development).
  - Supporting those working and training in Cumbria through education and personalised support, to match their career intention with portfolio roles, across primary, community and secondary care.

We are already making progress in joint work across NCUHT and CPFT in terms of recruitment branding and streamlining processes; a GP Recruitment Collaborative has been established to

explore how best to attract and retain GPs in WNE Cumbria, involving practices/Federations, the CCG, CPFT and Cumbria Health Out of Hours (CHOC).

#### 4.16 Organisational Development

Throughout this PCBC we have recognised and acknowledged that to be successful and achieve the scale, spread and then sustain the level of improvement to quality we aspire to, whilst achieving and maintaining financial performance, a different approach to change and improvement is required. We cannot underestimate the size of the task; it will be a marathon not a sprint.

The Organisational Development work area is about supporting health and care system improvements and change through our people. We recognise that the system will demonstrate success in terms of measurable improvements to quality of care, workforce, financial performance, public confidence and system wide organisational stability. Success in the OD work area is when clinicians and managers work together, showing leadership and alignment to the system and when they problem-solve respectfully and deliver improvements together in the interests of the people who use our services.

To achieve success, the OD approach will:

- Add value to existing OD plans within organisations and align them to our system plan.
- Engage the hearts and minds of our clinical workforce, involving staff at all levels, building leadership and improvement capability and helping them really believe that we can be successful.
- Focus on working together in multiple and cross organisational 'teams' coordinating and improving care around the needs of our patients.

There is much to do, but work has already started and a number of building blocks are in place:

- A commitment to learn together through CLIC, common tools and a model for improvement.
- A number of development programmes in place within individual organisations and links to support networks such as the North West Leadership Academy (NWLA) and Advancing Quality Alliance (AQuA).
- A body of evidence and clear 'manifestos' such as the Berwick Report and the work of Michael West to guide our plans.
- A nucleus of knowledgeable, experienced and engaged people to lead and support development.

CPFT, CCC and NCUHT have invested in establishing in-house improvement teams to support change and build the capability in continuous improvement. This resource is now working together to support CLIC in developing a single culture and a shared sense of purpose across the system, focusing on improving outcomes with and for patients through high performing teams and continuous system development.

### Our OD Approach – *Learning, working and solving problems together*

- Supporting staff to lead, improve and adapt what they already have across all existing services through building leadership and improvement capability through education in modern improvement science: "I do my work; I improve my work" – *Learning together*
- Supporting the new emerging teams and networks to work together in a way that enables them to deliver change according to the plan (and doesn't merely suppose they will comply with logical, modern, evidence based plans & guidance) – *Working together*
- Making clear our system aims and create a sense of purpose, helping people develop compassionate and constructive relationships – *Solving problems respectfully together*

Our approach is underpinned by strong evidence to show that this can lead to high levels of staff engagement and productivity (West 2015); its strength is that it can create a great place to work and a future working environment that can attract and retain staff.

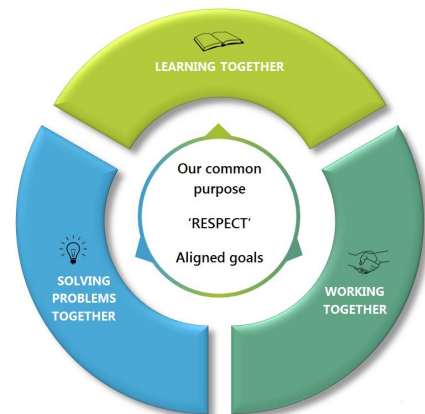
See **Appendix E** for Workforce Baseline details.

#### What have we achieved so far:

An exercise to map the development programmes and OD resources that are currently in place across organisations has been undertaken by the OD work group and used to inform a system OD plan. The high-level plan relates to building leadership and improvement capability in all staff through developing our existing OD programmes and through introducing new and specific OD interventions to targeted teams/groups of staff that are critical to the delivery of the SR programme.

Targeted teams/groups will be identified through:

- Stakeholder mapping of staff in key roles supporting delivery of the programme.
- Identifying individuals/teams supporting key areas for focused improvement within existing services, for example, reducing waits within the cancer pathway.
- Identifying individuals/teams supporting critical elements of system change identified within the SR delivery plan, for example, place-based teams.





## 2015-16 at a glance...





	Action / Initiative	Timescale
<b>Learning together</b>		
All staff	Continuation of CLIC improvement programmes <ul style="list-style-type: none"> <li>• 0.5-day CPS awareness</li> <li>• 3-day CPS Practitioner</li> </ul> Continuation of Forerunner clinical skills programme	Ongoing  Ongoing
Targeted*	Programme to support specific groups e.g. Board, SRO using established common tools and models.	Started June 2016
<b>Working together</b>		
All staff	Continuation of CLIC collective leadership programmes <ul style="list-style-type: none"> <li>• 0.5-day Making an Impact</li> <li>• 3-day improvement leaders</li> </ul>	Ongoing
Targeted*	Programme to support specific groups e.g. Board, SRO, pathways to include team development, leadership to meet specific needs of group using established common tools and models.	Started Spring 2016
	CLIC System leadership programme to support integrated care teams	Pilot evaluation in progress
<b>Solving Problems respectfully together</b>		
All staff	We have captured our organisational values and behaviours and will use these within organisational programmes to agree 'how' we will work together respectfully in teams across the system.	Ongoing
	Agree a common narrative and develop a comms plan and engagement programme to make clear the aims of system change, clarify purpose to help all staff see where they fit and what is expected of them.	Planned August 2016
Targeted*	Coaching skills – 2-day programme	Started Spring 2016
	Action learning sets to support identified groups as required	

*\*Targeted programmes are likely to combine all three elements in to a single specific programme tailored to the needs of the group.*

## Resources

The delivery of established programmes is currently resourced through individual organisations with a commitment to collaborate through CLIC. Success Regime funding has supported an additional resource of 6.0 WTE OD facilitators, these will be fixed term Secondment opportunities for existing staff within the health and care system.

The OD work group will ensure that the organisational development plans / programmes are aligned to the system plan, they act as a reference group and support the development of a more detailed delivery plan. A number of sub groups, for example leadership, with representatives from across the system provide expertise in designing specific programmes and providing support for targeted groups.

Close alignment between the OD, Communications and Engagement and Workforce work areas will be required for implementation.

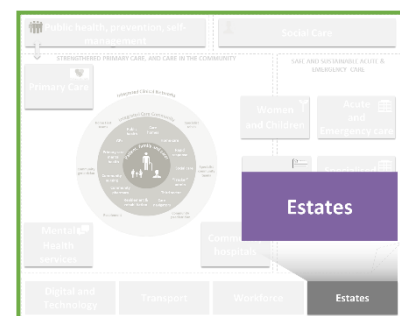
### Measuring success

We will take an OGIM (objectives, goals, initiatives and metrics) approach to support delivery of our OD plan and achieve the objectives within the OD mandate. This is currently under development.

The AQuA integration framework and a relational coordination tool will be used at an organisational and team level to measure how well we work together as a system.

## 4.17 Estates Improvements

We recognise that no single aspect of our health and social care system can be considered in isolation, and therefore the work undertaken through the WNE Cumbria Success Regime seeks to ensure a “whole system” approach is taken to inform our proposals for change. This identifies significant work that is already progressing across WNE Cumbria as part of “business as usual”, as well as opportunities that we believe would benefit from more formal engagement and consultation.



This pre-consultation business case therefore focuses specifically on our proposals for acute hospital services, inpatient mental health services and community hospitals. It is, however important to recognise that these proposals, and the assumptions that underpin them reflect our commitment to progressing the improvements planned for our out of hospital services at pace and with purpose.

The task of delivering sustainable healthcare in WNE Cumbria will be supported by strategic plans for our estate that will ensure that it is able to support care provision with optimal efficiency.

The current estate in WNE Cumbria is fragmented, largely due to the sparsity of the population and the physical geography of the area with two district general hospitals, eight community hospitals and many primary care premises. As we progress new models of care, embrace new technology and ways of working, the expectation is that this will have a significant impact on our estate requirements and our plans will need to reflect this.

The NHS also funds the provision of premises for primary care. The buildings are owned/ leased by practices; in some cases, from NHS Property Services Ltd or CHP Ltd.

#### 4.17.1 Immediate Priorities

We recognise that there are several immediate challenges that need to be worked through, to provide the foundations for future changes, specifically:

- Ensuring the continued expert contract management of Private Finance Initiative funded estate which account for approximately 50% of expenditure on NHS estates in WNE Cumbria, maximising the potential for adaptation and releasing cost.
- To agree the scope of the next phase of the WCH development to release double running costs.
- To support the development of locally-owned ICC estate plans which focus on the opportunity to co-locate services and maximise the use of good quality estate releasing buildings that are no longer suitable for the provision of modern health and social care. This should include primary care estates plans.
- Appraising potential options for wholesale strategic estates partnering (ownership and development) across all organisation in both WNE Cumbria and beyond (e.g. Morecambe Bay).

These priorities inform our nine-point plan (summarised below):

	Key Issue or Driver	Planned Response
1	Develop services to allow safe and timely discharge from hospital	Work with local authorities, HCA and housing associations to develop step-down or extra care facilities, potentially on existing hospital sites, to provide nursing-led facilities that will be easily accessible by service users. This will consider sharing facilities with other services / private sector, and will involve an open dialogue at a local level over the most appropriate types of care and settings.
2	Make optimum use of existing fit-for-purpose building stock	<ol style="list-style-type: none"> <li>1. Challenge the use of buildings to achieve usage reflecting patient flows.</li> <li>2. Undertake detailed utilisation studies on sites where assets may have potential to deliver more to ensure investment is correctly targeted.</li> <li>3. Consider re-use of traditional centres to deliver more appropriate types of care. Re-appraise nature and quality of provision in traditional community hospitals.</li> <li>4. Undertake local area studies of demand and total capacity of all existing buildings to assess opportunities for service improvements and securing efficiency savings. Select areas for study on the basis of a suspected miss-match or proposals for change (e.g. primary care proposals).</li> <li>5. Review location of admin support – introducing new ways of working and avoiding use of expensive clinical space for more generic functions.</li> </ol>

3	Improve primary care estate to deliver accessible integrated services over longer hours	Stimulate bids from localities and support CCG in prioritising bids for PCTF support. Ensure facilities incorporate a wider range of services and the providers of such services are committed to their delivery in localities.
4	Maintain and develop shared understandings between partners	Be aware of potential barriers to sharing facilities and use SEG to initiate problem solving.
5	Establish an inclusive planning approach with local communities	Build on proposed consultation through the Success regime, links with district councils and local Health and Well Being Forums
6	Resolve issues that compromise the efficiency and economics of PFI funded schemes	Joint action by the two Trusts occupying PFI buildings where cost/ use is sub-optimal.
7	Resolve GP ownership issues that constrain strategic planning of the estate, compromise efficiency and limit service delivery	Review options for consolidating ownership of properties in to fewer organisations with increased NHS control.
8	Maintain capability and capacity to support work on infrastructure	Between the key agencies make provision for a shared service that can manage a programme of estates work in at least the medium term.
9	Develop the skills and techniques to deliver a "system" economic view of the costs of healthcare provision so expenditure and gain is not portrayed in terms of single agency impact	The economics of the Barrow scheme in Morecambe Bay illustrate this point; providers operating from the building will pay more while the "system" gains through the improvement of services, reduced travel cost and the disposal of unsuitable buildings carrying significant backlog maintenance liabilities.

#### 4.17.2 Overview of current challenges

The estates utilised across eleven key sites are, for the most part, operated at a higher-than-average cost. This is primarily because the hospitals work at a sub-optimal level of scale, so the staff required are not efficiently used – due to a sub-optimal level of usage, and because the buildings were often designed for different purposes, resulting in excessive operating costs.

The issues driving the sustainability and quality challenge for estates are summarised below:

- **The distribution of facilities.** The location of the current facilities is largely a legacy of historical decisions the rationale for which has long been lost. *The inclusive planning approach with local communities should inform how we approach this challenge.*

- **Purpose-built facilities.** Much of the estate has been adapted for its present usage. In some instances, this has involved updating old health buildings, but in many cases it has required the conversion of other buildings, typically houses. The result is that many are not suitable for delivering healthcare services. *Making optimum use of existing fit-for-purpose building stock can provide a short-term solution whilst a longer-term solution is worked up.*
- **Space and building condition.** There is a mismatch between the size of many facilities and the size of the population that they serve, which can lead to cramped working, lack of privacy, infection control issues, low-space utilisation, or inflated running costs (e.g. rent, rates, cleaning). Additionally, the age and maintenance regime of buildings varies widely. Buildings can be non-compliant with current health guidance. The condition and suitability of the NHS Provider Trust and NHS Property Services estate is well understood, but less is known about the primary care estate. Finally, the current estate cannot readily accommodate change and a lack of coordination means there are no efforts to maximise the overall utilisation of the estate. *Making optimum use of existing fit-for-purpose building stock can provide a short-term solution whilst a longer-term solution is worked up.*
- **Accessibility.** Some facilities are inaccessible to parts of the patient population (e.g. there are facilities without lifts where clinical space is not confined to the ground floor). Additionally, many facilities are not well served by public transport and, or, there is a lack of dedicated staff and visitor parking. *The inclusive planning approach with local communities should inform how we approach this challenge.*
- **Lack of integration.** There is a lack of integrated service delivery, largely due to the distribution of the estate. Services are often delivered from too many buildings, making for poor patient experience, inefficient service delivery, and high costs. In addition, separate non-clinical support functions use space that could allow for some flexibility to achieve improved clinical adjacencies and to avoid further capital investment. *Developing skills and techniques to deliver a 'system' economic view of the costs of healthcare provision should inform how we approach this challenge.*
- **Estate ownership.** The majority of the North Cumbrian health estate is in the ownership of four organisations: Cumbria Partnership Foundation Trust (CPFT), NHS Property Services (NHS PS), North Cumbria University Hospitals Trust (NCUHT), and eLIFT Cumbria. However, many buildings are subject to freeholds or leaseholds held by GPs. The fragmented ownership structure makes the development and delivery of a single strategic estate plan more complex and difficult than necessary. The task is made more challenging where there are PFI contracts in place. *It will be important for the trusts to take action together on this.*
- **GP ownership** presents some very specific challenges with regard to the reconfiguring of the estate (*it is important to review the options around this*):
  - GP property income. For some GPs, buildings are a source of income and while this supports practice sustainability, it reduces opportunities for change.
  - Negative equity. Some practices are in negative equity, due to falling property values, accounting treatment or borrowing against the property. There are provisions to use local discretion and find local solutions to facilitate estate restructuring, however this is becoming more difficult.

- Planning blight. With the uncertainty of practice income and the high level of retirements anticipated in the next five years, there is a reluctance among many practices to commit to the considerable effort associated with moving to new premises. There are also indications that the younger incoming workforce is generally less likely to wish to invest in buying buildings.
- Understanding of existing costs. The costs associated with any one building often lie with different organisations meaning that there is a lack of understanding of the true costs of occupation (and under-utilisation) associated with that building. Subsequent attempts to quantify the cost of the health estate in North Cumbria have reinforced the extent to which this is a problem.

# SECTION C

## How do we get there?

This section explores identified options, determines preferred options and makes the case for development and implementation through a process of consultation.

### Section checklist

#### Options development

Shortlisting

Appraisal – evaluation and assessment

Preferred options

#### Implementation planning

Consultation planning

Governance

Risks

Dependencies

Next steps

Post-programme evaluation planning



## 5 ESTABLISHING A SHORTLIST OF OPTIONS

*Chapter Five outlines the process used to consider options for service change where we believe there are important choices to be made that should be tested through formal public consultation (as identified in Chapter Four). Specifically, we consider options for the provision of emergency and acute medicine and paediatric and maternity services across our two acute hospital sites. We also consider options for the provision of community inpatient beds. The process used to determine a short list for each service area is outlined.*

### 5.1 Introduction

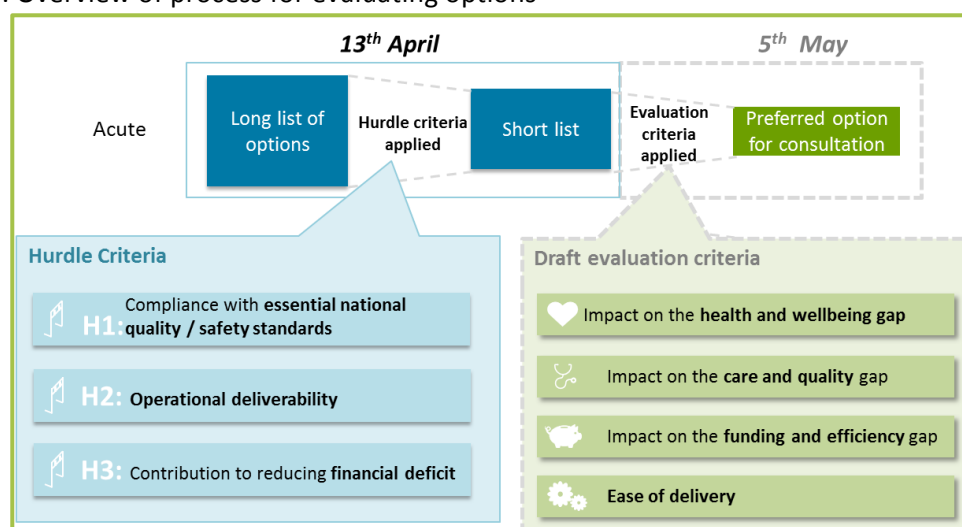
As detailed in Chapter Four, clinical workstreams have been working since September 2015 to consider the opportunities to improve services across WNE Cumbria. They have identified a number of areas where the current configuration of services may not be optimal to achieve improved outcomes nor sustainable in terms of workforce, efficiency and effectiveness. These areas include the service model for our community hospital inpatient beds, emergency and acute medical care at CIC and WCH and paediatric and maternity care at CIC and WCH.

Through these discussions, a significant number of options have been considered, which through a process of clinical engagement, informed by engagement feedback, have in turn informed the development of a long list of options. These focus on the potential changes that could be made, ranging from the 'Do Nothing' option to more significant changes.

### 5.2 Process for Consideration of Options

Working with the WNE Cumbria Success Regime and key stakeholders, we have developed a two-stage process for identification of preferred options from long lists. This includes the application of a set of 'hurdle criteria', then a more detailed set of evaluation criteria to appraise short-listed options. The outcome of this process is to enable the CCG, through the WNE Cumbria Success Regime Programme Board, to determine preferred options for each area that will be subject to full public consultation. The two-stage process is set out in Figure 49 below.

Figure 49: Overview of process for evaluating options



Source: WNE Cumbria Success Regime

### 5.2.1 The 'Hurdle Criteria'

The 'hurdle criteria' are in line with NHS England's Five Year Forward View and were signed off by the CCG governing body in April 2016. The purpose of the 'hurdle criteria' is to eliminate any options assessed as not being able to satisfy any one of the three hurdles, using a binary pass/fail process:

**Hurdle 1: compliance with essential national quality / safety standards within two years:**

- Can this option meet a minimum level of safety?
- Can this option meet required quality standards?

**Hurdle 2: operational deliverability within two years**

- Are the staffing assumptions for this option credible?
- Is the training requirement for this option feasible?

**Hurdle 3: contribution to reducing financial deficit within five years**

- Can this option be delivered with the capital funding we can secure?
- Can this option make a net positive contribution to the 2020/21 forecast gap?

The application of the 'hurdle criteria' and the testing of the process of moving from long-list to short-list benefited from engagement with patient and public representatives, health and social care experts and programme and clinical boards. The table below summarises activities.

Date	Event	Attendees	Objectives	What was achieved
13 <sup>th</sup> April	Acute options: long list to shortlist workshop	Representatives from CCG, NCUHT, CPFT, primary care, social care and the public	Apply hurdle criteria and recommend options for removal to the Programme Board	Two options recommended to be removed from the long list
13 <sup>th</sup> April	Community hospitals engagement workshop	Representatives from social care, CPFT estates, NCUHT, primary care and League of Friends	Socialise the options for the future for future options	A long list of options for community hospital bed configuration
14 <sup>th</sup> April	Programme Board	Success Regime Programme Board members	Confirm the short list of options	Two options agreed to be removed from the long list
14 <sup>th</sup> April	Clinical Advisory Group	SR Medical Director and selected clinicians	Apply clinical perspectives to acute option shortlist	Acute shortlist confirmed and reframed
20 <sup>th</sup> April	Acute Task and Finish group	Clinical leaders and senior managers from NCUHT	Incorporate clinical insight to the shortlist and provide preliminary evaluation feedback	Received feedback on clinical aspects of shortlist
21 <sup>st</sup> April	Community hospitals task and finish group	Representatives from social care, CPFT estates, CCG, NCUHT	Application of hurdle criteria to CH bed long list of options	Recommended shortlist of options for community bed configuration
25 <sup>th</sup> April	Programme Executive Board	Representatives from CCG, NCUHT and SR Medical Director	Repackage the acute options shortlist into distinct service configurations to facilitate evaluation	Repackaged acute service shortlist
28 <sup>th</sup> April	Programme Board	Success Regime Programme Board members	Sign off the short list for acute and community hospital beds	Short list for acute and community hospitals signed off

### 5.3 Community Hospitals Inpatient Bed Options

In considering the options for community hospital inpatient beds, it has been recognised that these must be seen in the context of the changing needs of the population and the wider changes being considered to support safe and sustainable health and care services in WNE Cumbria. While community hospitals are considered primarily as having beds, as we develop strengthened out of hospital care, they have a much broader role in the context of ICCs – acting as natural hubs, providing a focus for the delivery and co-ordination of care.

This section focuses on options for community hospital inpatient beds, which should be considered in the context of the paper prepared for the WNE Cumbria Success Regime – which

outlines in greater detail the rationale for our approach and our vision for community hospitals in WNE Cumbria attached at Appendix H.

In considering the configuration of community hospital inpatient beds, a long list of options has been scoped. The options consider all the possible ways in which we could provide clinical care for patients who have a level of need that cannot currently be supported safely in their own home, but which does not require admission or an extended stay in an acute hospital bed (often referred to as step up care/step down care). The options have been informed by a set of principles developed through discussions with staff and stakeholders and endorsed through the WNE Cumbria Success Regime (see Figure 50 below).

Figure 50: WNE Cumbria Principles for the planning of community hospital inpatient beds.

#### **WNE Cumbria Principles for the planning of community hospital inpatient beds**

- Wherever possible, people should be supported in their own homes. Admission to hospital, including community hospitals, should be on the basis of clinical need.
- As the ICC model is embedded across WNE Cumbria, a proactive approach to supporting people living with frailty and the provision of end of life care should reduce the need for hospital admission and therefore the need for inpatient care, including care in community hospital inpatient beds.
- In order to be deliverable – in particular with regard to workforce resilience – any community hospital site providing inpatient care should have a minimum of 16 inpatient beds, with 24 or 32 beds being optimal.
- Any site requiring capital investment must deliver a net contribution to reducing the system's deficit in the long term, through increasing operational cost savings.

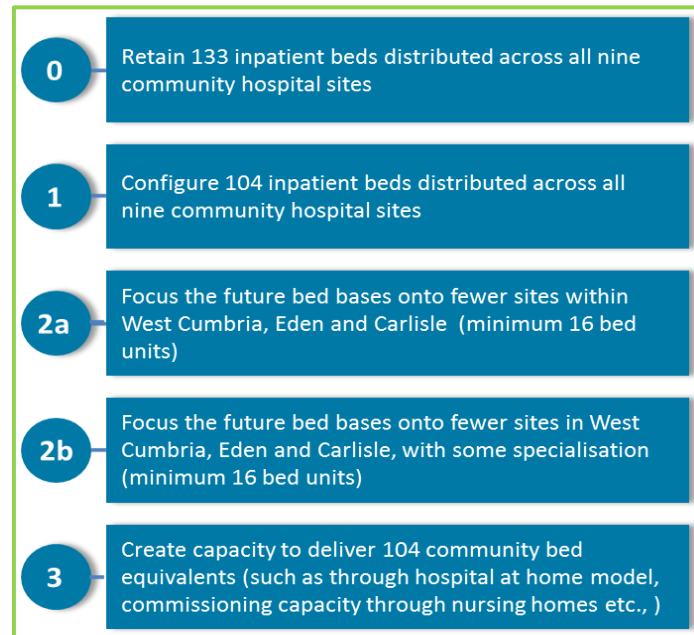
In considering the needs of the population, a review of community hospital inpatient capacity has been undertaken using benchmark information from other rural and remote areas, and local data such as the Oak Group audit. This has suggested that WNE Cumbria currently has a significantly higher number of community hospital inpatient beds compared to most other areas in England. (Based on a population of 330,000, and making a presumption that the beds are used appropriately, WNE Cumbria the data would indicate the need for 84 community hospital beds, compared with 133 beds currently).

The numbers above do not include end of life care, and we have recognised the important role of WNE community hospitals in supporting end of life care. Our bed modelling has therefore included provision for palliative and end of life care based on the needs identified in the local plans. The result of this work has suggested that we should plan for 102 community inpatient beds or bed equivalents.

Reflecting opportunities for improved efficiency across the whole system to reduce bed capacity, and with the development of ICCs, we have concluded that the optimal number of community inpatient beds, or bed equivalents at this point in time is 102 (increased to 104 to reflect the requirement for a multiple of eight based on NICE guidelines in relation to safer staffing which indicates that bed numbers are most efficient in multiples of eight, with 16-bed wards being the minimum and 32 beds the maximum).

A long list of five options was developed by the Clinical Working Group and discussed with stakeholder representatives. See Figure 51 below.

Figure 51: Identified community hospital inpatient bed options



Source: WNE Cumbria Success Regime

The 'hurdle criteria' were applied to identify any options not able to meet the minimum requirements set by the CCG. The outcome of this is summarised in Figure 52 below.

Figure 52: Application of the 'hurdle criteria' to community inpatient bed long list options

			Quality	Deliverability	Finances
<b>0</b>	<b>FAIL</b>	Retain 133 inpatient beds distributed across all nine community hospital sites	Yellow circle	Red circle	Red circle
<b>1</b>	<b>FAIL</b>	Configure 104 inpatient beds distributed across all nine community hospital sites	Yellow circle	Red circle	Red circle
<b>2a</b>	<b>PASS</b>	Focus the future bed bases onto fewer sites within West Cumbria, Eden and Carlisle (minimum 16 bed units)	Green circle	Green circle	Yellow circle
<b>2b</b>	<b>PASS</b>	Focus the future bed bases onto fewer sites in West Cumbria, Eden and Carlisle, with some specialisation (minimum 16 bed units)	Green circle	Green circle	Yellow circle
<b>3</b>	<b>PASS</b>	Create capacity to deliver 104 community bed equivalents (such as through hospital at home model, commissioning capacity through nursing homes etc., )	Yellow circle	Yellow circle	Yellow circle

The application of the 'hurdle criteria' confirms that the 'do nothing' option is not considered to be viable as it fails two of the three tests. It fails the financial hurdle due to its inability to make any contribution to the financial deficit.

In relation to operational deliverability, the initial judgement regarding suitability of current community hospital sites for future sustainability is:

- It would be prohibitive to expand two of the current sites to support the minimum of 16 beds (Maryport Community Hospital and Alston Community Hospital);
- Wigton is assessed as no longer being suitable for long-term provision of inpatient beds, with minimal scope to address current issues given the estates condition.

The remaining options pass the hurdle criteria and have been confirmed as the short list of options to be taken forward for detailed appraisal. There is recognition that the opportunity of creating 'virtual beds' capacity will need to be considered at a local level as the development of ICCs is progressed, and this therefore should be progressed differentially across WNE Cumbria.

The short list of options for community inpatient beds for formal evaluation agreed by the WNE Cumbria Success Regime Programme Board is set out overleaf (this relates to the possible configuration of 102 (plus the additional two beds to reflect NICE guidelines) inpatient beds – the number could be reduced if bed equivalent capacity is proposed).

Figure 53: Community hospital options

NOTE: "Do nothing" did not pass the hurdle criteria

		Do nothing	1 New ways of working	2 Partial consolidation		3 Full consolidation
		Nine CH sites	Minimal consolidation of beds to six sites across WNE Cumbria	Consolidation around 5 sites, with effective use of other sites (inc. Cockermouth)	Consolidation around 5 sites, with effective use of other sites (inc. Workington)	Full consolidation around three sites, with effective use of other sites
West Cumbria	Copeland	15 beds inpatient beds	16 beds	32 beds	32 beds	48 beds
	Cockermouth	11 inpatient beds Other CH services	16 beds Enhanced ICC Hub	16 bed unit Enhanced ICC Hub	Enhanced ICC Hub NB The two GPs are already located in the hospital	Enhanced ICC Hub NB The two GPs are already located in the hospital
	Workington	14 beds Other CH services	16 beds Enhanced ICC Hub	ICC Hub Relocation of GP premises	16 bed Enhanced CH Services	ICC Hub Relocation of GP premises
	Maryport	13 beds Other CH Services	Enhanced ICC Hub	Enhanced ICC Hub	Enhanced ICC Hub	Enhanced ICC Hub
East Cumbria	Penrith	28 beds Other CH services		24 beds Enhanced ICC Hub		
	Alston	6 beds Other CH services		Integrated health and social care hub		
North Cumbria	Brampton	15 beds		16 beds Enhanced ICC Hub		Enhanced ICC Hub
	Wigton	19 beds		Enhanced ICC Hub		
	Keswick	12 beds		16 beds Enhanced ICC Hub		Enhanced ICC Hub
	New site					32 beds either using o capacity at CIC or o new build
Total number of beds		133 beds	104 beds	104 beds	104 beds	104 beds

Source: WNE Cumbria Success Regime



## 5.4 Acute Hospital Services

Our hospital-based services must work seamlessly across the two sites, and also increasingly with Out of Hospital services. We must support the development of strong clinical networks within WNE Cumbria, and beyond, particularly with the Newcastle upon Tyne Hospitals (NUTH) and with Northumbria Healthcare (NHFT) NHS Foundation Trusts. The principles underpinning any future configuration of services are:

- We must be able to provide safe, effective, patient-focused, compassionate care at all times.
- Our services must be compliant with regulatory and quality standards.
- Services should be provided locally where possible and consolidated where necessary.
- We will eliminate waste and will aim to develop 'one stop' services; and
- Specialty support should be available where needed and can be secured through new and innovative approaches (e.g. visiting consultants, 'virtual clinics').

As we have considered the future configuration of acute hospital services we have also taken in to account service co-dependencies. For example, A&E, intensive care and acute medicine are inter-reliant; to function as a Trauma Centre requires A&E, intensive care, general surgery, trauma and orthopaedics, blood products, laboratory and radiology support. Equally, consultant obstetric provision requires support from anaesthetics, ITU, and paediatrics and there are limitations in operating without the support of the range of other surgical specialties, creating interdependencies for general surgery, gynaecology, T&O, ortho-geriatric, and endoscopy. We have used the South East Coast Clinical Senate report *The Clinical Co-Dependencies of Acute Hospital Services: A Clinical Senate Review* to inform our work.<sup>43</sup>

The process of developing options for acute hospital services was informed by the response to the CQC developed by the Success Regime, which made reference to a number of possible scenarios. (See Appendix I). These scenarios informed the development of a long list of options which considered different combinations of acute services configurations across the two hospital sites, focusing specifically on those areas where there was recognised as being possible optionality as set out in Chapter Four.

It was explicitly recognised in all options that both hospital sites would continue to provide a range of core services for their local catchment populations, specifically:

- 24/7 urgent care services providing walk in minor illness and minor injury services.
- Elective surgical care.
- Full outpatient and ambulatory services aligned to local need (and in line with new pathways).
- Comprehensive diagnostic services including radiology and access to pathology support.
- Relevant clinical support services to support inpatient and outpatient activity.

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<sup>43</sup> South East Cost Clinical Senate, *The Clinical Co-Dependencies of Acute Hospital Services: A Clinical Senate Review*, December 2014

It was also recognised that all options must support the strengthening of specialised service networks linking with the NUTH, NHFT, and other neighbouring providers.

The long list of options focused specifically on emergency and acute medical care and paediatric and maternity care. This long list was considered in detail at a stakeholder event on 13<sup>th</sup> April at which the potential combinations of services that could be delivered at each acute hospital site were considered (see Figure 54).













**Option 1** builds on the status quo, describing a configuration that maintains core acute services at both sites, delivered through innovative workforce solutions and modernised ways of working with minimal reconfiguration.

**Options 2 to 6** progressively consolidate more acute services onto one site, demonstrated as consolidation onto the CIC site. Thus option 6 has all acute services at CIC, with an Urgent Care Centre, antenatal maternity services and an elective centre of excellence at WCH.

**Option 7** is an example configuration of switching the primary acute site from CIC to WCH. This could be any combination of options 2 to 6, with 24/7 A&E and all non-elective medicine, a consultant-led maternity unit, inpatient paediatrics and frail elderly unit at WCH and CIC as an elective centre of excellence.

Finally, the option to relocate all acute services to one new build site was also described (**Option 8**). No location in WNE Cumbria was proposed for this new site.

Figure 54: Long List Options Considered at the 13<sup>th</sup> April Event

Option	CIC						WCH					
												
	A&E	Non-elective	Maternity	Paediatrics	Elective	Frail elderly	A&E	Non-elective	Maternity	Paediatrics	Elective	Frail elderly
① Maintain existing services at CIC & WCH, and add MLUs to both sites	24/7 A&E	All non-elective	CLU with SCBU & MLU	Inpatient and SSPAU	Acute and complex	Unit and inpatient beds	24/7 A&E	Some complex is transferred	CLU with SCBU & MLU	Inpatient and SSPAU	Low risk surgery	Unit and inpatient beds
② Maintain existing services at CIC & WCH, but change WCH's CLU to an MLU	24/7 A&E	All non-elective	CLU with SCBU & MLU	Inpatient and SSPAU	Acute and complex	Unit and inpatient beds	24/7 A&E	All complex transferred	MLU	14 hr SSPAU; low acuity beds	Low risk surgery	Unit and inpatient beds
③ Selected "blue light" cases and higher-risk maternities at CIC	24/7 A&E	All non-elective	CLU with SCBU & MLU	Inpatient and SSPAU	Acute and complex	Unit and inpatient beds	24/7 A&E with more transfers	All complex transferred	MLU	14 hr SSPAU, low acuity beds	Low risk centre of excellence	Unit and inpatient beds
④ Selected "blue light" cases, reduced A&E hours and all maternity at CIC	24/7 A&E	All non-elective	CLU with SCBU & MLU	Inpatient and SSPAU	Acute and complex	Unit and inpatient beds	Daytime A&E	All complex transferred	Outpatient	14 hr SSPAU, low acuity beds	Low risk centre of excellence	Non-acute beds
⑤ All acute services at CIC, MLU at WCH	24/7 A&E	All non-elective	CLU with SCBU & MLU	Inpatient and SSPAU	Acute and complex	Unit and inpatient beds	UCC	Complex and some non complex transferred	MLU	14 hr SSPAU	Low risk centre of excellence	Non-acute beds
⑥ All acute services & maternity/ paed at CIC	24/7 A&E	All non-elective	CLU with SCBU & MLU	Inpatient and SSPAU	Acute and complex	Unit and inpatient beds	UCC	Complex and some non complex transferred	Outpatient		Low risk centre of excellence	Non-acute beds
⑦ All acute services and higher risk maternities at WCH	UCC	Complex, some non complex transferred	MLU	14 hr SSPAU	Low risk centre of excellence	Non acute beds	24/7 A&E	All non-elective	CLU with SCBU & MLU	Inpatient and SSPAU	Acute and complex	Unit and inpatient beds
New site												
⑧ All acute services relocated to new site	24/7 A&E	All non-elective	CLU with SCBU & MLU	Inpatient and SSPAU	Acute and complex	Unit and inpatient beds						

Note: darker colours reflect the relative intensity of a service

The application of 'hurdle criteria' to the long list of options led to the recommendation to eliminate Options 7 and 8 (see Figure 55 below).

Option 7, which proposed making WCH the primary site for acute hospital services fails two of the three hurdle criteria. It is not considered to be operationally deliverable on the basis that it will exacerbate the workforce issues. It also fails the financial hurdle as a result of patient choice resulting in significant activity going out of area and capital affordability.

While Option 8 – consolidating all acute services on to a new build site – was assessed as meeting the first hurdle in relation to essential quality and safety standards, and in terms of operational deliverability, we recognise that the capital investment required would not enable the delivery of a safe and sustainable service within the five-year timeframe we have set ourselves.

The 'Do Nothing' option has also been considered and rejected other than for comparison purposes as the current model is not performing against safety, workforce or financial criteria.

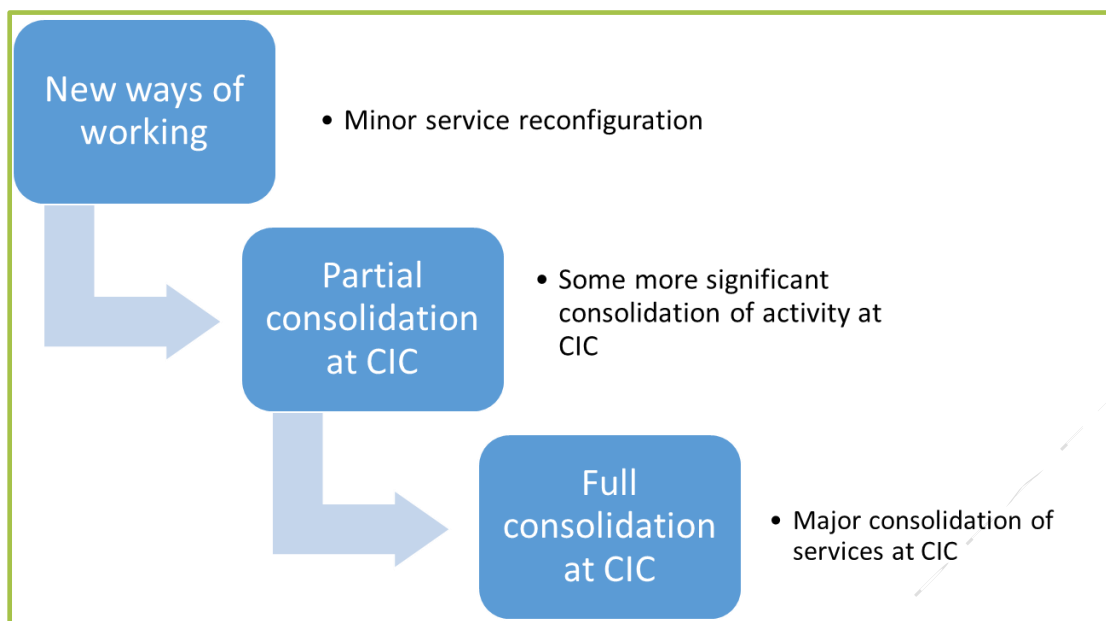
Figure 55: Summary of application of hurdle criteria to the long list of acute service options

Option	Hurdle			Pass / Fail	Reason
	1	2	3		
1	●	●	●	PASS	Innovative workforce solutions and modernised ways of working to maintain core acute services at both sites could be deliverable.
2	●	●	●	PASS	Downgrading the consultant led maternity unit at WCH to a midwife led unit, and directing high risk maternity to CIC, could improve patient safety and outcomes.
3	●	●	●	PASS	Direct transfer of pre-agreed categories of emergency patients, as well as higher-risk maternities, to CIC could further improve patient safety and outcomes.
4	●	●	●	PASS	Reducing A&E hours at WCH and consolidating all maternity at CIC would have a significant impact on operational costs and workforce pressures.
5	●	●	●	PASS	Consolidating all acute medicine at CIC with an Midwife led maternity unit at WCH would deliver operational improvements, although the safety of a standalone MLU was questioned.
6	●	●	●	PASS	Consolidating all non-elective services at CIC has the highest impact on workforce pressures and operational efficiencies due to economies of scale, but raises concerns around accessibility to the single emergency site.
7	●	●	●	FAIL	Making WCH the primary site would exacerbate workforce issues and a significant proportion of activity would be delivered out-of-area, limiting the savings achievable. Capital investment would also be needed to develop the WCH site.
8	●	●	●	FAIL	Consolidating all acute services onto a new build site was eliminated as the capital investment requirement is not likely to be available, and it would not deliver a sustainable service within the next two years.

In order to facilitate evaluation of the remaining options, emergency and acute medicine options were considered separately from maternity and paediatric service options, recognising that there is little interdependency between them.

In each case, we believe that there are three broad potential options (in addition to "Do Nothing", which was discounted as an option as it did not pass the 'hurdle criteria'):

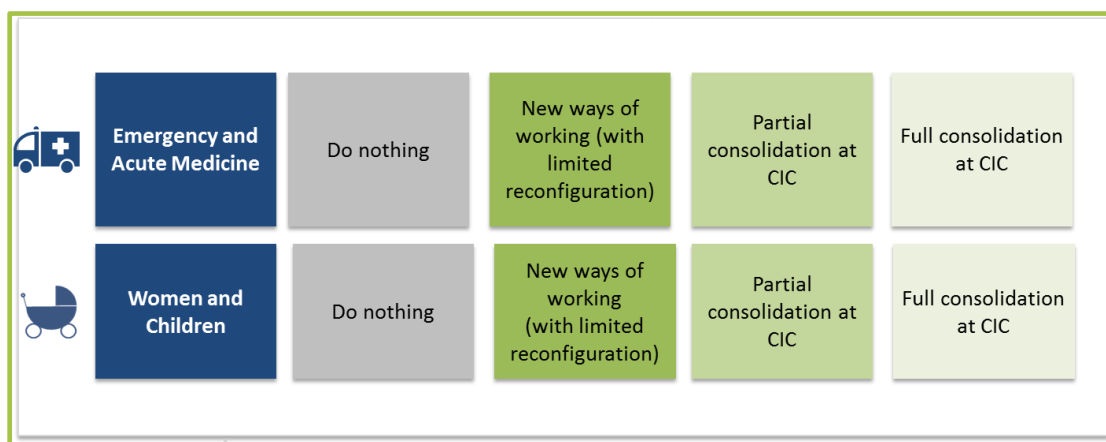
Figure 56: Options for evaluation



Source: WNE Cumbria Success Regime

This resulted in the following shortlist of options to evaluate:

Figure 57: Options to evaluate



Source: WNE Cumbria Success Regime

A summary of the emergency and acute medical care and women and children shortlist options, and what they would mean in service terms is summarised in Figures 58 and 59 below.

Figure 58: Emergency and acute medical care – options for assessment

Emergency and Acute Medical care – options for assessment								
NOTE: “Do nothing” did not pass the hurdle criteria	Do nothing		1 New ways of working		2 Partial consolidation		3 Full consolidation	
	WCH	CIC	WCH	CIC	WCH	CIC	WCH	CIC
A&E	24/7 A&E	24/7 A&E	24/7 A&E	24/7 A&E	Daytime A&E	24/7 A&E	UCC	24/7 A&E
Non elective	Acute medicine	Surgery, trauma and acute medical	Reduced complexity	Surgery, Trauma I and complex medical	Ambulatory and selected GP admissions	All surgical, trauma and acute medical	Ambulatory	All acute non elective
Frail Elderly	Inpatient and rehab	Inpatient and rehab	Frailty assessment inpatient & rehab	Assessment and inpatient	Frailty assessment, step up and rehab	Frailty Assessment, inpatient and rehab	Frailty assessment, step up and rehab	Frailty Assessment, inpatient and rehab
What this means for ICCs	<ul style="list-style-type: none"><li>Limited alternatives to admission.</li></ul>		<ul style="list-style-type: none"><li>ICCs providing alternatives to admission and proactive care to those at risk of admission, and early supported discharge.</li><li>Maximising efficiency and networks with community hospital beds</li></ul>					
What this means for CIC	<ul style="list-style-type: none"><li>24/7 A&amp;E.</li><li>Centre for surgical non elective and trauma and some complex medicine.</li><li>Hyper acute stroke care.</li><li>Inpatient beds and rehab including specialist rehab.</li></ul>		<ul style="list-style-type: none"><li>24/7 A&amp;E with UCC streaming</li><li>Integrated emergency floor, including hot clinics.</li><li>Minor increase in ICU, EAU and inpatient specialty beds.</li><li>Hyper acute stroke unit and ASU.</li><li>Frailty assessment unit and rehab including specialist rehab.</li></ul>		<ul style="list-style-type: none"><li>Increased capacity in 24/7 A&amp;E with UCC streaming.</li><li>Integrated emergency floor, including hot clinics.</li><li>Increase in ICU, EAU and inpatient specialty beds.</li><li>Hyper acute stroke unit and ASU.</li><li>Frailty assessment unit and rehab including specialist rehab.</li></ul>		<ul style="list-style-type: none"><li>Significant increase in capacity in 24/7 A&amp;E to take all blue light ambulances, with UCC streaming.</li><li>Integrated emergency floor, including hot clinics.</li><li>Increase in ICU, EAU and inpatient specialty beds.</li><li>Hyper acute stroke unit and ASU.</li><li>Frailty assessment unit and rehab including specialist rehab.</li></ul>	
What this means for WCH	<ul style="list-style-type: none"><li>24/7 A&amp;E.</li><li>Selected transfers (all emergency surgery, trauma and small number of medicine diversions).</li><li>Hyper acute stroke care.</li><li>ICU.</li><li>Inpatient beds and rehab.</li></ul>		<ul style="list-style-type: none"><li>Integrated emergency floor with UCC streaming, including hot clinics &amp; day time specialty support</li><li>Selected admissions for complex patients where no advantage to transfer.</li><li>Limited provision of low risk non elective surgery and trauma</li><li>Small ICU.</li><li>Frailty Assessment unit and rehab.</li></ul>		<ul style="list-style-type: none"><li>Daytime A&amp;E with UCC 24/7, including hot clinics and day time specialty support</li><li>Selected blue light admissions and GP referrals during day time.</li><li>Limited provision of low risk non elective surgery and trauma</li><li>No ICU, but day time intensivist support.</li><li>Frailty assessment, non complex admissions and rehab.</li></ul>		<ul style="list-style-type: none"><li>UCC only with access to hot clinics and day time specialty support.</li><li>Ambulatory and “step up” inpatient care only, no acute admissions.</li><li>No ICU.</li><li>Frailty assessment, non complex admissions and rehab.</li></ul>	
Other (Tertiary)	<ul style="list-style-type: none"><li>Strong networks with Newcastle and Northumbria</li></ul>		<ul style="list-style-type: none"><li>Strong networks with Newcastle and Northumbria</li></ul>					



Figure 59: Women and Children's services – options for assessment

NOTE: “Do nothing” did not pass the hurdle criteria

	Do nothing		1New ways of working	2Partial consolidation	3Full consolidation			
	WCH	CIC	WCH	CIC	WCH	CIC		
Paediatrics	Full Inpatient	Full Inpatient	14 hour SSPAU; low acuity beds	14 hour SSPAU and Inpatient	14 hour SSPAU	Inpatient and SSPAU	Outpatient only 9-5 hot clinic	Inpatient and SSPAU
Maternity	Full obstetric	Full obstetric	Low risk CLU and MLU	CLU and MLU	MLU	CLU and MLU	Ante and post natal only	CLU and MLU
What this means for ICCs	<ul style="list-style-type: none"><li>Birthing centre at Penrith.</li><li>Community midwifery service including some antenatal and post natal care.</li></ul>		<ul style="list-style-type: none"><li>Integrated child health model including paediatric nursing teams reducing need for hospital care.</li><li>Continued antenatal care provided in the community through strengthened ICC networks, IT enabled where possible.</li></ul>					
What this means for CIC	<ul style="list-style-type: none"><li>Full outpatient service and inpatient paediatric services.</li><li>Consultant led obstetric service, and SCBU.</li></ul>		<ul style="list-style-type: none"><li>Full outpatient service, 14 hour SSPAU and inpatient paediatric beds with some marginal increase in beds)</li><li>Consultant led obstetric service, with MLU and SCBU with marginal increase in beds</li></ul>	<ul style="list-style-type: none"><li>Full outpatient service, 14 hour SSPAU and inpatient paediatric beds with increased inpatient beds.</li><li>Consultant led obstetric service, with MLU and SCBU with increase in beds and access to second theatre.</li></ul>	<ul style="list-style-type: none"><li>Full outpatient service, 14 hour SSPAU and inpatient paediatric beds with increased inpatient beds.</li><li>Consultant led obstetric service, with MLU and SCBU with increase in beds and access to second theatre.</li></ul>			
What this means for WCH	<ul style="list-style-type: none"><li>Full outpatient and inpatient paediatric services.</li><li>Consultant led obstetric service and SCBU.</li></ul>		<ul style="list-style-type: none"><li>Full outpatient service and 14 hour SSPAU with low acuity beds.</li><li>Early pregnancy assessment unit, outpatients and “lower risk” CLU &gt; 34 weeks.</li></ul>	<ul style="list-style-type: none"><li>14 hour SSPAU and outpatient services.</li><li>Antenatal / post natal and early pregnancy assessment unit and MLU.</li></ul>	<ul style="list-style-type: none"><li>Outpatient paediatric service with 9-5 hot clinic facility.</li><li>Antenatal / post natal and early pregnancy assessment unit. Birthing centre</li></ul>			
Other / Specialist	<ul style="list-style-type: none"><li>Tertiary and highly specialist paediatric and obstetric care networked with Newcastle.</li></ul>							

NOTE: "Do nothing" did not pass the hurdle criteria



## 5.5 Summary and Conclusion

There has been considerable work undertaken to weigh up the options for key service areas where the clinical workstreams have identified the potential need for major service change. An initial exercise by clinical workstreams considered an exhaustive list of all the options, before an initial clinical assessment was used to identify the long list of viable options.

The long list of options for community hospital beds, emergency and acute medical care, and maternity and paediatric services were developed through significant discussion and analysis of different scenarios. These options have been subject to an assessment against three hurdle criteria to create a shortlist of options for detailed appraisal. The shortlisted options are further detailed in Chapter Six.

## 6 APPRAISING OUR SHORTLISTED OPTIONS





*This chapter describes the evaluation criteria used to appraise the shortlist of options for community hospitals, emergency and acute medicine and women and children's services, and how we have applied our criteria to establish preferred options.*

### 6.1 Evaluation Criteria

To arrive at our preferred options, we have undertaken an appraisal process to better understand the potential impact and opportunity associated with each.

The appraisal criteria were agreed by the CCG Governing Body meeting on 6 April 2016 subject to testing and confirmation at the Success Regime engagement workshop on 13 April 2016. They are based on the three gaps highlighted in the NHS Five Year Forward View, with an additional criterion to enable assessment of ease of delivery. The four criteria are equally weighted. The table below summarises the evaluation criteria.

Figure 60: Summary of evaluation criteria and potential areas for consideration

 Impact on the health and wellbeing gap within two years	<ul style="list-style-type: none"> <li>Public health outcomes</li> <li>Health inequalities, including access</li> </ul>
 Impact on the care and quality gap within two years	<ul style="list-style-type: none"> <li>Patient safety</li> <li>Clinical outcomes</li> <li>Patient experience</li> </ul>
 Impact on the funding and efficiency gap within five years	<ul style="list-style-type: none"> <li>Operating costs and profitability</li> <li>Capital requirements</li> </ul>
 Ease of delivery	<ul style="list-style-type: none"> <li>Timescale for implementation</li> <li>Likelihood of retaining/recruiting required workforce</li> </ul>

Source: Success Regime

#### 6.1.1 Our Approach to Assessing the Impact on the Health and Wellbeing Gap

To assess the impact of each option on the health and wellbeing gap, the main groups whose health and wellbeing may be impacted (in a positive or negative way) by the proposed options have been identified. (See **Appendix G** for details.) For example, the options in relation to women and children's services have focused on the impact for pregnant women and babies, while community hospital inpatient options have considered the impact particularly on older people living with frailty and their carers.

For emergency and acute medicine, we consider people with conditions who are most likely to access accident and emergency departments and people who require rapid access to medical care.

For all options we have given particular attention to people living in rural areas and people with protected characteristics.

A range of public health datasets have been identified for WNE Cumbria relevant to these groups to support the assessment and the potential impact of the options. In reviewing these data sets, it is of particular note that:

- In West Cumbria — several measures of deprivation are higher than the England average. (See **Appendix F** for full profile of each area in WNE Cumbria).
- The population in West Cumbria is rapidly ageing, suggesting that changes in the way that services are provided will particularly affect the elderly, and their relatives. 21.7% of the population in Allerdale are over 65 years old (Copeland = 19.8%) compared to 16.9% in England. Population projections estimate an increase of 2500 persons (11.9%) over 65 in Allerdale by 2017 and 1700 (12.1%) in Copeland<sup>44</sup>.

A number of overarching key themes were established through a review of the evidence:

- Consolidating services can deliver better public health outcomes if the consolidation achieves improved clinical outcomes. These benefits can be offset if travel and access risks are not mitigated.
- People living in areas of high deprivation will generally experience poorer health and wellbeing.
- Changes to services can impact on the health and wellbeing of carers and family members, as well as patients e.g. accessibility to respite and ability to make hospital visits.
- People living in rural areas may experience more stress, anxiety and cost than those living in urban areas, if access to services close to home is reduced.
- The analysis suggests the proposed options would not significantly impact on health and wellbeing linked to the following protected characteristics: ethnicity, sexual orientation, gender reassignment, religion and belief. However, some of the proposed options may impact on disabled people, women, children and young people, pregnancy/maternity and older people (aged 65+). This is explored in more detail in Chapter 8 with recommendations and mitigations.

### 6.1.2 Our Approach to Assessing the Impact on the Care and Quality Gap

Assessment against the care and quality gap has considered the potential impact of each option on patient safety, patient outcomes and patient experience.

In developing the service options, it is recognised that each clinical workstream has considered the evidence available, and where appropriate has taken advice from the Clinical Advisory Group, the Senate and Royal Colleges.

To enable a better understanding of the impact of each option on patient access, an initial travel analysis has been completed to model the impact of the options. The emerging findings were used to inform the evaluation process.

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<sup>44</sup> ONS

Overall, the evidence suggests that consolidation of services in WNE Cumbria could lead to higher patient safety, enable greater compliance with national standards, and better outcomes where it enables specialist expertise to be available. It also offers potential in the service areas being considered to improve access to specialist support in and out of hours recognising the relatively low volumes of activity associated with the current duplication of some services across the two acute hospital sites, both covering small catchment populations. These potential benefits in safety and outcomes must, however, be weighed against the increase in travel time and reduction in access to services for some of the population.

### 6.1.3 Our Approach to Assessing the Impact on the Finance and Efficiency Gap

Reconfiguration of services across acute care consists of the benefits obtained by maximising potential economies of scale across different hospital sites and redesigning the organisations' service offering.

The overall approach to the service reconfiguration modelling is summarised in **Appendix I**. This modelling approach and evaluation criteria also apply to community hospitals.

The future configuration of services needs to be affordable from a financial perspective for the system to be sustainable. Finance and efficiency has been considered in three ways:

#### Shortlist evaluation criteria

##### 1. Capital cost to the system

The first component of the financial assessment is the capital expenditure that would be required to deliver the option. Typically, this includes the costs of new buildings, equipment, IT infrastructure or the refurbishment of existing buildings for new purposes. The key question for the evaluation is:

*Which options would likely have the lowest capital costs?*

The indicators used for this assessment include:

- Estimated capital costs for new capacity, based on the number of additional beds that would likely be required for each site – this overall capital cost has been estimated at c. £225k per additional bed required, which accounts for the building of beds but also support and facilities; and
- Further additional capital costs for specific elements such as increased number of ambulances supporting greater ambulance transfers.

##### 2. Five year LHE income and expenditure (I&E)

The five year I&E position for the LHE is considered for each option, with reference to the 'Do Nothing' option. The key question for the evaluation is:

*Which options generate the greatest net savings over the 5-year period, i.e. which would reduce the financial challenge the most?*

The overall 'Do Nothing' I&E position could be impacted by each option by a number of factors.

- **Consolidation benefits.** As services are consolidated, greater economies of scale are achieved. Across health care services, economies of scale can occur through a number of sources including greater rota efficiencies and spreading minimum staffing requirements over a greater level of activity.
- **Service delivery impacts.** In a number of the options, the actual model of delivering care is significantly altered. For example, delivering emergency services to patients through a UCC rather than an A&E. When new models are employed, this can often lead to changes in costs above and beyond those related to scale.
- **Fixed cost savings.** There are a number of costs health care providers incur which are more fixed in nature as volume increase or decrease. These costs typically include the costs of estates and some back office functions. Although fixed in the short-run, changes to the clinical model and volumes could mean there are opportunities to re-size such costs. For example, reducing the number of sites where services are delivered could allow some estates to be divested whilst potentially requiring greater capital investment at receiving sites.
- **Clinical standards costs.** The do nothing scenario included significant investment required to achieve a number of clinical requirements, including in maternity services and to achieve seven day working. The changes in service delivery implied by the options could reduce this investment. Typically, this is the case where services are refocused around a smaller number of sites.
- **Additional running costs.** The options could lead to higher costs in a number of instances. For example, the increased requirement on ambulances transferring patients between hospital sites.
- **Overall capital cost charges.** As discussed above, capital costs may be required in order to realise some of the savings set out. These costs are included in the I&E as an annualised value encompassing depreciation and capital charges.
- **Efficiency stretch.** Additional cost efficiencies associated with the efficiency stretch are discussed in section 2.5.4. These could be unlocked given the level of transformation included in the different reconfiguration options, and if cost savings are targeted more significantly on reducing agency spend.

### 3. NPV

As set out in the Treasury Green Book<sup>45</sup>, the key measure in understanding the relative economics of the different options is the Net Present Value (NPV). This measure looks at all the flow of costs and benefits over the period resulting from an option accounting for the higher value placed on more near term impacts. The NPV considered; transition costs, ambulance costs, consolidation

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<sup>45</sup> See [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/220541/green\\_book\\_complete.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/220541/green_book_complete.pdf)

saving and fixed cost savings amongst others. By estimating a single value for each option, NPVs allow the financial benefits (or costs) of the options to be easily compared to each other and assessed against the base case.

The key assumptions around the NPV are:

- A 20-year time period is assumed.
- A discount rate of 3.5% has been applied.
- Recurrent cash flows in years subsequent to year 5 have been held constant at the year 5 level.
- After full depreciation, the value of assets is zero.

#### 6.1.4 Our Approach to Assessing the Ease of Delivery

The assessment of ease of delivery has focused on the impact on the workforce – specifically in relation to the medical and nursing workforce. It has also included a high level view on the likely time and complexity of implementation.

The workforce analysis has been undertaken by the Workforce Repository and Planning Team (WRaPT) using Electronic Staff Records from NCUHT and CPFT, creating clinical units to reflect clinical reality, aligned to activity data and the proportion of activity performed by bank and agency staff. The proposed changes were modelled for each service option.

Implementation has been assessed through mapping the dependencies associated with each option and considering the feedback from the engagement undertaken to understand the views and concerns of both staff and public.

The key themes emerging include:

- Consolidating services can significantly improve workforce pressures and improve workforce resilience. This is because fewer total staff will be required to run a large consolidated service than multiple low volume services, and rota frequency can be more attractive to both current staff and new recruits.
- Consolidation may result in a surplus of highly skilled nurses, providing opportunities for enhancing the skillset of nursing staff and other allied health professionals, for example advance nurse practitioner (ANP) training.
- Where there are national shortages of groups of staff or roles, regardless of any of the proposed models, it would still be difficult to recruit if additional clinical staff are required.
- The public and staff are anxious about change that may affect patterns of access, particularly in West Cumbria.

#### 6.1.5 Summary

An assessment of each of the short-listed options for each service area has been undertaken, building on the methodologies outlined above. The results were tested through a stakeholder workshop held on 5<sup>th</sup> May 2016.

## 6.2 Appraising the Options for Community Hospital Inpatient Beds

### 6.2.1 Introduction

The shortlisted options confirmed in Chapter 5 are summarised below.

Figure 61: Shortlisted options for community hospital beds.

	<i>Do nothing</i>	① <i>New ways of working</i>	② <i>Partial consolidation</i>	③ <i>Full consolidation</i>
Community hospital beds	133 beds across nine inpatient sites	Minimal consolidation of beds to 104 beds in six sites across WNE Cumbria	Consolidation on 5 sites, including Cockermouth, with effective use of other sites Development of "virtual capacity" to support care in people's homes or alternative care settings	Consolidation on 5 sites, including Workington, with effective use of other sites Full consolidation on 3 sites (Penrith, Carlisle, WCH) with effective use of other sites

It is recognised that the application of the hurdle criteria concluded that continued inpatient bed provision at Alston, Wigton and Maryport community hospitals is not sustainable largely due to estate issues and critical mass issues. In reaching this conclusion, we recognise the need to prioritise work to strengthen out of hospital services in these areas, and have committed to reinvest a minimum of 50% of any savings associated with the closure of these beds in to community services in these areas. The exact nature of these changes may vary between areas and will be developed by the Integrated Care Community development work and be informed by active public and patient engagement.

The appraisal below therefore focuses on the options for the configuration of capacity across the six sites which have been identified as capable of providing a minimum of 16 inpatient beds. We are clear that our aim is to reduce demand for hospital care through the implementation of Integrated Care Communities. The role of community hospitals therefore needs to adapt and evolve over time and therefore the assessment is at a point in time in what will undoubtedly be a continuing journey of change as recognised in the rationale and vision for community hospitals set out in **Appendix H**.

The analysis of travel impacts on the various options for community hospitals shown below has been recently updated. Further interpretation of the findings will be undertaken and the implications reconciled in the narrative appraisal of each option. See **Appendix K**.

### 6.2.2 Our Appraisal of Community Hospital Inpatient Bed Options

#### 6.2.2.1 Health and Wellbeing



#### Impact on the health and wellbeing gap

- Public health outcomes
- Health inequalities, including access

The key issues identified are summarised below:

- In terms of public health outcomes, any episode of inpatient care should be on the basis of a clinical need that cannot be best met in the patient's own home.



- The development of strengthened out of hospital services through the development of Integrated Care Communities should result in an overall reduction in the number of admissions to an inpatient bed and associated length of stay.
- Community hospital inpatient services must have sufficient critical mass and skills to provide a level of care and support ensuring best use of limited resource.
- A significant increase in travel time to the place of care could have a negative impact on health and wellbeing, particularly if an admission is for a prolonged period. This could particularly affect vulnerable elderly patients who rely on the support of carers and family members who may need to travel further to visit.
- A model of care that ensures better alignment between community hospital inpatient bed capacity and population need could have benefit for WNE Cumbria recognising that currently patients are receiving care in community hospitals which are not local to them.
- 20.8% of households in Allerdale (and 23.4% in Copeland) do not own cars<sup>46</sup>. Relying on others/public transport may impact on wellbeing and finances and is especially problematic for disabled people or those supporting a patient receiving palliative care.
- Based on the travel times analysis undertaken (see **Appendix K**) (summarised in Figure 62 below), the average maximum additional travel time would be 18 minutes and 44 seconds for patients who would previously have received care at Maryport under the full consolidation option. The fewest people are impacted under the 'Do Nothing' option.

Figure 62: Travel times analysis (based on an average speed of 35 miles per hour)

	Option	Configuration detail	Groups affected	Total affected	Estimated additional average travel time
Community hospitals	Do minimum	Maintain beds at Workington, Keswick, Penrith, Brampton, Copeland and Cockeremouth	Alston Hospital (Orton Lea)	110	02:14
			Wigton Hospital	149	11:29
			Maryport Hospital	252	04:17
	Partial consolidation	Consolidation on 5 sites including Cockeremouth	Workington Community Hospital	313	10:08
			Workington Community Hospital (oral surgery)	92	Reduced
			Alston Hospital (Orton Lea)	110	02:14
			Wigton Hospital	149	11:27
			Maryport Hospital	252	07:25
	Partial consolidation	Consolidation on 5 sites including Workington	Alston Hospital (Orton Lea)	110	02:18
			Wigton Hospital	149	13:41
	Full consolidation	Full consolidation on Penrith, Carlisle and WCH	Maryport Hospital	252	05:09
			Cockeremouth Hospital	287	05:38
			Workington Community Hospital	313	06:43
			Workington Community Hospital (oral surgery)	92	Reduced
			Keswick Hospital	170	10:33
			Brampton Hospital	181	Reduced
			Alston Hospital (Orton Lea)	110	01:54
			Wigton Hospital	149	05:06
			Maryport Hospital	252	18:44
			Cockeremouth Hospital	287	04:35

Source: WNE Cumbria Success Regime Travel Times Analysis

<sup>46</sup> ONS

### 6.2.2.2 Care and Quality



#### Impact on the care and quality gap

- Patient safety
- Clinical outcomes
- Patient experience, including access / travel

The key issues identified are summarised below:

- Wherever possible, the aim should be to support people in their own homes with inpatient care provided on the basis of a clinical need that cannot be met within the individuals own home (or place of residence).
- Consensus that 16 beds should be the minimum number of beds within any community hospitals, to provide sufficient resilience challenges in terms of staffing. 24 or 32 beds is preferable to enable more effective multi-disciplinary working.
- Greater consolidation on fewer sites will allow a higher degree of specialisation.
- Travel times are likely to increase with consolidation, noting that in West Cumbria car ownership is lower than the national average (see above).
- Another consideration under care and quality is the suitability of estate at each of the sites. A consideration of the estates and future plans for development are summarised in **Appendix H**.

### 6.2.2.3 Funding and Efficiency



#### Impact on the funding and efficiency gap

- Operating costs and affordability
- Capital requirements

For all options, the expectation is that the implementation of ICCs will strengthen out of hospital care and reduce the need for unplanned hospital admissions and enable a significant reduction in length of stay. As a result, the financial plans are assuming a reduction in the total number of inpatient beds across the system over time. For example, to mitigate the impact of additional travel for the three hospitals without in-patient beds (Alston, Wigton and Maryport), we are proposing to reinvest 50% of the savings to greatly strengthen local primary and community nurse and therapy teams aimed at supporting more people to stay in their own homes.

The financial analysis undertaken confirms that the greater the level of consolidation the greater the scope to drive efficiency and release resource, noting that there is potential for significant capital costs associated with full consolidation, as summarised below.

#### Capital Cost to the System

The potential capital requirement for some of the community options is dependent on the level of consolidation of acute services. In particular:

- Full consolidation in acute and emergency medicine is likely to drive a capital requirement in Carlisle for community inpatient capacity for example at the Carlton clinic, given there is no space at CIC to provide community services.

- For New Ways of Working in acute and emergency medicine, there is likely to be some spare capacity at CIC which could be used to provide community inpatient services, given the Out of Hospital / ICCs model reduces bed demand at CIC and the level of activity transfer from WCH is relatively small.
- Given the reduction in bed demand from the Out of Hospital / ICCs model, there is always space at WCH to accommodate the required bed demand for each option at the Copeland unit.

### I&E impacts and NPV rank

If there is spare capacity at CIC i.e. under New Ways of Working or Partial Consolidation in acute and emergency medicine, the greater the consolidation the greater the benefit and also the higher the NPV.

Based on Full Consolidation in acute and emergency medicine, there is no spare capacity at CIC, as discussed in the acute reconfiguration section. As such, there is a requirement for more capacity in Carlisle for community beds for some of the community options. In particular, there is a more significant capital expenditure requirement at CIC or the Carlton Clinic in the Full Consolidation option in community. The net benefit of this option and the associated NPV is lowest of the three options despite the greater level of consolidation benefits. The Partial Consolidation in this case has the highest benefit and NPV.

Figure 63: Financial evaluation of community hospital options (assuming “new ways of working” for acute option)

Benefits area		New ways of working	Partial consolidation	Full consolidation
Total beds post out of hospital		119	119	119
Total beds post consolidation		104	104	104
Number of sites		6	5	3
Capital requirement (£m):		£2.7	£1.6 – £2.3	£0
<i>Bed reduction savings:</i>		£0.9	£0.9	£0.9
<i>Consolidation savings</i>		£0.3	£0.4	£0.6
<b>Total Benefits (£m)</b>		<b>£1.2</b>	<b>£1.3</b>	<b>£1.5</b>
Spare capacity - CIC	Annualised Capital Charges (£m):	£0.3	£0.2	£0
	<b>Total Net Benefit (£m):</b>	<b>£0.9</b>	<b>£1.1</b>	<b>£1.5</b>
	<b>NPV rank</b>	<b>3</b>	<b>2</b>	<b>1</b>
No spare capacity - CIC	Annualised Capital Charges (£m):	£0.3	£0.2	£0.7
	<b>Total Net Benefit (£m):</b>	<b>£0.9</b>	<b>£1.1</b>	<b>£0.8</b>
	<b>NPV rank</b>	<b>2</b>	<b>1</b>	<b>3</b>

### 6.2.2.4 Ease of Delivery

Ease of delivery	<ul style="list-style-type: none"> <li>• Timescale for implementation</li> <li>• Likelihood of retaining / recruiting required workforce</li> </ul>
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The key issues identified are summarised below:

- Each option will require a degree of capital investment.
- With regards to workforce, the evidence suggests that consolidation of community beds may result in some short term risks for the current workforce, but will result in long term benefits in terms of recruitment, retention and performance and more sustainable and resilient models of staffing.

### 6.2.3 Summary

Figure 64: Summary of appraisal

Community Hospitals	New ways of working	Partial consolidation	Full consolidation
Health and wellbeing	Retains beds at most sites, protecting high-risk groups from negative impact in terms of access. However, it will not be able to provide the most effective clinical care.	Degree of negative impact on vulnerable groups in terms of access, but offers opportunity for greater specialisation and strengthened multi-disciplinary working that could positively impact on outcomes.	Negative impact in W. Cumbria due to travel times/ access; less impact on Carlisle, where majority of the population lives. Enables specialisation and stronger multi-disciplinary working, with positive impact on outcomes.
Care and quality	Enables sufficient critical mass to be established, providing a more resilient model.	While having the potential to increase travel times, this option would provide a more resilient model.	Provides greatest scope for multi-disciplinary working and specialisation, but this would have greatest impact on travel and access.
Funding and efficiency	Neutral impact on operating costs and affordability and capital requirements	Neutral impact on operating costs and affordability and neutral impact on capital requirements.	Small impact on operating costs and affordability and a potential capital requirement depending on the acute and emergency medicine option.
Ease of delivery	While resulting in least disruption to the current workforce it is not considered sustainable in workforce or estates terms.	Requires some capital investment, but has potential to provide safe and more resilient workforce model.	Requires greater capital investment (assuming no available capacity), however will offer the greatest opportunity to develop the workforce.

The outcome of the appraisal has highlighted the strengths and weaknesses associated with each option, and confirmed the ambition to strengthen out of hospital care, to include frailty assessment services, and reduce the need for community hospital inpatient capacity further over time.

To support this, based on the appraisal undertaken our preferred option is to reconfigure our community hospital inpatient capacity on the six sites that have been assessed as able to deliver

the minimum 16 bed capacity. We believe that this will give greatest flexibility for our ICCs to develop local solutions to meet local needs.

## 6.3 Appraising the Options for Emergency and Acute Medicine

### 6.3.1 Introduction

The short-listed options confirmed in Chapter 5 are set out below.

Figure 65: Short-listed options for emergency and acute medicine

	<b>1 New ways of working</b>		<b>2 Partial consolidation</b>		<b>3 Full consolidation</b>	
	<i>WCH</i>	<i>CIC</i>	<i>WCH</i>	<i>CIC</i>	<i>WCH</i>	<i>CIC</i>
A&E	24/7 A&E	24/7 A&E	Daytime A&E	24/7 A&E	UCC	24/7 A&E
Non elective	Reduced complexity	Surgery, Trauma and complex medical	Ambulatory and selected GP admissions	All surgical, trauma and acute medical	Ambulatory	All acute non elective
Frail Elderly	Frailty assessment inpatient & rehab	Assessment and inpatient	Frailty assessment, step up and rehab	Frailty Assessment, inpatient and rehab	Frailty assessment, step up and rehab	Frailty Assessment, inpatient and rehab

### Option 1 – New Ways of Working

New Ways of Working	
CIC	WCH
24/7 A&E with UCC streaming. Integrated emergency floor, including hot clinics. Minor increase in ICU, EAU and inpatient specialty beds. Hyper acute stroke unit and ASU. Frailty assessment unit and rehab including specialist rehab.	Integrated emergency floor with UCC streaming. Including hot clinics & day time specialty support. Selected admissions for complex patients where no advantage to transfer. Limited provision of low risk non elective surgery and trauma. A small ICU. Frailty Assessment unit and rehabilitation.
<p>New ways of working with more emphasis on anticipatory and ambulatory care alongside innovative workforce models is a significant departure from previous attempts to work differently and solve the workforce problems, particularly at WCH.</p> <p>Composite workforce model: providing a minimum of 24/7 ST3 clinical competency, in each of the 3 x key specialties (Acute Medicine, A&amp;E and ICU/Anaesthetics) delivered by clinicians of any clinical background who are appropriately trained and experienced, and assessed as competent. Integrated delivery, particularly at night and weekends through a 'single team' concept, taking full advantage of the new 'Emergency floor' layout at WCH, and drawing upon all available resources and skills, across all speciality teams, with appropriate co-ordination, and full utilisation of additional support available from WCH and CIC non-resident on-call consultants.</p> <p>Based on current activity levels we would expect this option to affect 1092 patients (each year who would have their care provided at CIC rather than WCH).</p>	

### Option 2 – Partial Consolidation

Partial Consolidation	
CIC	WCH
<p>Increased capacity in 24/7 A&amp;E with UCC streaming.</p> <p>Integrated emergency floor, including hot clinics.</p> <p>An increase in ICU, EAU and inpatient specialty beds.</p> <p>Hyper acute stroke unit and ASU.</p> <p>Frailty assessment unit and rehab including specialist rehabilitation.</p>	<p>Daytime A&amp;E with UCC 24/7, including hot clinics and day time specialty support.</p> <p>Selected blue light admissions and GP referrals during day time.</p> <p>Limited provision of low risk non elective surgery and trauma.</p> <p>No ICU, but day time intensivist support.</p> <p>Frailty assessment, non-complex admissions and rehabilitation.</p>
<p>Volumes of acute medical patients at the WCH site would be reduced by diverting all blue lights and all acute admissions (including GP and self-referrals) to CIC at night time, eg 8pm to 8am. Between these hours, WCH would operate as an Urgent Care Centre (UCC), utilising the composite workforce model described above.</p> <p>Based on current activity levels we would expect this option to affect up to 4,083 patients each year who would have their care provided at CIC rather than WCH.</p>	

### Option 3 – Full Consolidation

Full Consolidation	
CIC	WCH
<p>Significant increase in capacity in 24/7 A&amp;E to take all blue light ambulances, with UCC streaming;</p> <p>Increase in transfers requiring 10 – 20% additional paramedics.</p> <p>Integrated emergency floor, including hot clinics.</p> <p>Increase in ICU, EAU and inpatient specialty beds.</p> <p>Hyper acute stroke unit and ASU.</p> <p>Frailty assessment unit and rehab including specialist rehabilitation.</p>	<p>UCC only with access to hot clinics and day time specialty support.</p> <p>Ambulatory and “step up” inpatient care only, no acute admissions.</p> <p>No ICU.</p> <p>Frailty assessment, noncomplex admissions and rehabilitation.</p>
<p>An UCC will operate 24/7 at WCH. CIC would have a 24 A&amp;E department with a dedicated UCC to ensure appropriate streaming.</p> <p>All acute admissions would be directed to CIC, with selected GP referrals for step up or end of life care only at WCH. The UCC would be staffed by GPs and Advanced Nurse Practitioners to triage patients correctly into pathways based on risk and presentation, and to expedite their passage through the system.</p> <p>Based on current activity levels we would expect this option to affect 11048 patients (100% of Type 1 A&amp;E patients) each year who would have their care provided at CIC rather than WCH.</p>	

## 6.3.2 Our Appraisal – Emergency and Acute Medicine

### 6.3.2.1 Health and Wellbeing



#### Impact on the health and wellbeing gap

- Public health outcomes
- Health inequalities, including access

The key issues identified are summarised below.

- Between 2008/09 – 2012/13 the rate of emergency hospital admission (all causes) across Copeland and Allerdale was significantly lower than the England average, however rates for CHD, stroke and MI were significantly higher than the England average (COPD – no significant difference<sup>47</sup>).
- There is strong evidence that there are improved outcomes for stroke patients if they have access to timely specialist stroke care.
- Healthcare professionals' experience cites that greater consolidation of A&E could result in non-attendance by those living furthest from the service, posing a public health risk.
- Consolidation will have significant implications for travel times and access (See **Appendix L**) (see Figure 66 below).

Figure 66: Consolidation impact on travel times (based on average speed of 35 miles per hour)

	Option	Configuration detail	Groups affected	Total affected	Estimated additional average travel time
Emergency and acute	New ways of working	WCH: • 24/7 A&E • Reduced complexity non-elective • Frailty assessment, inpatient beds and rehab frail elderly	A&E Type 1 NEL inpatient complex	3247	47:39
		CIC: • 24/7 A&E • Surgery, Trauma and complex medical non-elective • Assessment and inpatient beds frail elderly		672	45:06
	Partial consolidation	WCH: • Daytime A&E • Ambulatory, selected GP admissions non-elective • Frailty assessment, step up beds and rehab frail elderly	A&E Type 1 NEL inpatient complex	4248	47:39
		CIC: • 24/7 A&E • Surgery, Trauma and complex medical non-elective • Assessment and inpatient beds frail elderly		672	45:06
	Full consolidation	WCH: • UCC • Ambulatory non-elective • Frailty assessment, step up beds and rehab frail elderly	A&E Type 1 NEL day case NEL inpatient complex NEL inpatient non-complex	10066	47:39
		CIC: • 24/7 A&E • Surgery, Trauma and complex medical non-elective • Assessment and inpatient beds frail elderly		1601 1904 672	45:35 45:06 45:06

Source: WNE Cumbria Success Regime Travel Times Analysis

<sup>47</sup> Local Health



### 6.3.2.2 Care and Quality



#### Impact on the **care and quality** gap

- Patient safety
- Clinical outcomes
- Patient experience, including access / travel

The key issues identified are summarised below.

- There is evidence supporting a link between consolidation of some specific services and higher patient safety. In a House of Commons report, it was stated that "The bulk of the evidence we received made a strong case for centralisation of treatment with certain conditions such as...cardiac care and major trauma"<sup>48</sup>. This is particularly important for stroke and deteriorating high risk patients.
- Benefits of consolidation can include concentrating specialist expertise resulting in the full skills and experience across a team and between teams and being able to ensure necessary levels of cover in and out of hours. This view is reflected in feedback through the Chatty Van engagement, where comments included "I would go as far as needed to get the expert treatment needed".
- Introducing a separate stream for minor injuries could reduce the number of trauma patients waiting over an hour of about 30%, without sacrificing the needs of patients with more urgent needs<sup>49</sup>.
- Whilst in-hospital patient experience may be improved, access and travel times to reach the hospital would have a negative impact on quality and care.
- Concern that there is evidence that daytime A&E could result in increased risk out of hours creating potential confusion with patients and professionals alike and increased 'hand-offs' of care.

### 6.3.2.3 Funding and efficiency



#### Impact on the **funding and efficiency** gap

- Operating costs and affordability
- Capital requirements

Emergency and acute medicine constitutes c.£290m of spend currently in the health economy, which could rise to c.£320m by 2020/21. The ICCs are therefore specifically targeting these services to try and ensure that patient care is provided in the right location at the right time. This could reduce the spending in five years by £30m to c. £290m and the financial assessment has assumed the ICCs deliver planned impact.

<sup>48</sup> House of Commons, Urgent and Emergency services, report of Session 2013-14, following evidence from Bruce Keogh, Barbara Hakin, Keith Willett, et al

<sup>49</sup> The effect of a separate stream for minor injuries on accident and emergency department waiting times, MW Cooke, S Wilson, S Pearson, *Emerg Med J*, 2002

In summary, the greater the level of consolidation, the greater the potential to release recurrent resource – however, there are capital cost considerations and costs associated with transport that need to be considered.

### Capital cost to the system

The first component of the financial assessment is the amount of additional capital expenditure that might be required to support any option. Depending on the option, different sites will require greater or fewer beds, which drives the capital requirement estimates for each option. These capital requirements, as discussed, are though somewhat abated by the ICCs holding back activity growth and in some instances reducing the demands on the current bed base.

The capital requirements and bed estimates for each of the options are summarised in the table below.

Figure 67: Capital requirements for each option - Emergency and acute medical care

	New ways of working		Partial consolidation		Full consolidation	
	WCH	CIC	WCH	CIC	WCH	CIC
Estates capital costs (£m)	£0.0		£0.0		-£2.9	
Ambulance costs (capital + recurrent, £m)	-£0.4		-£0.4		-£1.7	
<b>Total cost (£m)</b>	<b>-£0.4</b>		<b>-£0.4</b>		<b>-£4.6</b>	

The Full Consolidation option requires additional capital of around £4.6m, based on the small increase in beds and the ambulance capital costs. Both New Ways of Working and Partial Consolidation have the lowest capital requirements given the lower consolidation.

The capital requirements in Figure 67 include only the capital linked with the options for reconfiguration, rather than the total capital requirement across WNE Cumbria, irrespective of the preferred options – of which there is a significant sum. Additional items relating to the total capital requirement, and not relating to reconfiguration, are discussed in greater detail in **Appendix I**. In addition, a consolidated list of capital costs and their associated cash cost is included.

### I&E impacts and NPV rank

The overall I&E impacts and NPV rank for each of the options are included in Figure 67 for acute medical care services.

Figure 67: I&amp;E and NPV for each option – acute medical care services

	New ways of working		Partial consolidation		Full consolidation	
	WCH	CIC	WCH	CIC	WCH	CIC
Consolidation savings (£m)		£0.3		£0.3		£2.4
Service delivery savings (£m)		£0.0		£0.0		£2.3
Fixed cost benefits (£m)		£0.0		£0.1		£1.1
<b>Total benefit (£m)</b>		<b>£0.3</b>		<b>£0.5</b>		<b>£5.8</b>
Estates annualised capital charges (£m)		£0.0		£0.0		-£0.4
Ambulance costs (capital + recurrent, £m)		-£0.5		-£0.9		-£3.8
<b>Total cost (£m)</b>		<b>-£0.5</b>		<b>-£0.9</b>		<b>-£4.2</b>
<b>Net benefit (£m)</b>		<b>-£0.2</b>		<b>-£0.5</b>		<b>£1.6</b>
Efficiency stretch (£m) (greater agency spend reduction)		£0.8		£0.8		£4.5
<b>Net benefit post efficiency stretch (£m)</b>		<b>£0.7</b>		<b>£0.4</b>		<b>£6.1</b>
<b>NPV rank relative to base case</b>		<b>2</b>		<b>3</b>		<b>1</b>

- **Benefit** - As with Maternity, the Acute and Emergency Medicine total benefit for each option is combination of consolidation savings, service delivery savings and fixed costs benefits. Full Consolidation offers the higher benefit with £5.8m whilst £0.3m for New Ways of Working offers the lowest benefit.
- **Cost** – The larger cost item for the options is the additional ambulance costs which could incur cost of c. £4m in Full Consolidation given the greater number of transfers.
- **Efficiency stretch** – it could unlock the Full Consolidation option offers the greatest transformation, and as such the highest savings of £4.5m.
- **Net benefit** – The overall net position of each option shows Full Consolidation to offer the highest five year I&E position for Acute, an estimated £6.1m in 2020/21.
- **NPV** – Full consolidation generates the highest NPV. For a detailed breakdown of NPV see **Appendix I**.

#### 6.3.2.4 Ease of Delivery

 <b>Ease of delivery</b>	<ul style="list-style-type: none"> <li>• Timescale for implementation</li> <li>• Likelihood of retaining / recruiting required workforce</li> </ul>
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The key issues identified are summarised below:

- Delivering new ways of working will be a considerable challenge. There is currently a vacancy gap of 8 WTE acute medicine consultants and 8 WTE for ST3+ medical doctors at WCH, and in A&E, there are consultant and non-consultant vacancies of 3.0 and 6.0 WTE respectively.

- Under partial consolidation with daytime A&E at WCH, the A&E would not require an overnight medical presence, enabling some reduction in the staffing requirements although there would still be a need for the currently problematic overnight medical cover given acute admissions during the daytime.
- Reducing the ICU capacity at WCH would require an increase in the ICU at the CIC but there would still be a small net surplus of nursing. This minor surplus of staff could be able to be trained as ANPs for either A&E or acute medicine.
- Full consolidation would require some capital investment at CIC to create capacity.
- All options will have transport challenges due to the increase in transfers, with full consolidation having greatest impact.
- The current paramedic workforce vacancy rate is 16% and an additional 10 to 20% would be required to deliver a fully consolidated service.
- Converting the A&E at WCH to a UCC could confer significant workforce benefits.
- Ease of delivery of any option is strongly linked to ICCs and their ability to reduce avoidable admissions compared to the current situation.
- In an open letter from Cumbria's health leaders, dated 18<sup>th</sup> November 2015, it was stated that stakeholders are "fully committed to the continued delivery of the 24 hours a day, 7 days a week, Accident and Emergency service at West Cumberland Hospital" – which may make the delivery of certain options more challenging.

### 6.3.3 Summary

Figure 68: Summary of the options appraisal

 <b>Emergency and acute</b>	New ways of working	Partial consolidation	Full consolidation
	Improved outcomes, minimal impact on access	Improved outcomes, negative impact on access	Improved outcomes, significant negative impact on access,
	 <b>Care and quality</b> Could improve safety, experience, outcomes for West Cumbria	Some concerns around safety of partial model, neutral impact on experience and outcomes for West Cumbria	Could significantly improve safety and outcomes across WNE Cumbria, negative impact on experience for West Cumbria
	 <b>Funding and efficiency</b> Neutral impact on operating costs, affordability, capital requirements	Positive impact on operating costs and affordability, relatively neutral impact on capital requirements	Significant positive impact on operating costs and affordability, negative impact on capital requirements
	 <b>Ease of delivery</b> Easiest option to deliver, some workforce-related risks	Some physical infrastructure and transport challenges	Significant physical infrastructure and transport challenges

We have concluded that, while there are significant operational risks, 'new ways of working' is our preferred option. It is important to recognise that this will require a major change for our staff and the way that they work to implement a radically new composite workforce model across A&E, acute

medicine and intensive care. If it proves impossible to deliver this option, we believe that full consolidation of emergency and emergency medicine will need to be considered.

## 6.4 Our Appraisal of the Options for Maternity and Paediatrics

### 6.4.1 Introduction

The shortlisted options confirmed in Chapter 5 are summarised below.

Figure 69: Options for maternity and paediatrics.

	<i>Do nothing</i>		① <i>New ways of working</i>		② <i>Partial consolidation</i>		③ <i>Full consolidation</i>	
	<i>WCH</i>	<i>CIC</i>	<i>WCH</i>	<i>CIC</i>	<i>WCH</i>	<i>CIC</i>	<i>WCH</i>	<i>CIC</i>
Paediatrics	Full Inpatient	Full Inpatient	14 hour SSPAU; low acuity beds	14 hour SSPAU and Inpatient	14 hour SSPAU	Inpatient and SSPAU	Outpatient only 9-5 hot clinic	Inpatient and SSPAU
Maternity	Full obstetric	Full obstetric	Low risk CLU and MLU	CLU and MLU	MLU	CLU and MLU	Ante and post natal only	CLU and MLU

While there is a dependency between maternity and paediatric services, each has been considered separately for the purpose of the appraisal.

The high-level service implications for the maternity options are summarised below. It is important to note that for all options, local antenatal and post-natal care will continue to be provided across WNE Cumbria.

- **New ways of working**, will retain a CLU at WCH with risk stratification such that women assessed as higher risk will be advised to have their intrapartum care at CIC. This option also proposes an MLU be established at CIC and WCH. Based on current estimates, between 200-300 women would be impacted by this change – specifically women expecting twins, with a BMI greater than 169, women who have had a previous section and where the expected foetal weight is under 4kg. If planned inductions and caesarean sections would have transferred this would further reduce the number of women delivering in Whitehaven by 30% (330).
- **Partial consolidation** would consolidate a single CLU at CIC, with a midwifery-led unit at Whitehaven providing an option for women assessed as low risk and suitable for midwifery led care. This would also incorporate day assessment unit and a Dedicated Ambulance Vehicle (DAV). Based on current data 489 would be advised to have consultant led care, however given the geographic distance some lower risk women may choose to deliver their babies at CIC.
- **Full consolidation** of all intrapartum care (and all gynaecological services) at CIC. All deliveries, other than home births would be provided at CIC. Based on current data this would have an impact on just over 1300 women a year who would receive their care at CIC rather than WCH and may require multiple journeys. A day assessment service would also be provided at WCH.

The shortlisted options for paediatric services are as follows:

- **New ways of working**, would see the establishment of a 14-hour SSPAU with nurse-led low-acuity beds at WCH. SCBU and inpatient paediatrics would be consolidated at CIC. In relation to paediatric care, we believe that the establishment of consultant led paediatric assessment

units at both CIC and WCH represents the optimal model to provide rapid, expert assessment, diagnosis, treatment and assessment.

- Based on current activity, this would have an impact on just under 250 episodes of care for children in West Cumbria who may need consultant-led inpatient care at CIC.
- **Partial consolidation** would result in all inpatient beds being consolidated at CIC, with a 14-hour SSPAU at WCH and a Dedicated Ambulance Vehicle (DAV). Based on current activity this would have an impact on just over 300 episodes of care for children living in West Cumbria who would have their care provided at CIC.
- **Full consolidation** would result in a single SSPAU at CIC, with outpatient paediatric services at WCH to include 9am to 5pm hot clinics. Based on current activity this has the potential to have an impact on over 1600 episodes of care each year.

## 6.4.2 Option Appraisal

### 6.4.2.1 Health and Wellbeing



#### Impact on the health and wellbeing gap

- Public health outcomes
- Health inequalities, including access

The key issues identified for maternity services are summarised below:

#### Maternity

- Allerdale and Copeland have higher teenage pregnancy rates (2.1%) than the national average (1.5%)<sup>50</sup>.
- In 2014/15 the percentage of mothers in Allerdale who initiated breastfeeding was 64.8% and 59.2% in Copeland – both areas were significantly lower than the England average (74.3%)<sup>51</sup>. Mothers from West Cumbria requiring consultant-led care to deliver their baby may also be more likely to experience difficulties breastfeeding.
- Travel time for intrapartum care is perceived as a significant risk and issue for West Cumbria. (See travel impact assessment below). The travel analysis suggests that the average additional travel time is up to 47 minutes and 37 seconds under all maternity options (see Travel Impact Analysis for Acute Care in WNE Cumbria undertaken specifically for this business case at **Appendix L**. The option 'new ways of working' affects the lowest number.

#### Paediatrics

- Although we have pockets of deprivation in WNE Cumbria, overall we do not have significant childhood deprivation levels compared to the national average.
- Travel time analysis suggests that the average additional travel time is up to 48 minutes.

<sup>50</sup> Local Health, 2008/9 to 2012/13

<sup>51</sup> PHOF


- 37% of children admitted to hospital stay less than 12 hours and 83% stay only one day. Nationally the evidence shows that up to 97% of children referred as emergencies can be safely managed through a SSPAU without needing an inpatient admission.

Figure 70: Impact on travel times for maternity and paediatric options (based on average speed of 35 miles per hour) – see Appendix L for details of the Travel Impact Analysis for Acute Care in WNE Cumbria

	Option	Configuration detail	Groups affected	Total affected	Estimated additional average travel time
Maternity	New ways of working	WCH Low risk CLU CIC CLU and MLU	Mat day case	245	45:05
			Mat inpatient	244	45:50
			Neonatal inpatient	6	46:44
			Neonatal day case	1	47:37
	Partial consolidation	WCH MLU CIC CLU and MLU	Mat day case	245*	45:05
			Mat inpatient	244*	45:50
			Neonatal inpatient	32	46:44
			Neonatal day case	3	47:37
	Full consolidation	WCH Ante and post-natal only CIC CLU and MLU	Mat day case	815	45:05
			Mat inpatient	813	45:50
			Neonatal inpatient	32	46:44
			Neonatal day case	3	47:37
Paediatrics	New ways of working	WCH: 14 hour SSPAU, low acuity beds CIC: 14 hour SSPAU and inpatient	NEL non-complex inpatient	49	46:58
			NEL complex inpatient	44	46:58
			Elective inpatient	2	35:11
	Partial consolidation	WCH: 14 hour SSPAU CIC: SSPAU and inpatient	NEL inpatient	291	46:58
			Elective inpatient	11	35:11
	Full consolidation	WCH: Outpatient only and 9-5 hot clinic CIC: SSPAU and inpatient	Elective day case	53	48:06
			NEL inpatient	291	46:58
			NEL day case	1323	46:27
			Elective inpatient	11	35:11

Source: WNE Cumbria Success Regime Travel Time Analysis

#### 6.4.2.2 Care and Quality

 <b>Impact on the care and quality gap</b>	<ul style="list-style-type: none"> <li>• Patient safety</li> <li>• Clinical outcomes</li> <li>• Patient experience, including access / travel</li> </ul>
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The key issues identified are summarised below.

#### Maternity

- For the New Ways of Working and Partial Consolidation options involve adding an MLU to the CIC and WCH site. This would increase patient choice. MLUs tend to result in higher normal delivery rates, are as safe as CLUs for straightforward cases, and tend to have lower rates of intervention. A prospective study in 2011 showed that women who planned birth in a



midwifery unit had significantly fewer interventions than women who planned birth in an obstetric unit<sup>52</sup>.

- Consolidating CLUs could make service more sustainable by centralising skills, resources and experience.
- There is an association between frequent exposure to complex cases and more favourable outcomes for patients across all aspects of medical care and it is important that clinical staff are regularly exposed to these complex cases in order to maintain their skills<sup>53</sup>.
- Paediatric support to meet the clinical standard to deliver neonatal resuscitation within 10 minutes is not currently met on either hospital site in WNE Cumbria.
- In terms of access, consolidating high risk maternities at CIC with an MLU at WCH would impact c. 500 people per year (245 maternity day cases and 244 maternity inpatients), adding an additional 45 minutes to their travel time, based on the travel analysis. (See above)
- If there was no maternity service at WCH, over 1,500 people would be affected each year (815 maternity day cases and 813 maternity inpatients).
- Consolidation of maternity and paediatric services at CIC is likely to impact some of the most deprived people in West Cumbria.

### Paediatrics

- Consolidating inpatient paediatric services could improve patient outcomes by centralising skills, resources and experience.
- Higher volumes of cases help to maintain clinicians' exposure to less common childhood diseases: failure to spot the severity of a child's illness because of lack of paediatric expertise and training is a key cause of avoidable child death<sup>54</sup>.
- Nationally, the evidence shows that up to 97% of children referred as emergencies can be safely managed using a Short Stay Paediatric Assessment Unit (SSPAU), without needing an inpatient admission.
- In terms of access, consolidating inpatient paediatrics at CIC would affect almost 300 paediatric patients per year, adding an extra 47 minutes to their travel time, on average.
- Spreading the paediatric workforce to across two inpatient paediatric services could potentially jeopardise the sustainability of the service.

<sup>52</sup> Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: The Birthplace in England national prospective cohort study, BMJ, 25 November 2011

<sup>53</sup> RCOG report 2014: reconfiguration of obstetric and maternity services in Cumbria.

<sup>54</sup> The reconfiguration of clinical services, what is the evidence? The King's Fund, November 2014, and Pearson 2008

### 6.4.2.3 Funding and efficiency



#### Impact on the funding and efficiency gap

- Operating costs and affordability
- Capital requirements

The financial analysis undertaken confirms that the greater the level of consolidation the greater the scope to drive efficiency and release resource, noting that there is the potential for significant capital costs associated with full consolidation as summarised below.

#### Capital cost to the system

The first component of the financial assessment is the amount of additional capital expenditure that might be required to support any option. Depending on the option, different sites will require greater or fewer beds, which drives the capital requirement estimates for each option. These capital requirements, as discussed, are though somewhat abated by the ICCs holding back activity growth and in some instances reducing the demands on the current bed base.

The capital requirements and bed estimates for each of the options are summarised in the table below.

Figure 71: Capital requirements for each option – Maternity & Children

	New ways of working		Partial consolidation		Full consolidation	
	WCH	CIC	WCH	CIC	WCH	CIC
Estates capital costs (£m)	-£0.0		-£0.0		-£0.3	
Maternity specific dedicated ambulance (£m) *	-£0.0		-£0.2		-£0.2	
<b>Total cost (£m)</b>	<b>-£0.0</b>		<b>-£0.2</b>		<b>-£0.5</b>	

The Full Consolidation option requires additional capital of around £0.5m, based on the small increase in beds and maternity specific ambulance capital costs. New Ways of Working is likely to require no capital based on the assumptions outlined; and Partial Consolidation could require some additional ambulances for maternity.

The capital requirements in Figure 71 include only the capital linked with the options for reconfiguration, rather than the total capital requirement across WNE Cumbria, irrespective of the preferred options – of which there is a significant sum. Additional items relating to the total capital requirement, and not relating to reconfiguration, are discussed in greater detail **Appendix I**. In addition, a consolidated list of capital costs and their associated cash cost is included.

#### I&E impacts and NPV rank

The overall I&E impacts and NPV rank for each of the options are included in Figure 72 for acute medical care services.

Figure 72: I&amp;E and NPV for each option – Maternity and children

	New ways of working		Partial consolidation		Full consolidation	
	WCH	CIC	WCH	CIC	WCH	CIC
Consolidation savings (£m)	£0.3		£0.4		£0.7	
Service delivery savings (£m)	£0.1		£0.2		£0.2	
Fixed cost benefits inc. clinical standards (£m)	-£0.3		£0.8		£1.0	
<b>Total benefit (£m)</b>	<b>£0.1</b>		<b>£1.4</b>		<b>£1.9</b>	
Estates annualised capital charges (£m)	-£0.0		-£0.0		-£0.0	
Maternity specific dedicated ambulance (£m) *	-£0.0		-£0.9		-£0.9	
<b>Total cost (£m)</b>	<b>-£0.0</b>		<b>-£0.9</b>		<b>-£0.9</b>	
<b>Net benefit (£m)</b>	<b>£0.1</b>		<b>£0.5</b>		<b>£1.0</b>	
Efficiency stretch (£m) (greater agency spend reduction)	£0.1		£0.1		£0.4	
<b>Net benefit post efficiency stretch (£m)</b>	<b>£0.2</b>		<b>£0.6</b>		<b>£1.4</b>	
<b>NPV rank relative to base case</b>	<b>3</b>		<b>2</b>		<b>1</b>	

- **Cost** – The biggest cost item for the options is specific maternity ambulances which cost £0.9m in both the Partial Consolidation and Full Consolidation options.
- **Benefit** – The total benefit of each option is a combination of consolidation savings, service delivery savings and fixed costs benefits. Full Consolidation offers the highest benefit with £1.9m whilst £0.1m for New Ways of Working offers the lowest benefit.
- **Efficiency stretch** – The efficiency stretch saving is only likely to be achievable through more significant transformation, with the level of saving being apportioned to the degree of transformation. Since Full Consolidation offers the greatest transformation, it achieves the highest savings of £0.4m, whilst the other options only save £0.1m.
- **Net position** – The overall net position of each option shows Full Consolidation to offer the highest five year I&E position for Maternity and children, saving £1.4m.
- **NPV** – Full consolidation achieves the highest NPV. For a detailed breakdown of NPV see **Appendix I**.

#### 6.4.2.4 Ease of Delivery



### Ease of delivery

- Timescale for implementation
- Likelihood of retaining / recruiting required workforce

The key issues identified are summarised below.

#### Maternity

- To achieve 24-hour consultant-delivered care at both CIC and WCH sites would require recruitment/development of Advance Midwife practitioners, successful recruitment to 6 'middle grades' and investment in training.
- Consolidation of consultant-led services at one site would help allow the trust to more easily provide 24/7 consultant obstetrician cover.
- To achieve 24-hour consultant care on both sites would also require an additional 5.3 WTE advanced critical care nurse practitioners (ACCPs), a further 5 consultant anaesthetists working within a single trust-wide team, and a dedicated theatre staffing team.
- Establishing a stand-alone MLU at WCH would be achieved with 10-12 WTE midwives.
- The risk for this option is the current level of clinical support for a standalone MLU at such distance from a CLU, with the risk that current midwives would be professionally uncomfortable with this configuration, making retention and training / upskilling for this service more challenging. However, MLU's elsewhere have proved attractive to Midwives because of clinical autonomy and upskilling.
- Consolidation of maternity services would require an increase in physical infrastructure at CIC, including a second theatre.
- Paediatric support to meet the clinical standard to deliver neonatal resuscitation within 10 minutes is not currently met on either hospital site in WNE Cumbria, and is unlikely to be met by continuing to have two inpatient paediatric units, due to these staffing difficulties. If the issues relating to delivery of medical cover (resident on-call) can be resolved, this would also resolve the neonatal resuscitation challenge.






#### Paediatrics

- The current vacancy gap for consultant paediatricians is 5 WTE – 4 of which are at WCH, and 5 WTE for non-consultant paediatricians.
- New ways of working and partial consolidation alleviate some paediatric workforce pressure. However, to operate this model across the sites with nurse-led low acuity beds with (non-resident) medical cover would still need a further 4 consultants and a tier of 8 paediatric nurse practitioners.
- Partial consolidation of inpatient paediatric services, with a 14 hour SSPAU at WCH, would create a surplus of highly trained paediatric nurses, up to 6-8 WTE. These nursing staff would be suitable for training in enhanced roles for example as ANPs.

- Full consolidation of paediatric inpatient services at CIC with consultant run hot clinics at WCH would further reduce workforce pressures. Assuming WCH paediatric consultants spent half of their contracted time staffing the clinics, a 9am-5pm weekday service could be provided with no middle grade cover. This could potentially remove the vacancy gap for paediatric middle grades across the trust and reduce the consultant vacancy gap to 2 WTE (from 5 WTE) at WCH.





### 6.4.3 Summary

Figure 73: Summary of options for maternity services

 <b>Maternity</b>		New ways of working	Partial consolidation	Full consolidation
 <b>Health and wellbeing</b>		Limited impact on the health and wellbeing of pregnant women in West Cumbria, but the fragility of services may impact on outcomes, and the opportunity costs would be significant.	Improved outcomes associated with larger more stable unit for all women in WNE Cumbria. Negative impact on pregnant women in West Cumbria due to distance a consultant-led maternity unit.	Improved outcomes associated with larger more stable unit for all women in WNE Cumbria. Negative impact for women in West Cumbria due to distance to a consultant-led maternity unit.
	 <b>Care and quality</b>	Improved patient choice by adding an MLU at CIC and WCH, births at each CLU would remain low (though these can be mitigated) and meeting the standard on neonatal resuscitation would remain challenging due paediatric workforce issues.	Improved safety and outcomes in maternity by streaming high risk births to a high volume CLU at CIC and delivering low risk births at an MLU in WCH. However, access for high risk births would be impacted.	Improved safety and outcomes, enabling fulfilment of standard on neonatal resuscitation, supporting a full anaesthetic rota and guaranteeing a consistent epidural service. Access for most births from W. Cumbria would be impacted; but antenatal and postnatal services would continue locally.
	 <b>Funding and efficiency</b>	Neutral impact on operating costs and affordability and capital requirements	Small positive impact on operating costs and affordability and neutral impact on capital requirements.	Stronger positive impact on operating costs and affordability and a small capital requirement
	 <b>Ease of delivery</b>	Challenging to deliver, in particular recruitment of staff grade doctors as there is a national shortage of this speciality.	Requires more time to implement but could alleviate some workforce pressure in relation to obstetric rotas by consolidating the CLU. However, recruitment, retention, training / upskilling for a standalone MLU may be difficult.	Requires increased physical capacity at CIC. Workforce pressures could be alleviated by consolidating all maternity at CIC.

The work to date has highlighted the very complex issues impacting on maternity services, which cannot be seen in isolation from the pressures and issues associated with paediatric services given the critical clinical dependencies. As a result further work has been undertaken to give more detailed consideration to transport and transfers between sites. Having discussed and explored the clinical scenarios a preferred option for the provision of maternity services has been established, which aligns with option 2b of the RCOG review and the 'partial consolidation' option above and is outlined in more detail in **Addendum I**.

Figure 74: Summary of options for paediatric services

Paediatrics	New ways of working	Partial consolidation	Full consolidation
 <b>Health and wellbeing</b>	Limited impact on the health and wellbeing of the population in West Cumbria with a small number of children having to travel further if they are acutely unwell and require inpatient care.	Some impact on the health and wellbeing of the population in West Cumbria with a greater number of children having to travel further if they require overnight observation.	Greater impact on the health and wellbeing in West Cumbria children due to distance from a paediatric assessment service.
 <b>Care and quality</b>	Improved safety and outcomes by consolidating inpatient paediatrics at CIC.	Impact on access for paediatric patients needing to be admitted.	Improved safety and outcomes for paediatrics but with a higher impact on access with no assessment unit at WCH.
 <b>Funding and efficiency</b>	Neutral impact on operating costs and affordability and capital requirements	Small positive impact on operating costs and affordability and neutral impact on capital requirements.	Stronger positive impact on operating costs and affordability and a small capital requirement
 <b>Ease of delivery</b>	Alleviates paediatric workforce pressures by removing inpatient paediatrics from WCH, in the face of a national shortage of this specialty.	Requires more time to implement but could further alleviate some workforce pressure in relation to paediatric rotas.	Requires increased physical capacity at CIC. Workforce pressures could be alleviated by consolidating all paediatric services except outpatients at CIC.

Having considered the analysis of the options and the feedback from the engagement activity, the preferred option is to focus on new ways of working, with a 14 hour SSPAU. We propose to commission low acuity beds at WCH and review the utilisation of these beds through regular audits to assess impact and effectiveness.

## 7 OUR PLANS AND PREFERRED OPTIONS

*Chapter Seven sets out our preferred options for service change, which we believe should be tested through formal public consultation. We explain why we are recommending our preferred options, setting out our case in the context of wider changes that will achieve greater efficiency and effectiveness in the way we deliver health and care services across WNE Cumbria.*

### 7.1 Introduction

We have been clear throughout this document that there is a shared ambition between all partners within the WNE Cumbria Success Regime to be recognised as a centre of excellence for integrated health and care provision in rural, remote and dispersed communities.

To meet this challenge, we must:

- Ensure that our citizens and carers who use our services are at the centre of everything we do.
- Achieve a step change in efficiency as we know that this is the most significant step to returning our health and social care system into financial balance.
- Support transformation with innovative use of information technology and telehealth and by creating a culture of continuous improvement.
- Support our workforce to stay in Cumbria and to grow and develop in their roles and careers, as well as attracting new staff to help solve our recruitment and retention challenges; and
- Responsibly progress service reconfiguration options that have the potential to increase safety and service resilience.

We have set out our plans for the development of strengthened public health and prevention services that will change patterns of demand and make real impact on the health and wellbeing of our population.

We have also set out our plans for the development of strengthened out of hospital services through the rapid implementation of Integrated Care Communities, with thriving general practice providing the foundation for placed based care based on registered lists. We will have a network of Community Hospitals providing a range of local services which reflect local needs and which provide a base for truly integrated health and care services in collaboration with our third sector partners.

We will aim to design our services, with local people, to enable care to be provided as locally as possible. This includes our plans to increase the range and volume of certain elective surgical activity at WCH to reduce the need for patients from West Cumbria to travel CIC when this care can be safely and effectively provided locally.

Our work, led by our senior clinicians, has identified areas where we believe that there are changes that we need to make to address safety and service resilience in addition to improved levels of efficiency and better use of limited resources. We have described the work we have undertaken to develop our preferred options and this is summarised below.



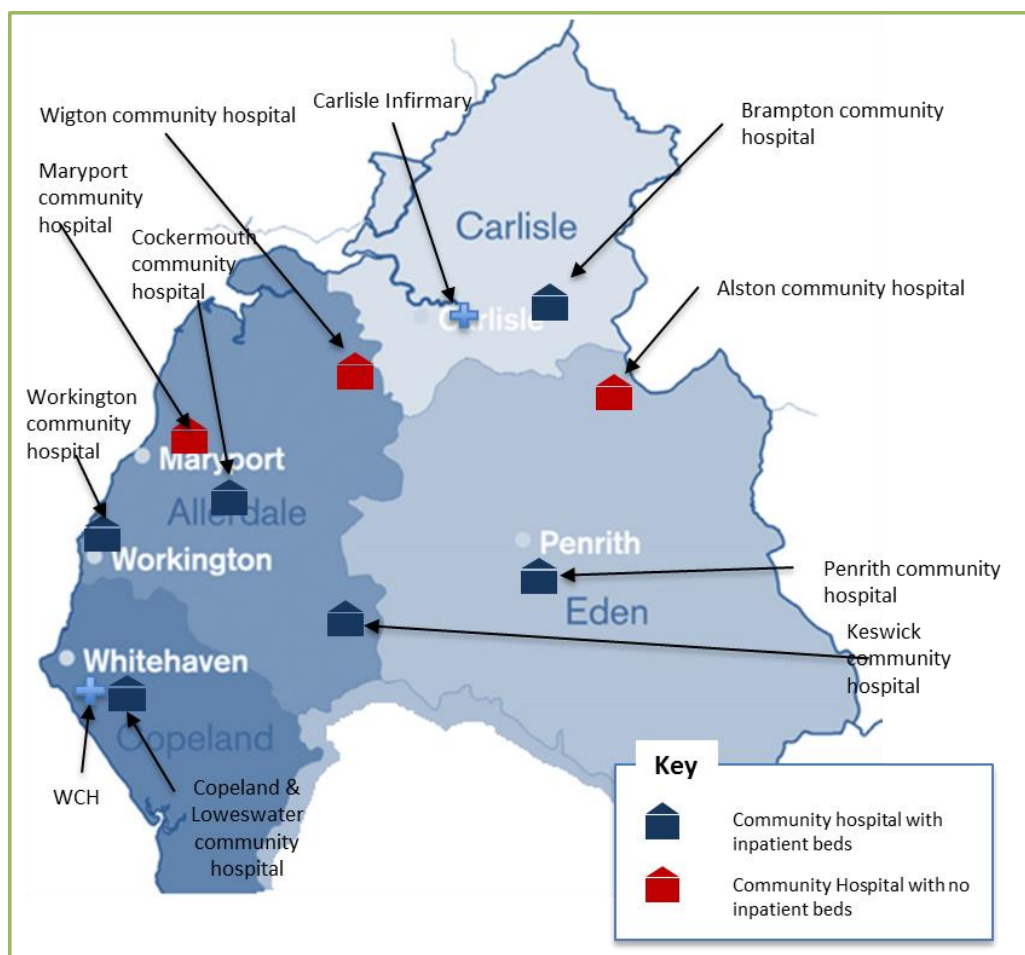
## 7.2 Community Hospital Inpatient Beds

Our planning is based on the need to configure 102 beds (or bed equivalents), plus the additional two to reflect NICE guidelines, capable of providing care for people who do not need the clinical support that is provided in an acute hospital setting, but for whom at present there is not suitable alternative health care available to support them in their own homes, or an alternative care setting, such as a residential, nursing or extra care facility. The methodology is set out in Appendix H.

Our preferred option is minimal consolidation of the current community hospital inpatient beds. We believe that this option achieves the best fit against the key principles set out in section 5.3. We also believe that this option offers the greatest flexibility that will enable us to respond to the new models of care that will be developed by ICCs to support people in their own homes or alternative care settings.

Our proposals will result in the minimal consolidation of services on six sites as summarised below.

Figure 75: Minimal consolidation of community hospital services on six sites.



We recognise that our preferred option will mean some changes for each community hospital inpatient unit. It will create opportunities to develop community hospitals in the context of ICC developments and as hubs for health and wellbeing. This reflects the key role of community hospitals across WNE Cumbria and establishes a clear vision of how we see them developing as an integral part of the Integrated Health Community model.

#### 7.2.1 Why This Is Our Preferred Option

We believe that this option will secure improvement in the quality of care. Creating a minimum number of beds on six sites will provide the opportunity for improved multi-disciplinary working and service resilience. It will also enable us to configure services in estates capable of providing inpatient care in a suitable environment, while releasing capacity over time to support the development of strengthened community based services.

#### 7.2.2 Services That Will Be Provided as a Result of This Option

There are no plans to close any of the community hospital sites. We will expect to see a greater range of services provided at each of our eight community hospitals including public health and prevention services as well as an increased range of specialist services provided locally (see Figure 75 above).

#### 7.2.3 Activity Implications

Through improved ways of working and some consolidation, we would expect to see significant improvements in the performance of our community hospital inpatient capacity, focusing on reducing current unexplained variation, reducing length of stay and, through close working with social care partners, eliminating delays in discharge and delayed transfers of care.

As we develop our ICCs and frailty services we would expect the number of admissions for step up care to reduce, and strengthened community reablement services should enable effective step down without the need for community hospital care. We will also look to provide strong end of life care, offering choice for individuals and their carers.

#### 7.2.4 Summary of Workforce Impact

We are confident that the changes proposed, which will offer the opportunity to improve multi-disciplinary working, will have a significant impact on our workforce in terms of improving opportunities for development and reducing professional isolation. This will directly address the issues raised by the CQC in autumn 2015 when they highlighted concerns with regard to the impact of workforce recruitment, sickness and isolation on patient safety.

While there may be some nursing and allied health professional staff employed by CPFT who are impacted by the changes in terms of their primary location, we do not anticipate any reductions in permanent staffing as a result of these changes. We do, however expect there to be a significant reduction in the use of bank and agency staff.

We are particularly mindful of the key role played by some local GP practices in the support of community hospital inpatient beds, and the importance of ensuring the changes proposed do not impact on the sustainability of local general practices. We are confident that the opportunities

offered through the development of ICCs and the commitment to strengthen out of hospital services will ensure that this risk can be effectively and positively managed.

### 7.2.5 Summary of Financial Impact

Given the preference for New Ways of Working (based on overall evaluation criteria) across acute and emergency medicine, the total net benefit in 2020/21 from the preferred community option is estimated to be c. £0.9m. For a more extensive approach to community option appraisal see **Appendix I**.

### 7.2.6 Conclusion

The three options that we will put forward for consultation each have their strengths and weaknesses. We believe that the option for minimal consolidation, as we strengthen our Out of Hospital services through the development of ICCs, has the potential to achieve the best outcomes for WNE Cumbria in terms of quality, safety and best use of resources. This has therefore been recommended as the preferred option.

## 7.3 Women and Children's Services

### 7.3.1 Maternity Services

We have set out three options for the future provision of the provision of maternity services in WNE Cumbria. Further work has since been undertaken to give more detailed consideration to transport and transfers between sites. Having discussed and explored the clinical scenarios a 'combined' preferred option for the provision of maternity services has been established and is outlined in more detail in Addendum I.

### 7.3.2 Paediatric Services

With regards to children's services, we wish to consult on consolidating our consultant led paediatric inpatient services at CIC with a short-stay paediatric assessment units (SSPAUs) with access to nurse led low acuity beds at WCH. CIC will provide consultant led inpatient care for the small number of sick children who require medical and nursing supervision, ensuring rapid onward referral and timely transfer to tertiary centres as needed. SCBU will also be consolidated at CIC. The service will be supported by an enhanced integrated nursing team ensuring community support.

### 7.3.3 Why This Is Our Preferred Option

In relation to paediatric care, we believe that the establishment of consultant led paediatric assessment units at both CIC and WCH represents the optimal model to provide rapid, expert assessment, diagnosis, treatment and assessment. As referred to in chapter six, this model reflects the fact that 37% of children admitted to hospital stay less than 12 hours and 83% stay only one

day. Nationally the evidence shows that up to 97% of children referred as emergencies can be safely managed through a SSPAU without needing an inpatient admission.

#### 7.3.4 Services That Will Be Provided as a Result of This Option

Our preferred option will see the establishment of short stay paediatric services at both WCH and CIC which will work seamlessly with community paediatric services and more specialist paediatric services as part of the Great North Children's Hospital network.

#### 7.3.5 Activity Implications

Moving to a Short Stay Paediatric Unit at WCH with low acuity overnight beds will result in a shift in inpatient paediatric activity from WCH to CIC, affecting approximately 300 children per year. The low acuity beds at WCH will be subject to regular audit and review to inform future commissioning intentions.

#### 7.3.6 Summary of Workforce Impact

We are confident that the preferred option for acute paediatric services will significantly improve our workforce resilience, particularly in the face of national shortages in this area. It would be beneficial from a workforce perspective as it would create a surplus of highly trained paediatric nurses. These nursing staff would be suitable for training in enhanced roles for example as ANPs. It is important to note that paediatric ANPs are likely to be a key group of staff in the future as there is a national shortage of paediatric middle grade doctors. This reconfiguration would also reduce the requirement for paediatric middle grade doctors and consultants by 2-3 WTE each. High-level modelling suggests this would likely reduce the current locum spend of £1.2 million by between 0.3-0.4 million pounds assuming a locum WTE equates to £100,000.

#### 7.3.7 Summary of Financial Impact

The estimated savings associated with the preferred option for maternity and paediatrics (outlined in Addendum I), are £0.3m per annum. The overall methodology for estimating the savings associated with the preferred option remains the same, however a number of refinements have been made in light of the greater detail developed for the preferred options. These include revising the potential savings from reduced agency spend associated with the option; increasing the incremental ambulance cost requirement; and other updates. A full appraisal of the benefits is contained in Appendix I.

#### 7.3.8 Conclusion

The options that we will put forward for consultation each have their strengths and weaknesses. We believe that the option for new ways of working for our paediatric services has the greatest potential to achieve the best outcomes for WNE Cumbria in terms of quality, safety and best use of resources.

## 7.4 Emergency and Acute Medicine

Our preferred option for consultation is to implement new ways of working to maintain 24/7 emergency and acute medical services at both WCH and CIC. The preferred option is based upon a composite workforce model where Advanced Clinical Practitioners and Physician Associates provide many clinical roles traditionally performed by medical staff. We recognise that this option is not without risk and will require an open and transparent dialogue with staff, patients and the community as we progress implementation. However, the model is built upon experience gained at WCH where all FY1 roles are already successfully provided by Advanced Nurse Practitioners and Advanced Practitioners in two Specialities are already working at middle grade (Registrar) level.

In confirming our preferred option, we are proposing important changes to improve outcomes for some clinical conditions, where outcomes can be improved through the consolidation of skills and expertise. Building on previous successful service changes, this option would seek to establish a single hyper-acute stroke unit at CIC as well as making provision for the transfer of “deteriorating” patients to CIC where they can benefit from greater levels of specialist support than are routinely available at WCH. In addition, we would also look to transfer back to WCH some minor trauma surgical activity where there is no patient benefit of having to travel to Carlisle and where it can be safely provided at WCH.

Whilst we recognise the risks associated with this option, it must be recognized that many Trusts are extending the roles and responsibilities of Advanced Practitioners in response to emergency service capacity pressures and medical staff shortfalls. Nevertheless, it is recognised that the proposed staffing model is at the leading edge of workforce development and the timescales for delivery will require strong milestones and contingency plans to be in place.

We have established some key milestones that will be reviewed. If these milestones are not met, this will trigger a review of the deliverability of this model and the need to consider full consolidation.

### Triggers for Review of WCH Acute Medicine - Composite Workforce Strategy

Our plans to deliver sustainable acute and emergency medicine services at WCH are long term in nature and based on new Advanced Practitioner and Physician Associate roles, as well as improved recruitment, leading to less reliance on locum and agency staff. We recognise that these plans are relatively ambitious and therefore have developed an agreed trigger for review of alternative options in the event of lack of expected progress. These triggers have been recently revised on the basis of advice provided by our educational partner – the University of Central Lancashire.

In relation to medical staffing, we have set goals within the Success Regime that Acute Medicine at WCH would be operating with a 25% reduction in acute medicine locum Consultant costs (or equivalent) within 1 year (April 2017), a 50 % reduction in junior & middle grade medical staff locum usage within 2 years (April 2018), and no more than 25% locum usage across the entire WCH acute medical workforce within 3 years (April 2019). We aim to achieve these objectives through a combination of increased GP trainee recruitment, utilisation of Advanced Clinical Practitioners and Physician Associates and substantive Medical recruitment, plus input in the short-term to medium term from the national clinical task force (Doctors in Partnership) if/when

that progresses.

We will assess progress towards achieving these objectives annually. If we are operating with more than 75% locum medical (or equivalent) staffing at the time of an assessment, this would trigger a review of the continued viability of the plan, to be undertaken jointly with the CQC. If that review considers that patient and population health is at risk and there is no likelihood of significant locum usage reduction in the foreseeable future, we would then trigger options to adopt an alternative service reconfiguration, which will be set out in the Success Regime consultation document to be published in July 2016.

Any service reconfiguration options are likely to need a significant implementation lead-in time and may incur significant transitional cost. An implementation timetable would need to be agreed at the point that the contingency plan is agreed, but would be likely to be circa 6 months.

#### 7.4.1 Why This Is Our Preferred Option

We have concluded that the maintenance of emergency and acute medicine at WCH and CIC through new ways of working is the preferred option, having reflected on the health needs of the population, the impact on travel associated with consolidation and the commitment of staff to progress with the proposed model of care. We recognise that this option is not without risk, however we believe at this point in time it represents the best solution for our population. Identification of this option allows the CCG to reserve the right to opt for a different approach, if certain criteria are not met

It is also noted that this option is dependent upon the development of services that identify and support individuals at risk of unplanned admission through the development of ICC services including frailty assessment clinics and acute assessment services.

#### 7.4.2 Services That Will Be Provided as a Result of This Option

There will be some minor reconfiguration of services under this option, specifically:

- The establishment of a hyper acute stroke service at CIC, with direct admissions for acute stroke patients from across WNE Cumbria.
- The repatriation of some low-risk trauma surgery to WCH.
- New pathways for deteriorating high risk patients who require specialist management.

#### 7.4.3 Activity Implications

Under new ways of working, the selected diversion of some complex patients to CIC would affect 3,247 patients requiring type 1 A&E services, and a further 672 non-elective inpatients would be affected.

#### 7.4.4 Summary of Workforce Impact

There is currently a vacancy gap of 5 WTE acute medicine consultants and 8 WTE for ST3+ medical doctors, and in A&E, there are consultant and non-consultant vacancies of 5 and 13.5 WTE respectively. However, by improving our recruitment and retention strategy and implementing a composite workforce model across A&E, acute medicine and intensive care, we are confident that we can deliver, with the commitment from our staff, a sustainable workforce for emergency and acute medicine. It will reduce reliance on locums, improve the quality and consistency of care provided, and positively impact on resilience against turnover.

The composite workforce model will provide a minimum of 24/7 ST3 clinical competency, in each of the three key specialities delivered by clinicians of any clinical background who are appropriately trained and experienced, and assessed as competent. Integrated delivery, particularly at night and weekends through a 'single team' concept, taking full advantage of the new 'Emergency floor' layout at WCH, and drawing upon all available resources and skills, across all speciality teams, with appropriate co-ordination and full utilisation of additional support available from WCH and CIC non-resident on-call consultants. We are also improving the recruitment of qualified nurses, building on the successful approach with the University of Cumbria which resulted in recruitment of 44 qualified nurses in September 2015, with offers made to a further 31 students in advance of their training completion in September 2016. In addition, our partnership with UCLan to develop medical education in Cumbria, and the develop a rural/mountain centre of excellence, will attract more recruits to the region.

#### 7.4.5 Summary of Financial Impact

The estimated savings associated with the preferred option for acute and emergency medicine are £0.8m per annum. The overall methodology for estimating the savings associated with the preferred option remains the same, however a number of refinements have been made in light of the greater detail developed for the preferred options. These include revising the potential savings from reduced agency spend associated with the option; increasing the incremental ambulance cost requirement; and other updates. A full appraisal of the benefits is contained in Appendix I.

#### 7.4.6 Conclusion

The three options that we will put forward for consultation each have their strengths and weaknesses. We believe that the option of implementing new ways of working for our emergency and acute medicine services has the greatest potential to achieve the best outcomes for WNE Cumbria in terms of quality, safety and best use of resources. This option is therefore recommended as the preferred option.



## 8 THE IMPACT OF THE PREFERRED CHANGES

*Chapter Eight will be completed for the final submission of the PCBC to NHS England. It has not been possible to complete the full impact assessments for the provisional case. Some high-level themes are identified in this document.*

### 8.1 Quality Impact Assessment

A Quality Impact Assessment (QIA) process was developed and led by the Clinical Advisory Group. All of the relevant service changes within each of the proposed options that have been described have been fully assessed/evaluated to consider any adverse quality impacts. Each QIA was coordinated by the SRO for the relevant clinical workstream, using a standard agreed template. In each case appropriate clinical input was ensured and the results of the QIA were presented to the Clinical Advisory Group. The quality impacts of each proposed service change developed by the clinical workstreams on the composite options under consideration were incorporated into an over-arching options evaluation workshop. The process for consideration of options is described at section 5.2.

The Northern Clinical Senate has provided support to work areas in developing the clinical models and a Senate review was carried out by the Greater Manchester, Lancashire & South Cumbria Clinical Senate who will continue to have a key role into development of plans in to implementation.

Specifically, the Quality Impact Assessment (QIA) of the proposed future models of care will provide assurance that any resultant reconfiguration services will not adversely affect the quality of patient care. This is defined by NHS England as care that is clinically effective, safe and that provides as positive an experience for patients as possible.

### 8.2 Equality Impact Assessment

The detailed Equality Impact Assessment (EQIA) will describe the impact of service changes as a result of implementation of potential preferred options set out in Chapter Seven. It will build on the work already undertaken to inform the preferred options, including travel times analysis.

Emerging themes for note at this point in time include:

- The changes proposed by the PCBC may impact on protected characteristic groups and our duties towards them. To analyse that potential impact an initial desk top exercise has been undertaken outlined in **Addendum I**. All protected characteristic groups have been considered sufficiently for these proposals to be taken to formal Public Consultation, where further work will be undertaken.
- Equality Impact Analysis should be completed for all services as they are redefined/relocated this should be an iterative process every time there is significant change.

## 9 RESIDUAL FINANCIAL CHALLENGE

*The preferred options described in the previous sections drive a more financially sustainable position. However, there are a number of additional considerations which have an impact on the overall finances and are discussed in this section:*

1. *Additional planned investments; and*
2. *Residual financial challenge mitigations.*

### 9.1 Additional Planned Investments

There are a number of additional planned investments which are not linked to the reconfiguration options considered. Some of these are within the scope of the financial analysis included in this PCBC, other areas are expected to be funded separately.

**WCH Phase 2:** Current estimates suggest that c. £20m of capital expenditure could be required in order to complete the build of the WCH site and this is the figure included in the PCBC for planning purposes. This is expected to reduce double running costs of c. £2m per annum.<sup>55</sup> This would also reduce the value of the backlog maintenance at NCUH by c. £10.5m. These capital costs are annualised and included for the purpose of the 5 year financial position, which results in an overall cost saving of c. £0.9m in 2020/21.

**Heli Medicine:** Heli-care: Applicable only for the full consolidation option, there would be commitments to roll out a Heli-care / retrieval service, implying investment of c. £2.2m per annum, benchmarked based on Scotland's EMRS model (excludes capital). As such, this is excluded from the waterfall.

There are a number of other capital expenditures, for example investment in specialised services, primary care and the Cumbria-wide mental health strategy. The mental health investment is considered in section 9.3 and primary care and specialised are expected to be funded outside of this PCBC – the value of the capital expenditure is included in the consolidated list of capital items in **Appendix I**, but these expenditures are not included in the 5-year financial position in the PCBC. Greater detail on each of these areas is included in the relevant sections of the PCBC.

A consolidated list of all capital expenditures is presented in **Appendix I**.

Figure below presents the financial position post the included investments.

The full list of capital expenditures includes capital costs included in the financial challenge such as backlog maintenance, capital requirements linked to the options and other planned investments not linked to options.

#### 9.1.1 Transition Costs

Transition costs refer to costs associated with the transfer of activity, this can either be where activity includes transfers to an Out of Hospital setting or transfers between sites. The type of

<sup>55</sup> Success Regime capital requirements.

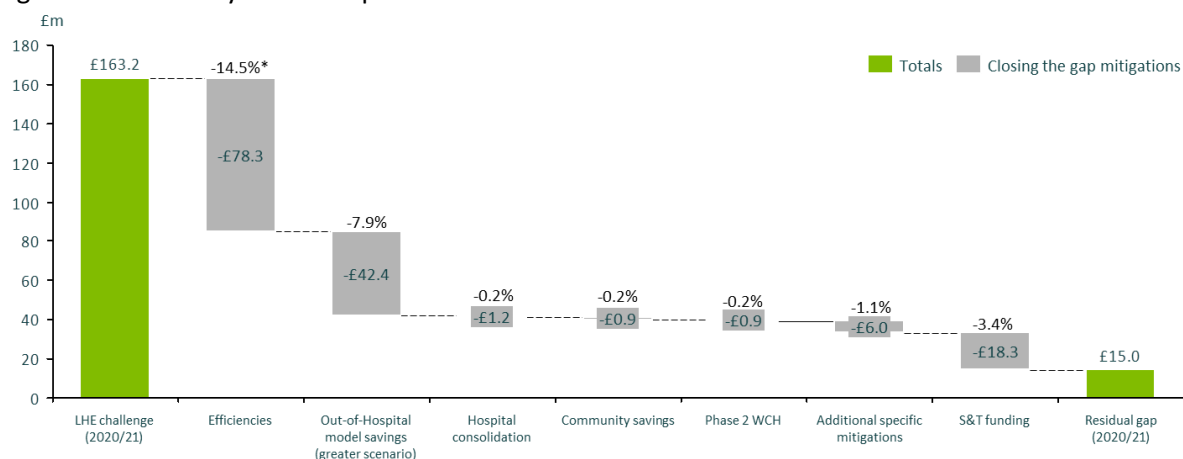
costs includes: double running of staff, services needing to remain open across both sites on a short term basis, training and staff training. Initial estimates from the Finance Directors Group suggest potential implementation costs could be c. £5m in 17/18, £2.5m in 18/19, £1.5m in 19/20, and c. £1m in 20/21 (with Success Regime funding of c. £5m in 16/17). The costs of double running could be c. £12.4m across the 5 years in addition to this. Greater detail on transition costs is presented in Appendix I.

The transition costs are not included in the 5-year financial position; given they are non-recurrent items.

## 9.2 Summary of Five Year Financial Position

The new ways of delivering care to the local population in WNE Cumbria described in the previous sections drive a more financially sustainable position. This is illustrated in Figure 76 where the financial challenge is reduced by c. £148m from c. £163m to c. £15m by 2020/21, based on the preferred options.

Figure 76: Summary of Year 5 position



Source: Success Regime financial analysis. %s relate to total 5 year provider expenditure of c. £540m Revenue consequences of c. £0.3m associated with the community option are included in the out of hospital savings.

However, across the suite of initiatives around efficiency, ICCs rollout and preferred options for reconfiguration, a significant year on year financial challenge is likely to remain in 2020/21 of c. £45m.

As such, greater change will be required to further reduce this financial challenge to achieve financial sustainability.

A range of potential additional mitigations are considered in the next section.

### 9.3 Residual Financial Challenge

The current financial challenge implies a residual challenge of £44.7m. A range of mitigations are considered in this section:

- Additional mitigations;
- The potential impact of indicative 2020/21 STP funding including transformation; and
- Alternative options to mitigate the financial challenge.

Finally, post these mitigations, the potential revenue support required is estimated.

#### 9.3.1 Additional Mitigations

Two additional areas have been identified which could further reduce the financial challenge within the current preferred acute and community options:

1. **Additional specific mitigations** – these comprise of additional schemes and initiatives which could deliver further cost savings for WNE Cumbria and include consolidation savings through developing networks to deliver pathology services; role substitution within workforce delivery to support greater staffing efficiencies; and the potential economies of scale opportunities within GP services. These mitigations could reduce the financial challenge by c. £6m in 2020/21.
2. **OOH greater service change** – this comprises flexing the assumptions underpinning the out of hospital / ICCs model. In particular, this includes increasing the reduction in non-elective admissions over five years from c. 19% to 25%; and reducing the reinvestment rate required to deliver the out of hospital interventions services e.g. as part of the ICCs from 50% to 40%. Flexing these assumptions could reduce the financial challenge by a further c. £6m.

The potential impact of these additional mitigations on the financial challenge is illustrated in Figure 77.

Figure 77: Additional mitigations



Source: Success Regime financial analysis. %s relate to total 5 year provider expenditure of c. £540m

These mitigations could address the financial challenge significantly. However, there are risks associated with deliverability of these mitigations that have been highlighted in the context of these additional mitigations. As such, these mitigations reflect an illustrative desktop exercise and the purpose is to test the sensitivity of the residual challenge to flexing key assumptions.

Post these mitigations this leaves WNE Cumbria with a c. 32.7m residual challenge in year 2020/21.

### 9.3.2 Indicative 2020/21 STP Funding Including Transformation

The funding allocation identified as part of the financial challenge in this PCBC uses the place based funding allocations published by NHS England.

Separate additional funding has been identified and initially held at a national level for the Sustainability and Transformation Fund (STF), and other elements of transformation such as Primary Care.

In order to support STP footprints in developing plans for their areas in 2020/21, in May 2016, NHS England has published, on an indicative basis, the total additional funding which could be available in 2020/21 from all sources. This includes a proportionate element of the sustainability fund, and of those transformation funds expected to be made available for local investment and services.

This indicative Sustainability and Transformation (S&T) funding is c. £25m for WNE Cumbria in 2020/21.

This funding is linked to investing in a number of areas, including:

- Taking forward the programs set out in the General Practice Forward View and delivering extended GP access;
- Implementing the recommendations of the Mental Health Taskforce, Cancer Taskforce strategy and National Maternity Review, including increasing capacity of children and adolescent mental health services and implementing access and wait targets for eating disorder services; and
- Consistent seven-day quality of urgent and emergency care in hospitals.

Of the c. £25m S&T funding, c. £5m is the proportion based on current funding proportions that is related to primary care and specialised services.<sup>56</sup> This therefore leaves c. £20m as the indicative funding to WNE Cumbria within the scope of the financial analysis included in this PCBC.

Investment in a number of areas may in part be accounted for in the financial analysis included in this PCBC. For example, the investment required to deliver seven day services across urgent and emergency care is likely to be in part accounted for within the cost uplift included to reflect for the cost of clinical standards. However, other areas such as investment required to implement the recommendations of the Mental Health Taskforce are unlikely to have been fully accounted for. There is a Cumbria-wide Mental Health strategy which indicates a c. £15m capital requirement for reconfiguring mental health services; this has been included in the financial position to offset the S&T funding – the investment is capitalised net of c. £0.8m benefits per annum. However, there are likely to be further investments required in mental health in addition to this in order to receive the S&T funding.

The level of investment likely to be required each area is uncertain, given the level of information available at this stage. As such, a placeholder assumption is included for further investments required to receive the c. £20m funding.

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<sup>56</sup> It is therefore assumed that the required investments linked to the S&T funding related to primary care and specialised services would be funded as part of this c. £5m.

### 9.3.3 Section 9.3.3 has been removed

*The information contained 9.3.3 has been removed since the date of the original PCBC to reflect further financial analysis and modelling, Appendix I. All NHS organisations believed it important that the public had the most up to date financial information available, that has been agreed by those organisations. As this continues to be updated – it will be reflected in information, available to the public, through the Success Regime website*



### 9.3.4 Alternative Options to Mitigate the Financial Challenge

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

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

The system is committed to reaching financial balance. It is expected that the areas listed above would contribute to closing some of the residual challenge in 2020/21, however there are still further areas to be considered. Realising these benefits would close the residual challenge in 2020/21, as can be seen in Fig 80.

Figure 80: Potential impact of alternative mitigations



Source: Success Regime financial analysis. %s relate to total 5 year provider expenditure of c. £540m

The potential impact on the allocation of the full consolidation option in acute and emergency medicine could be a decrease in funding for WNE Cumbria as, for example, it becomes less eligible for some of the unavoidable smallness adjustments given this is linked to a number of structural issues such as providing full A&E services at acute sites and high agency spend, both of which are alleviated in the Full Consolidation option.

### 9.3.5 Potential Revenue Support Required

In addition to the residual financial challenge which remains in 2020/21 post S&T funding (and pre-S&T linked investments), further revenue support in the form of transitional funding is required to account for the phasing in of the mitigations considered.

Specific phasing assumptions have been developed based on either a range of benchmarks or current financial plans, which account for:

1. **Front loaded mitigations**, reflecting mitigations where significant savings are likely to be realised in the first two years, for example the core provider efficiencies.
2. **Medium phased mitigations**, reflecting savings associated with ICCs, which are likely to be rolled out in the first couple of years but will only likely reach scale and full impact in years 4 and 5. As such, phasing assumptions reflecting a gradual phasing in of the impact over the five years are applied to the out of hospital benefits.
3. **Back loaded mitigations**, reflecting savings which are likely to take more significant time to achieve given the level of change, in particular the acute and community reconfiguration options and savings associated with prevention.

Four scenarios around the savings profile have been estimated:

1. **Do Nothing** – based on the financial challenge estimate before any mitigations are considered, c. £655m could be required over the 5 years in this scenario, in addition to c. £163m per annum on an ongoing basis.
2. **Savings after the core mitigations but excluding any S&T funding** – based on the c. £33m residual challenge by 2020/21. This scenario implies c. £247m transitional funding could be required over the 5 years in addition to c. £33m per annum on an ongoing basis, which is significantly less than the do nothing option.
3. **Savings after the core mitigations but including any S&T funding** - based on the c. £15m residual challenge by 2020/21. This scenario implies c. £189m transitional funding could be required over the 5 years in addition to c. £15m per annum on an ongoing basis, which is significantly less than the do nothing option.
4. **Including the additional residual challenge mitigations** – based on the scenario above but including the c. £15m of additional challenge mitigations. In this scenario, transitional funding of c. £167m would be required.<sup>57</sup>

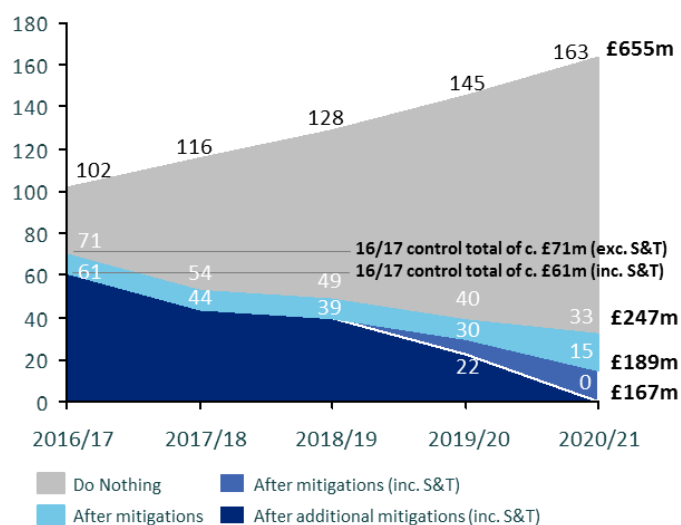
The four scenarios are summarised in Figure .

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<sup>57</sup> It is noted that the investment required to deliver services in the ICCs may have to occur in advance of the benefits associated with them, but the current assumptions phase costs and benefits in the same way.

Figure 81: Phasing scenarios – potential revenue support requirement

Source: Success Regime Financial analysis



Based on the four scenarios considered, the overall transitional funding requirement could be in the region of c. £167m to £247m. The implementation funding requirement would be in addition to this.

## 9.4 Deliverability and Risk

The WNE Cumbria system is setting itself a number of challenging targets to get closer to financial sustainability. As such, both core and stretch savings may prove to be particularly difficult to unlock given a suite of deliverability challenges, such as:

1. **Changes in leadership.** Across recent periods, the local health economy has witnessed significant change within the leadership positions of its key organisations.
2. **Governance structure.** Achieving significant transformational change in a short period of time requires a well-structured and fast paced governance approach which may be difficult to achieve within the local context.
3. **Challenging track record.** The health economy has delivered limited improvements against its efficiency targets over the past years (e.g. CIPs).
4. **Immediate pressures.** Local pressures may inhibit the ability to deliver transformational change in a fast and efficient manner.

## 9.5 Limitations to the Financial Analysis

Due to the overall timelines, there are a number of limitations to the financial analysis underpinning the PCBC:

1. **Top-down opportunity analysis.** The analysis around the efficiency and activity opportunities available which feeds the efficiency analysis and Out of Hospital impacts, has been undertaken based on available information (Lord Carter, Right Care and other benchmarking work). Further work has been undertaken to begin to underpin this opportunity with more granular plans and analysis and is outlined in Appendix L.
2. **Organisation-level impacts.** The financial analysis focuses on understanding the financial, activity and clinical impacts of the overall model of care at an overall health economy level. Whilst initial organisational-level impacts could be developed, these would likely change as pricing and organisational form questions remain to be answered.
3. **Estates and IM&T.** Analysis around space and capital changes often requires significant time, expertise and a considerably developed clinical strategy (e.g. granular locational information). At this stage, a set of high-level assumptions around fixed costs and capital costs have been applied, detailed estates space analysis is expected to be completed after the PCBC.
4. **Costs back in the system from OOH.** Simplifying assumptions have been made around the reinvestment rate to estimate the cost of running services in the ICCs in the top-down modelling, however as noted in Appendix I, further bottom-up work is being undertaken to underpin this.
5. **Travel time analysis.** Travel time analysis has been undertaken as part of a separate workstream to support an understanding of the patient flow dynamics in the local health economy. This travel time analysis uses the same activity inputs as the financial modelling.
6. **Other mitigations.** A range of mitigations related to areas such as prevention, Shared Organisational Arrangements and pathology consolidation have been considered in a simplified way only, for example based on applying simple benchmarks.
7. **Capacity impacts.** Capacity has been analysed in terms of total inpatient beds only, given these are the most material areas in terms of overall space requirements.
8. **Patient transfers.** Given the potential implications for the overall options appraisal, the cost of patient transfers has been considered in a simplified way based on assumptions around capacity and average cost of ambulance teams.

## 10 CONSULTATION AND IMPLEMENTATION

*Chapter Ten describes our consultation and implementation plans, including governance, risk analysis and next steps.*

Subject to agreement of this pre-consultation business case, we are committed to undertake a full public consultation to test our ideas and preferred options. The start date and duration of this consultation are decisions to be taken by the Cumbria CCG Governing Body and Health Overview and Scrutiny Committee (HOSC) locally, and NHS England and NHS Improvement (regionally and nationally). We hope to start public consultation in July 2016.

A Public Consultation Process Stakeholder Advisory Group (PCPSAG) to support and advise on matters related to the way in which the public consultation programme should be conducted.

### 10.1 Consultation Plan

#### 10.1.1 Consultation Principles and Process

The options to be considered during the consultation will set out what we think is the best way to deliver sustainable and high quality services for the people of WNE Cumbria. During the public consultation we will want to test these proposals thoroughly. We will want to hear views on our proposals, if they can be improved and whether people have better ideas that we might have missed. We will listen carefully to the views of our communities and local stakeholders who have an interest in health and social care.

The key principles that will be used to guide the consultation programme are as follows:

- It will be as visible as possible.
- It will be open and transparent.
- It will be engaging and accessible.
- It will be proportionate.
- It will give respondents an opportunity to express wider views as well as to indicate specific preferences.
- Key stakeholders will be involved in determining the details of the consultation programme.
- The consultation process will have an honest intention. The Consultor will be willing to listen to the views advanced by Consultees, and will be prepared to be influenced when making subsequent decisions.
- The Consultor will also be honest in explaining to the Consultees that decisions will be influenced by a number of factors of which the result of the public consultation is just one.

The consultation will be anchored in best practice including the following key guidance documents (guidance and advice will also be sought from the Consultation Institute):

- Cabinet Office - Consultation Principles (revised January 2016)
- The Consultation Institute - Consultation Charter
- NHS England – Planning, assuring and delivering service change for patients
- NHS England - Planning for Participation

The public consultation document will be:

- Consistent with the style of communication clear and concise, easy to comprehend, jargon free and expressed in plain English
- Supported with more detailed information on the Success Regime website
- Available both online and as a hard copy in a variety of public venues including GP surgeries, hospitals, libraries etc.

Our media and communication strategy will include a number of elements such as:

- Regular press releases, and ongoing media initiatives with local media outlets.
- Strategic advertising (including newspapers and online advertising as well as utilising social media).
- The use of TV screens in hospitals, GP practices and local authorities wherever possible.
- A regular electronic newsletter, published throughout the consultation period, to update members of the public and key stakeholders on the latest consultation activities.
- A dedicated consultation website.

The consultation activities deployed during this public consultation will include a range of traditional activities such as public meetings, drop in events, staff consultation meetings etc. and a range of more innovative activities that will be determined once the proposals and consultation options are known. These more innovative activities will be specifically selected and tailored to the options in such a way as to maximise the opportunities for meaningful public consultation.

Our plan is to hold a number of public meetings but, as suggested by members of the HOSC, must ensure that discussion remains relevant to the options under discussion. In this context we will endeavour to repeat our practice of the pre-consultation engagement period when we had an independent chair for the key meetings with the skills to keep discussions well focused.

We will establish a database of key stakeholders including local authorities, local MPs, GPs, other independent health contractors, Foundation Trust Governors, Leagues of Friends, media contacts, pressure groups, patient groups, campaign groups, community groups, third sector groups, voluntary groups, trades unions, business organisations, carers and members of the public.

Throughout the pre-consultation engagement period an engagement vehicle was deployed by Healthwatch Cumbria, to visit some of the more remote communities and ensure the involvement of people who may not otherwise have been engaged. We plan to use the engagement vehicle again during the public consultation programme.

It is an important part of any public consultation programme that seldom heard groups should be fully engaged. We will take advice from our key stakeholders and from patient and carer groups on which are the key seldom heard groups that need to be given special assistance to help ensure their full and proper engagement.

As some areas in Cumbria do not have good access to broadband and many people particularly older people, choose to use offline mechanisms for communication and consultation. We will ensure that consultees have both online and offline channels available for completing consultation questionnaires and will seek to use existing community groups to help facilitate consultation with these people. We will also make full use of social media platforms.

We will be clear that the results of public consultation are an important factor in health service decision making, and are one of a number of factors that need to be taken into account in decision making. The results of public consultation do not represent a veto over any form of change.

### 10.1.2 Consultation Timetable

The provisional timing for the consultation programme is that it should run from 4 July 2016 to 23 September 2016. In acknowledgement of government guidelines on consultation in the run up to elections and referenda, this consultation cannot begin until after the EU referendum on 23 June 2016.

We are proposing to have a minimum of sixteen public meetings. At the request of the HOSC, this is double the number of meetings originally proposed and includes public meetings in all eight of the community hospital localities. During the formal consultation period, at the request of the HOSC, we will also hold monthly briefing meetings for stakeholders to update them on consultation progress and also brief the County Council's four local committees on the consultation progress. We will aim to respond to all ad hoc meeting requests (for example from parish councils, town councils, patient groups etc.) in an appropriate and proportionate manner.

The results of the consultation process will be assessed and analysed independently with the final consultation report being published as soon after consultation as possible. Key internal dates relating to assurance process for the consultation are outlined below.

Meeting	Date
CCG Governing Body	10 <sup>th</sup> May 2016
HOSC	16 <sup>th</sup> May 2016
NHSE Investment Committee	23 <sup>rd</sup> May 2016
Self-Assessment	W/C 23 <sup>rd</sup> May 2016
Confirm and challenge meeting with Tripartite and key partners	w/c 30 <sup>th</sup> May 2016 (date to be confirmed)
CCG Governing Body (extraordinary meeting)	w/c 6 <sup>th</sup> June 2016
Programme Board	9 <sup>th</sup> June 2016
NHSE Investment Committee	20 <sup>th</sup> June 2016
Consultation Begins	4 <sup>th</sup> July
HOSC	25 <sup>th</sup> July 2016
CCG Governing Body Meeting	3 <sup>rd</sup> August 2016
Consultation Ends	23 <sup>rd</sup> Sept
CCG Governing Body Meeting	5 <sup>th</sup> October 2016
HOSC	13th December 2016



## 10.2 Implementation Plan

Following a post-consultation decision by the CCG (supported by regional and national health and local government bodies as appropriate) that will determine any essential proposed service reconfigurations, there will be a period of transition when the agreed changes to services will be planned in detail, in readiness for full implementation. This implementation process will be clinically-led and will involve clinical professions from all backgrounds and organisations. Patients, carers and members of the public will be invited to participate in the transition and implementation planning.

Implementation is a key element of any programme. If implementation is not carried out correctly, not only is there a risk that the programme will not work the way it was intended, but other unintended consequences such as decreased staff morale and participation in the project as well as increased costs can stop the programme.

### 10.2.1 Prior to Implementation

Prior to reaching the transition and implementation phase, a number of key activities must take place:

**Analysis of the consultation:** during this phase responses to consultation will be analysed and a report produced containing the findings from this analysis. This report will be provided to the HOSC and made available to the public.

**Impact Assessment:** in parallel to the consultation process there are a set of detailed analyses that need to be carried out on the proposals for consultation. Impact assessments of the proposals will be required for travel times and accessibility and equality. Furthermore, an over-arching health impact assessment will be undertaken. The outputs from all of the impact assessments will be provided to HOSC prior to finalisation of their responses to the consultation. Cumbria County Council public health colleagues will assist with preparation and assurance of the impact assessments to ensure that a wider population health and wellbeing approach is taken.

**Decision-making:** formal decision-making by the CCG will then take place, taking account of the output from the consultation including the integrated impact assessment, identification of variant options arising out of the consultation and advice from the Clinical Senate to make a recommendation for consideration.

**Ongoing development of the business case:** following CCG decision-making, the pre-consultation business case must be further developed to set out the strategic and clinical case for the selected option, the financial assessment of the selected option including investments required and cash releasing benefits and confirmation of affordability and an assessment of the risks and how these will be managed. This will enable the development of the Decision Making Business Case (DMBC).

**Implementation planning:** planning for implementation will have already commenced as during the consultation period in order to be ready for shortly after the end of the consultation period. This will enable the programme to commence implementation at the earliest opportunity and ensure that benefits can be realised as soon as possible. This planning cannot be completed in detail until the outcome of the consultation is known and a decision is taken to go ahead with a particular option. The outcomes may be that the preference is for a variant of option or a mix of a number of options. However, detailed implementation planning for those elements applicable to

all options for change and additional planning for a variant which can then be adapted once the outcome of the consultation is known can be undertaken.

### 10.2.2 Implementation Phase

This phase will begin following approval by the CCG. It is expected that implementation will commence in October 2015 noting that some proposals will be implemented prior to this period which are not dependent on post-consultation decision-making. Implementation of the changes will be coterminous with the delivery of the system-wide sustainability and transformation plan.

The first stage will be planning preparation to agree the following:

- The workstreams for this phase.
- Responsibility for undertaking the work.
- Key milestones for the planning phase.
- How the plans will be challenged and signed off.

A critical success factor for implementation will be the clear allocation of accountability during this phase, set out in a Programme Implementation Plan.

The workstreams currently identified in the implementation planning phase include:

**Workforce Strategy:** for the NHS WNE Cumbria-wide workforce strategy, we will need to outline the approach to how staff changes during implementation will be managed. The impact on staffing numbers and structures is potentially one of the most complex areas for transition and one likely to create significant concern amongst our current workforce. Policies for staff transition would need to be developed and communicated effectively and regular briefings developed and communicated to all staff in those providers likely to be affected by the proposed reconfiguration.

We expect to change settings of care, consolidate resources in different areas and change the way in which we provide services. The changes will therefore have a significant impact on the workforce in WNE Cumbria, including:

- A requirement for training / recruitment to develop new skills within the local health economy.
- A requirement for staff to move to work on different sites and potentially for different employers.
- Changes in the overall mix of skills / grades required across different settings of care.
- Improved integrated working across organisational boundaries, including closer working between health and social care.
- New roles development, such as care coordinators, urgent care practitioners, specialist community nursing, intermediate care clinicians and senior clinical leaders for community care.
- Greater number of roles requiring rotation between acute and community settings.

**Staff transition management:** the Implementation Plan will need to detail the approach to how staff changes during Implementation will be managed as the impact on staffing numbers and structures is potentially one of the most complex areas for transition. Preparatory activities will include collecting complete data about existing staff in the areas likely to be affected, including their current terms and conditions, lengths of service. This information will be needed for any staff that may be TUPEd to other organisations if a service is to be transferred, or for staff asking to retire early as part of the process. Policies for staff transition will need to be developed and communicated effectively. There will also be implications for staff skills. Changes in service delivery models may mean that staff require additional training or further development of existing skills.

We will need to continue to actively engage staff as stakeholders during implementation. To build awareness of the reconfiguration proposals and to consider and promote their central role in making these changes happen. Clinicians will need to be actively involved in the planning and implementation of service change to ensure patient safety is not compromised as changes are made – in particular, we need to work together with our partners in social care to co-design and begin to deliver the transformation to Community services which are critical to the success of the sustainability programme.

**Clinical workstreams:** it is envisaged that there will be a range of clinical workstreams to focus on the service changes needed. These will be agreed when the implementation plan is being prepared, and are currently identified as public health, prevention and self-management primary care, proactive and urgent care, community hospitals, emergency and acute medical care, women and children's services, mental health services (subject to a separate consultation process), planned elective care, specialised services. Each workstream will be responsible for planning the service transformation and reconfiguration programme.

**Non-clinical workstreams:** five non-clinical workstreams are currently identified to support the clinical workstreams. These are workforce, informatics and technology, estates, transport and organisational development. These workstreams will be critical in supporting the clinical workstreams to make the necessary workforce transformation.

**Estates planning:** proposed changes will have implications for the health and social care estate in WNE Cumbria, and particular properties that need to be changed to accommodate expansion in services or change of use of premises across the geography to enable delivery of the new care models. This will need to be planned in detail prior to the implementation phase so that lead-in times for changes to configurations are understood, and the full scope of activities are built into the implementation plan (design, planning, defining and awarding contracts, oversight of delivery, commissioning the new/ refurbished buildings, completion and snagging). There will also be elements of the estate that may become redundant and need to be closed down and disposed of. Given the expected expansion in community care, estates planning will need to cover all health and social care premises, not just acute and community hospital sites. The planning for this workstream will include planning for the management of transition (when facilities may be temporarily re-used) as well as investment/divestment of existing premises to reach the desired end state.

**Clinical Support Services:** changes in service configuration will have implications for the provision of clinical support services including diagnostics, theatres, clinical administration and similar.

**Facilities Management planning:** similarly, changes in service configuration will have implications for the facilities needed in the hospitals including cleaning, catering, ICT.

**Supplier Engagement:** there will need to be a workstream that focuses on existing external suppliers. This will need to include collecting information on relationships and contracts with external suppliers so that services are not compromised during the transition. The relationships will consequently need to be managed to ensure that contracts can be extended if required to maintain safe delivery of services during transition and to keep suppliers informed of future opportunities.

**Informatics & Technology:** focused on the informatics infrastructure and resources needed in the health and social care community to improve current systems and support the new models of care.

**Legal:** legal work will contribute across the workstreams, but is identified as a separate workstream, as the programme will need to call on legal resources throughout the process.

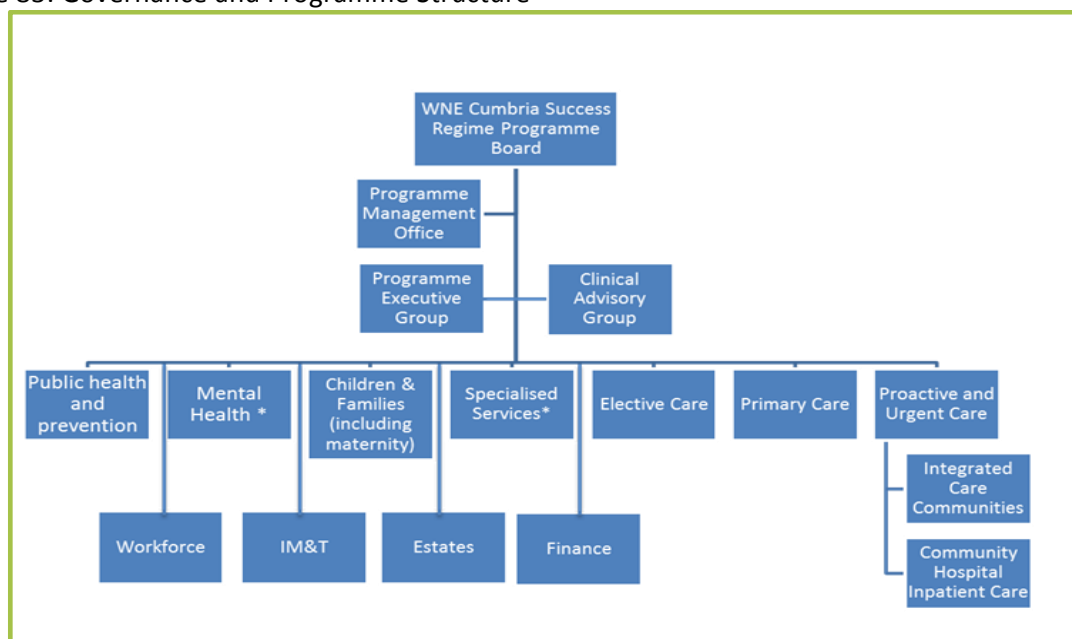
**Communications:** the communications and media handling activities will be critical during implementation. It will be key to ensuring that communications are continued during the planning phase – to maintain engagement, particularly with clinicians, and ensuring that there is a coherent communications plan in place to underpin implementation.

**Travel and patient transport:** depending on the option selected, there may well be significant action needed to change or enhance travel arrangements. These cover public transport, patient transport and blue light services. This will require coordination with key stakeholders including Cumbria County Council, patient transport providers, and North West Ambulance Service.

### 10.2.3 Governance

The WNE Cumbria Success Regime currently provides an overarching governance and programme structure, summarised in Figure x below.

Figure 83: Governance and Programme Structure



Source: WNE Cumbria Success Regime

We will develop a comprehensive programme of work to plan and manage these changes and developments across WNE Cumbria; some of which will need to be led by commissioners, and some by providers working collaboratively. Implementation of the post-consultation decisions should be driven through business as usual commissioning arrangements wherever possible. It is proposed that:

- An implementation SRO is appointed to take overall accountability for implementation.
- An implementation Programme Board is established to meet at least quarterly to plan, manage progress, resolve issues and manage risks and interdependencies. It is envisaged that this board will evolve from the existing STP Delivery Board.
- The Implementation Programme Board should consist of CCG and Provider representatives and be chaired by the SRO. The newly established board will develop and manage progress of an implementation plan in close partnership with partners in social services and Health and Wellbeing Boards.

Each provider will be required to:

- Nominate an Implementation SRO and an Implementation Manager.
- Develop a detailed Implementation Plan.
- Establish appropriate governance to manage progress against this.
- Report progress to the Implementation Programme Board, escalating any risks, issues and dependencies they are unable to resolve internally.

Implementation of the transformation to community-based care will be driven by of the CCG, working closely with statutory and voluntary sector providers. Work will be carried out immediately to confirm:

- Governance arrangements to ensure that community and acute aspects of implementation are fully aligned.
- How the community standards are to be implemented.
- Community transformation performance management arrangements and associated quarterly monitoring processes.
- Developing performance metrics to track and manage progress against key milestones or enablers of change (for example, reductions to acute ALOS, increasing UCC throughput for displaced A&E minor activity, shifts in care to Community settings).
- Developing targets for these measures that enable change to be delivered and support management of dependencies (for example, the need to improve out-of-hospital provision in an area before A&E services in that borough are changed).

## 10.3 Risk Analysis

A consistent approach to risk management is used across the programme. This ensures outline principles of measuring, managing and reporting risk are maintained. It provides a framework for the management of risk through rigorous governance arrangements and regular review by the Programme Board. (An exemplar risk register is illustrated below.)

Figure 84: Exemplar Risk Register

Risk identifier	Risk Category	Risk description (cause, risk event and impact)	Likelihood – CURRENT (Feb 16)	Consequence – CURRENT (Feb 16)	Expected d value for each risk – CURRENT	Risk Response Action	Likelihood	Consequence	Residual risk assessment post-mitigation
1	Programme Process Robustness	The programme is not sufficiently resources (in terms of capacity and expertise) to deliver its objectives within acceptable timeframe	3	4	12	Continuous review of programme resources monitored via the Programme Chair and Director	2	4	8
2	Clinical Services Safety, including harm to patient and staff	Service instabilities – failure to address the specific urgent issues in relation to acute non-elective hospital services given the current vulnerability of current services, failing actions to deliver cancer standards, A&E standards, RTT targets	4	5	20	Discussions with tripartite to address issues, SRG work plan in place to address immediate performance issues. Clinical Task Force proposal for engagement with Medical Directors being finalised	3	4	12
3	Public opinions regarding the programme and/or stakeholder organisations	Loss of public confidence in the future service model and delivery	4	4	16	Mobilisation of engagement plan and engagement workshops planned and signed off in January programme board	3	3	9
4	Staff opinions regarding the programme	Loss of staff confidence in future model and delivery	4	4	16	Mobilisation of engagement plan and engagement workshops planned and signed off in January programme board	3	3	9
5	Service continuity	Failure to implement the acquisition or alternative organisational form	3	3	9	Hold workshop in January and second workshop in February to develop and Organisation Form work plan with key milestones for delivery	2	3	6
6	Service continuity	Failure to demonstrate collaborative leadership behaviours in order to deliver the programme and achieve transformational change	3	3	9	Development of an Organisational Development plan including OD sessions with Programme Board members – plan agreed at Jan programme board. Gateway review planned for 11 <sup>th</sup> April 2016	3	3	9
7	Financial sustainability	The programme doesn't collectively address the challenges and identify options to sufficient scale to close the financial gap across the system	4	4	16	Financial modelling work undertaken in line with emerging options. Finance work plan in place and weekly DOF meetings in place to monitor progress against plan	3	4	12

### 10.3.1 Implementation Risks and Dependencies

The programme regularly reviews risks to delivery. The programme will need to develop robust mitigation for all risks, including:

- Delays in implementing workforce transformation, including staff training / migration from acute to community in addition to development of new roles.
- Delays to the capital procurement process and/or lack of availability of capital to create the required changes to physical capacity across WNE Cumbria.
- Removal of training accreditation / service closure due to safety DOF concerns, impacting on the planned sequencing of service transfer.
- Risk that acute hospital services fail in advance of reconfiguration.



- Risk to recruitment and retention through ongoing poor media coverage and damage to reputation of organisations including designated status of being in special measures for NCUHT

An underlying theme of the implementation plans for each option is that the community services are implemented to enable the proposed changes to acute care and that capacity is re-aligned accordingly. Progress on two critical dependencies therefore requires careful monitoring to ensure this happens:

- Community transformation delivering the reductions in acute hospital activity.
- Acute providers achieving efficiency and productivity improvements in their services to ensure sustainability of receiving major hospital sites.

### 10.3.2 Post-programme Evaluation Plans

Where possible, the implementation of changes will draw on lessons learnt from other health service changes in Cumbria (e.g. Better Care Together and Closer to Home initiatives) as well as work from other new models of care.

Regular update reports, milestone reports and programme reports will be made available during implementation alongside financial reviews and risks/mitigation reports.

### 10.3.3 Measuring the Impact of Change

We will establish a benefits framework to describe the patient, clinical, staff and operational benefits that we expect to realise across primary and secondary care through successful delivery of the proposed changes.

The WNE Cumbria Success Regime wants to make sure that it achieves all that it set out to do and will work with us and the local care system in WNE Cumbria to develop a comprehensive and pragmatic list of measurable performance indicators, focused on patient outcomes and patient experience. These will be firmly embedded within performance management arrangements as part of “business as usual”, both to minimise additional reporting requirements and to ensure that the performance improvements are embedded within performance management processes in the long term.

## 10.4 Next Steps

Throughout the formal consultation, we will respond to questions raised by the public, NHS staff and other stakeholders. We would wish that this process enables us to co-produce with each local community the future services that they wish to develop as partners with local statutory agencies. This will be an ongoing dialogue. Once the consultation process is complete, a full response to the consultation will be created and submitted to the Success Regime Programme Board and the CCG Governing Body.

Following consultation, all the responses received will be collated and taken into consideration. The Business Case will be refreshed, the proposals may be refined and there may be further examination of the impact of the proposals on some clinical pathways. There will also be an independent report compiled on the consultation responses. A final set of proposals will be presented to the CCG Governing Body.



In the months after consultation, further work will be done to refine proposals covering:

- Additional analysis based on questions raised during consultation.
- Further detail on options still under consideration.
- Any additional Impact Analysis requested by the CCG.

This analysis will be brought together in a Decision Making Business Case (DMBC), which will be submitted to the CCG Governing Body to enable it to take final decisions on service reconfiguration for WNE Cumbria, the programme for which will be developed following consultation. Throughout this process, we will make every effort to ensure that the underpinning themes of our Case for Change are developed and implemented. We will:

- **Maximise use of the strengths of our local communities.**
- **Use the opportunities associated with new technologies.**
- **Deliver health and social care in new ways.**

## Glossary

Medical Career Grades (New system, as per “Modernising medical careers”)		
Year 1	Foundation programme (2 years – FY 1, FY2)	
Year 2		
Year 3	Specialty Registrar (StR) (6-8 years)	Specialty Registrar (StR) (3 years)
Year 4		
Year 5		General Practitioner
Year 6-8		
Year 9+	Consultant  (total time in training: 8-10 years)	(total time in training: 5 years)
Optional	Training may be extended by obtaining an <a href="#">Academic Clinical Fellowship</a> for research, or a Clinical Fellowship for sub-specialisation. *due to competition for consultant posts, it may take longer than 8 years to gain Consultant status.	

Term	Explanation
<b>62-day wait cancer metric</b>	Refers to the length of time that patients with cancer or suspected cancer wait to be seen and treated in England. One of the current standards for adults is that no more than 85% of patients should wait a maximum of 62 days from urgent GP referral for suspected cancer to first treatment.
<b>ACO</b>	An Accountable Care Organisation (ACO) is a group of providers that agree to take responsibility for all care for a given population for a defined period of time under a contractual arrangement with a commissioner.
<b>Ambulatory care</b>	Ambulatory care is a patient focused service where some conditions may be treated without the need for an overnight stay in hospital.

<b>ALIS</b>	The Access and Liaison Integration Service (ALIS) provides assessment and support for people experiencing acute mental health distress and their carers
<b>APNP</b>	An Advanced Paediatric Nurse Practitioner (APNP) is an experienced Registered Children's Nurse who has undergone further training to enable them to take a comprehensive medical history, carry out a systemic medical examination, plan appropriate medical treatment and nursing care, prescribe appropriate medication, and review effectiveness of care and treatment.
<b>Better Care Fund</b>	The Better Care Fund (formerly the Integration Transformation Fund) is a local single pooled budget designed to incentivise the NHS and local government to work more closely together to ensure transformation the integration of health and social care.
<b>CCG</b>	Clinical Commissioning Group (CCG): NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England.
<b>CIC</b>	Cumberland Infirmary, Carlisle
<b>CLU</b>	A Consultant led unit (CLU) is a maternity unit led by a consultant which is able to take care of women with existing medical problems or who may need additional monitoring during labour. A CLU requires supporting obstetric, anaesthetic, neonatal and paediatric services.
<b>CPFT</b>	Cumbria Partnership Foundation Trust (CPFT) provides community and mental health services in WNE Cumbria.
<b>CQC</b>	The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England
<b>CT2</b>	Refers to the second year of the core training medical post.
<b>DPS</b>	Doctors in Partnership Scheme (DPS): an innovative idea to form a clinical team capable of immediate deployment to assist a failing health system or organisation in crisis.
<b>ECIP</b>	Emergency Care Improvement Programme (ECIP) is a clinically led programme that offers intensive practical help and support to 28 urgent and emergency care systems in England.

<b>EPR</b>	Electronic patient record
<b>FFT</b>	Friends and Family Test (FFT) is a quick and anonymous way to give your views after receiving care or treatment across the NHS.
<b>Five Year Forward View</b>	The Five Year Forward View sets out a vision for health and social care services in the future, the steps that need to be taken to get there and the action needed from others. This NHS document was first published in 2014.
<b>Front and back of house</b>	<p>Front of house refers to the following services: primary care, community capacity for rapid response to avoid unnecessary admission, step up care to prevent inappropriate admission to acute care, hot clinics and same day assessments, Minor Injury Unit and Emergency Department services, liaison psychiatry services, acute medical assessment and “back of house” support (to include modelling of any new transfer activity), and intensive care support.</p> <p>Back of house refers to the following services: integrated and multiagency discharge processes, early supported discharge services, step down care to facilitate a stepped pathway out of hospital, other rehabilitation and reablement services, residential care home, nursing home and home care services.</p>
<b>GPwSI / GPSI</b>	A GP with a Special Interest (GPSI) who supplements her / his role as a generalist by providing an additional service while still working in the community.
<b>GPVTS</b>	GP vocational training scheme (GPVTS) is a three-year training that doctors must undertake to become an independent general practitioner.
<b>Healthy Child Programme</b>	The “Healthy Child Programme” is the main universal health service for improving the health and wellbeing of children through health and development reviews, health promotion, parenting support, screening and immunisation programmes.
<b>HEE</b>	Health Education England (HEE) is an autonomous national body set up to provide system wide leadership and oversight of workforce planning, education and training. HEE is responsible for commissioning under and postgraduate education, to ensure a workforce in the right numbers, with the right skills, values and behaviours to respond to the current and future needs of patients.

<b>ICC</b>	Integrated Care Centres (ICCs) are proposed to be formed from general practice groups, community staff, such as community nurses, therapists, social workers, primary mental health care workers and third sector workers. ICCs will develop links with their local acute Trust to ensure their patients experience seamless episodes of care.
<b>ImROC</b>	The implementing recovery through organisational change (ImROC) programme supports local NHS and independent mental health service providers and their partners to become more “recovery orientated”.
<b>LEP</b>	Local Enterprise Partnerships are sub-national forms of government, primarily aimed at being the bridge between local/ regional government and the private sector. LEPs are the primary form of super-local/ sub-national form of government, since the abolition of Regional Development Agencies in 2010
<b>Local Health and Social Economy</b>	This Local Health Economy includes the health and social system covering West, North and East Cumbria. This primarily means the primary, secondary and tertiary care offered by the WNE Cumbria University Hospitals Trust and the Cumbria Partnership NHS Foundation Trust and Cumbria Council
<b>LSOA</b>	Lower Layer Super Output Areas (LSOAs) are a geographic hierarchy designed to improve the reporting of small area statistics in England and Wales, built from groups of contiguous Output Areas that have been automatically generated to be as consistent in population size as possible. There is a Lower Layer Super Output Area for each postcode in England and Wales.
<b>Low acuity beds</b>	Acuity refers to the level of nursing staff required to give good care to patients. Low acuity beds refer to beds designated for patients that have low nursing staff needs.
<b>MBBS Training</b>	Bachelor of Medicine & Bachelor of Surgery - an innovative approach to medical education for self-funded and sponsored international students (non UK/EU).
<b>Middle grade doctors</b>	A junior doctor (non-consultant) who has more experience than a FY2, but less experience than a consultant. Middle grade doctors include staff grade, clinical fellows and specialist registrars (ST1, ST2, and ST3).

<b>MLU</b>	A Midwife-Led Unit (MLU) is a birth-centre led by midwives, as opposed to consultants. An MLU can either be a stand-alone unit or a unit attached to hospital.
<b>NCUHT</b>	The North Cumbria University Hospitals Trust (NCUHT) are the secondary care provider of acute hospital services in north Cumbria, based at the Cumberland Infirmary in Carlisle and the West Cumberland Hospital in Whitehaven, with a birthing centre at Penrith Community Hospital
<b>NWAS</b>	North West Ambulance Service (NWAS) provides emergency medical services and non-emergency Patient Transport services in WNE Cumbria.
<b>PCBC</b>	A pre-consultation business case (PCBC) is a document that details proposals to reconfigure health and social care services.
<b>Primary Care Transformation Fund</b>	Multi-year £1 billion investment programme to help GPs make improvements, particularly in capital assets (e.g. technology) and estates.
<b>Primary Care Home initiative</b>	An initiative aimed at integrating the workforce from hospitals, primary care, community health services, social care and the voluntary sector. As a result, patients should be offered more personalised, coordinated and responsive care closer to home. The National Association of Primary Care are currently trialing primary care homes at rapid test sites.
<b>PSA</b>	Public service agreement
<b>PTS</b>	Patient Transport Services
<b>RTT</b>	Referral to treatment (RTT) 18-week performance metric: National, statutory performance target for the length of time between a hospital receiving a referral letter, or when the first appointment is booked, to the first treatment. The target is that at least 92% of all patients will receive the first treatment within 18 weeks.
<b>SCBU</b>	A Specialist Care Baby Unit (SCBU) provides babies with additional oxygen, heart rate monitoring, tube feeding with nasogastric tube, phototherapy for jaundice, and help for mums to establish breastfeeding. One of the key functions of a SCBU is as a step down unit for a Neonatal Intensive Care Unit.

<b>"Single team" concept</b>	The "Single Team" concept refers to the aggregation of teams in CIC and WCH. The intention is that teams across both sites work together, with some rotation, to ensure that skills are maintained and collaborative team working increases, thereby improving workforce resilience.
<b>Six-week diagnostic metric</b>	The six-week diagnostic metric is the key statutory measure for all diagnostics tests, measuring the number of people who have been waiting for a test (since requirement identified) for more than six weeks. The target is that less than 1% should wait more than six weeks for diagnostic tests.
<b>SpR trainees</b>	SpRs are Specialty Registrars - trainee doctors in their third to fifth years of training if their intention is to become a GP. Specialty Registrars can also refer to training doctors in all the way up to their eighth year of training if their intention is to become a consultant.
<b>SSPAU</b>	Short Stay Paediatric Assessment Units (SSPUs) are aimed providing care to children with minor-to-moderate illnesses, while minimising length of stay where possible and keeping children out of general admissions (in line with Sam's House principles). SSPAUs most commonly treat conditions requiring general medicine such as fevers, diarrhoea, vomiting, abdominal pain, seizures and rash, but also treat breathing difficulties, head injuries and non-intentional poisoning. A 14 hour SSPAU is open for 14 hours / day
<b>ST1/ST2/ST3/ST4/ST5</b>	Specialty trainee doctors, of different years of training (1 to 5). Over the years of training, doctors build up their knowledge, clinical skills and professional approach.
<b>Step up / step down</b>	Step up / step down refers to the management of a patient's movement between levels of acute and non-acute care with the aim of minimizing unnecessary occupation of high acuity beds and long length of stay.
<b>TDA</b>	Trust Development Authority (TDA) provides support, oversight and governance for all NHS Trusts.



<b>UCC</b>	An Urgent Care Centre (UCC) is an alternative to an accident and emergency department, providing a care setting for a range of minor injuries and urgent medical problems. It is a walk-in NHS service for patients whose condition is urgent enough that they cannot wait for the next GP appointment, but who do not require A&E emergency treatment. It is staffed by a GP, emergency nurses, and usually has the equipment for basic diagnostic tests (X-ray, CT, blood tests). Offers the same services as an MIU, but usually has a consultant on hand at all times.
<b>WCH</b>	West Cumberland Hospital
<b>WNE Cumbria</b>	West North and East Cumbria comprises the districts of Allerdale, Copeland, Carlisle and Eden.
<b>WTE</b>	Whole time equivalent

## APPENDICES

### APPENDIX A:

WNE Cumbria Success Regime Clinical Strategy March 2016

### APPENDIX B:

Patient Stories

### APPENDIX C:

ICCs Narrative

### APPENDIX D:

Integrated Care Communities – Local Case Studies

### APPENDIX E (a) and (b):

Cumbria Success Regime – Workforce Baseline Parts 1 and 2

### APPENDIX F (a) (b) (c) (d):

West Cumbria Public Health Data

### APPENDIX G:

Workshop – Impact on Health and Wellbeing Gap

### APPENDIX H:

Community Hospitals – Preferred Option for WNE Cumbria Success Regime

### APPENDIX I:

Financial analysis: *The information contained in this Appendix has been updated since the date of the original PCBC to reflect further financial analysis and modelling.*

### APPENDIX J:

Additional Financial analysis: *The information contained in this Appendix has been updated since the date of the original PCBC to reflect further financial analysis and modelling.*

### APPENDIX K:

Community Travel Impact Analysis

### APPENDIX L:

Acute Travel Impact Analysis