Cumbria Success Regime Clinical Senate Report

Response to Final Document

| **4.1 Vision, Clinical and Community Engagement and Communication** | |
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| **Clinical Senate Recommendation** | **Success Regime Response** |
| 4.1.2 Further develop the process for ongoing engagement to develop and implement a clearly articulated and universally owned clinically-led vision for improvement for all of the proposed clinical models | In advance of the roll-out of our comprehensive engagement programme, a number of documents were produced to ensure a universally owned, clear consistent and coherent vision was established for the North, West and East Cumbria Success Regime. This included the development of a suite of documents outlining an agreed and shared set of key messages, a narrative for the WNE Cumbria Success Regime programme and an explainer document. These documents served to:   * describe the nature and purpose of the WNE Cumbria Success Regime, covering the main/key issues of the moment in jargon-free “plain English” * be “owned” and approved by the Success Regime Programme Board and to enable everyone associated with the programme to understand the same coherent and consistent story * to provide all those in professional communications with a single, approved public position statement * provide content to be used in all public, staff and stakeholder communications   We would be happy to share any or all of these documents with the Clinical Senate.  Since the establishment of these preparatory documents, the Success Regime has adopted an open and transparent approach to communicating its vision and early clinical thinking.  This has seen the publication of a number of materials to help articulate its vision and early thinking from its clinical workstreams. Key documents published include:   * Progress Report (March 2016) * Key Baseline Facts and Figures document (March 2016) * CQC response document (April 2016) |
| **Clinical Senate Recommendation** | **Success Regime Response** |
|  | Please note that these documents have since been used as an update to our narrative and key messages.  Clinical leadership of key strands of the work has been put in place and is developing further the detailed vision and narrative, for example, the new Associate Medical Director leading the new Urgent Care model at WCH, the clinical leads for the early adopter for Integrated Care Communities.  All of these documents available on the Success Regime website, and have been sent to stakeholders personally to keep them informed.  Furthermore, meetings and workshops have been held to provide face-to-face updates and hear the views of the public, staff, patients and other key stakeholders in order for them to be captured as responses to our engagement programme.  Details of engagement events that have already taken place and a plan for forthcoming activities are set out in our attached documents and in the response below. |

| 4.1.3 Co-design and communicate a robust and meaningful clinically-led engagement process which supports all areas of the Success Regime   * HealthWatch Cumbria has led an excellent engagement process for maternity services. If possible, they should be involved in the other clinical areas.   Greater Manchester’s Healthier Together Programme and Healthy Liverpool will also provide some useful insights into the improvement process | The engagement programme for the WNE Cumbria Success Regime began in December 2015, although public and stakeholder views have been captured in a number of previous engagement programmes.  During this period of engagement the NHS has gathered feedback and opinions from well over 6,500 people on the future of health and care services in West, North and East Cumbria. This has been achieved through a number of engagement mechanisms and activities which to date (beginning of May 2016) have included:   * Public or private stakeholder meetings (including workshops and focus groups) * Staff engagement meetings * Written responses (letters, emails, blogs, etc.) * Online responses through the ‘Have Your Say’ form on the Success Regime website * A travelling Healthwatch engagement vehicle, “the chatty van”, which has travelled to communities across Cumbria – including some of the most remote communities   It is worth nothing that this engagement programme is ongoing, with further activities planned during May.  For a breakdown of the number of different engagement activities undertaken and the key themes arising from this, please see the attached “Engagement dashboard” document.    We would also be happy to send a detailed information on dates, venues and events, as well as copies of all written responses received by the Success Regime should the Clinical Senate wish to review these.  the Success Regime’s workstreams at regular agreed intervals. |
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|  | The feedback we have received during this engagement process has been formally fed back to the Success Regime’s workstreams at regular agreed intervals.  Furthermore, we completely agree with the Clinical Senate on the importance of ongoing engagement as the Success Regime programme progressing. In light of this, we attach for you our “Consultation strategy” document which outlines our plans for engagement during the consultation phase of the programme from July 2016 onwards. |

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| **Any Additional General Comments** |
| The West, North and East Cumbria Success Regime programme has seen two different forms of engagement activity. These are as follows:   1. Engagement from the individual clinical workstreams within the Success Regime to involve patients, carers, the community and staff in the development of their clinical proposals. This is the responsibility of the workstreams 2. A broad programme of communications and engagement activity to update the general public, staff, patients and specific stakeholders on the work of the Success Regime in a wider sense and to ensure their views are captured and fed back to the workstreams for consideration when developing clinical proposals. This is the responsibility of the WNE Cumbria Success Regime communications and engagement team   The WNE Cumbria Success Regime communications team, as stated above, is responsible for the second of these engagement areas, and therefore the detail outlined in this response looks at the broad programme of communications and engagement activity undertaken.  The Success Regime communications and engagement team would like it noting that it is not surprised that the Clinical Senate review team was unaware of engagement activity to date because the team was not asked to contribute or feed in to the original review process. We welcome the opportunity to feed in to this process.  As outlined above, we have attached two documents which help further demonstrate the Success Regime’s commitment to a comprehensive and inclusive engagement programme. These are: |
| **Any Additional General Comments** |
| 1. An “Engagement dashboard” document detailing the numbers we have engaged with, how many engagement events and activities have been organised, as well as the key themes emerging from these 2. Our “Consultation strategy” document which outlines our plans for engagement during the consultation phase of the programme from July 2016 onwards |

| **4.2 Clinical Standards, Improved Outcomes and Implementation of Best Practice** | |
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| **Clinical Senate Recommendation** | **Success Regime Response** |
| 4.2.1 Support clinical leaders to work with their teams and service users to identify, interpret, translate and customise national and other standards to their local environments. | The workstream structure of the Success Regime already ensures clinical leads and service users have support and structurally there are many enabling services – including an integrated knowledge and library service for all providers and the CCG. Specific support has also been arranged (and will be arranged where necessary) for example the RCOG led review for maternity; bringing in an experienced leader from Torbay for the ICC programme etc.  The Success Regime Clinical Advisory Group (including all the lead clinicians in the Success Regime) maintains an overview of progress and therefore of any additional support any group or individuals need.  The SROs and Clinical leads have access to Leadership Development and Technical QI methods through CLIC.  We held a seminar with the Academy of Royal Colleges and key national clinical leaders to support the workstreams in interpreting national standards into local context.  We have supported the clinical leaders via the existing networks (e.g. Maternity) and the North East Clinical Senate (e.g. Acute Care). |
| 4.2.2 Identify how public health and social care can be involved actively and made jointly accountable for addressing the challenges, co-creating the vision, developing the standards and plans and delivering the change. | The County Council have identified a lead consultant in PH who is working directly with the Success Regime on health impact assessment and public health strategy. The DPH has recently published a strategy to support health improvement and tackling inequalities.  Similarly, social care is represented at Board level and all relevant workstreams – particularly the ICC |
| **Clinical Senate Recommendation** | **Success Regime Response** |
|  | agenda.  Evaluation of specific Cumbria success (e.g. the Millom project) have focused attention on “co-creation” with all services and the local population and the Cumbria Learning and Improvement Collaborative (CLIC) has commissioned specific support for groups to get this principle embedded. |
| 4.2.3 Collaboratively co-design and develop a portfolio of clinical and patient experience standards for each clinical model and the system of care and ensure that they are used to:   * articulate the case for change in terms of patient experience and outcomes * inform any clinical assumptions for workforce, activity and economic modelling | CLIC has supported two tools to enable this objective: patient journey mapping and value stream mapping. Training and support is being rolled out for lead managers and clinicians.  Two conferences (one for adults, one for children and young people) have established the principle of experience based design and individual projects are supported to engage in the way described.  More work needs to be done to articulate the ‘case for change’ in this way and incorporate more service user and public value into the planning.  Full engagement exercises (See above 4.1.3) have been held both generally (commissioned via ‘Healthwatch’) and specifically (e.g. Maternity) to ensure the user and public voice is heard. |
| 4.2.4 Identify solutions from elsewhere and adapt them to local circumstances. | This is a key way of working – we have relationships with Torbay, Scotland, Wales, Sweden and of course constant literature and working group involvement (e.g. the ‘Grafton group’ of CCGs, the Kings Fund, etc.) and membership to ensure no potential learning is missed. |
| 4.2.5 Adopt a systematic approach to spreading best practice and quality improvement across the system. | This is part of the objective of CLIC. We have created systematic collaborative learning opportunities and projects (like the ‘Clinical Skills’ programme now in phase 2) to ensure spread and learning. |
| 4.2.6 Identify and prioritise key areas for improvement for rapid and focussed further development. | This is the core way of working of the programme. |
| 4.2.7 Identify areas where rapid progress could be made so that some “quick-wins” (within 6 months) can be achieved to provide encouragement for ongoing local engagement in further work. | The ICC early adopter sites, programmes in mental health, cancer pathways, frail elderly and the ECIP work for flow in the hospital are all aimed at this goal.  As part of the STP process we are working to develop an Implementation plan for short, medium and longer term improvements. |

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| **Any Additional General Comments** |
| The Success Regime benefits from the CLIC collaboration and has an OD approach built into its thinking.  More work needs to be done with service users to co-create solutions.  A fresh leadership approach, based on the evidence drawn from Kings Fund/Professor Michael West has been adopted and is supported by all the participating organisations.  We also benefit from a single knowledge and library service (and single strategy) and high IT connectivity to support clinical teams to advance in an evidence based, continuous learning way. |

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| **4.3 Workforce - Education, Training, Recruitment and Retention** | |
| **Clinical Senate Recommendation** | **Success Regime Response** |
| 4.3.1 Work with local clinicians and communities to think creatively about how best to meet the workforce challenges through the development of bespoke arrangements. | A 10 Point Action Plan for workforce and recruitment is in place with specific focus on the development of new roles and innovative approaches to education and training, based on the outcomes of the emerging clinical strategy. All activities are integrated across the partner organisations.  We specifically commissioned an evaluation of Millom community engagement which has been a very successful example of how the community has supported a workforce challenge. (e.g creating an advertising video for recruiting a GPs) |
| 4.3.2 Undertake more work with partners across the geography including local communities, schools, colleges and Health Education England North West and the Northern Deanery to design novel approaches to training and workforce development, recruitment and retention that includes both the medical and non-medical workforce. | As above. Key actions within the plan relate to:   * Engagement with HEE, local universities and colleges (including both Deaneries) * Innovative recruitment and retention approaches. These have already been launched with plans for further work going forward * Working with schools and colleges specifically in respect of work experience * Preparation for the introduction of the apprenticeship levy |
| 4.3.3 Undertake detailed workforce analysis and modelling informed by creative thinking as well as the necessary professional standards that deliver the agreed clinical models and patient outcomes. | The workforce repository and planning tool (WRaPT) is being deployed across all the clinical workstreams with support from the central team regarding analysis and modelling. |
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| **Any Additional General Comments** | |
| A copy of the most recent update to the 10 Point Plan is attached for information. | |

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| **4.4 Information Management and Technology Adoption** | |
| **Clinical Senate Recommendation** | **Success Regime Response** |
| 4.4.1 Develop clear information governance and sharing agreements across the whole system | The Cumbria health and care community uses the Information Sharing Gateway tool, developed by Information Governance staff jointly funded by CPFT and the CCG. The tool won an AQUA award in 2015, and has been endorsed by Cumbria and Lancashire IG leads as part of a wider Information Governance framework used across health and care organisations. |
| 4.4.2 Develop a business case to support the IMT strategy that is based on learning from others such as iLinks across Merseyside, ‘Data Well’ in Greater Manchester and Salford (which is the most digitally mature organisation in the NHS) and includes:   * routine use of technologies such as telemedicine etc. * information sharing * information governance * resources for health and care professional training | Cumbria CCG, working with health and care partners, is developing the Local Digital Roadmap, based on a Cumbria wide footprint. This is to be submitted as part of Sustainability and Transformation Plans for WNE Cumbria and Lancashire/South Cumbria S&TPs, at the end of June.  An initial IM&T strategy for the Success Regime has already been developed, based on the initial clinical workstream propositions, that are now being built into the Success Regime Pre-Consultation Business Case. This is in the process of being updated, as clinical workstreams define new models of care.  A workshop with the Universities of Lancaster and Cumbria are being held the week commencing 16th May and the Scottish Centre for Telehealth and Telecare are presenting two workshops in Carlisle, highlighting the opportunities to develop and roll out telehealth and telecare at scale. On the back of these workshops, we will produce our Digital Roadmap, recognizing the best practice contained in the iLinks and Datawell strategies. |
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| **Any Additional General Comments** |
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| **4.5 Patient Transfer, Transport and Repatriation** | |
| **Clinical Senate Recommendation** | **Success Regime Response** |
| 4.5.1 Clarify the impact of any proposed clinical changes on repatriation and access to specialist and other services for patients. | We have sought and agreed formal partnership arrangements with Newcastle Hospitals to ensure that all specialist services are managed with an eye to maximize both patient experience and clinical outcome. Specialised services commissioners are represented on the Success Regime Programme board and a recent product of collaborative working is the commissioning of an expanded Radiotherapy service in Carlisle.  The CCG is reviewing out of area activity to learn lessons about why patients (and their GP) are choosing to get their care in alternate providers.  The Success Regime Programme includes a specific workstream focusing on transport. The work of this group has included consideration of issues in relation to Patient Transfer, Transport and Repatriation and impacts of the proposed clinical models.  In developing the Pre-Consultation Business Case, the Success Regime has completed a travel impact analysis relating to the options beings considered. In addition, plans are being developed to support patient repatriation and transfer. |
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| **Any Additional General Comments** | |
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| **7.1 Mental Health Clinical Proposals** | |
| **Clinical Senate Recommendation** | **Success Regime Response** |
| 7.1.1 Focus on the acquisition, review and analysis of needs-based data across the system. | As we build the model of care we will focus on a needs based approach. We will ensure we utilise the health and social needs information available from Public Health and other sources, ONS etc. which we can apply to the Integrated Community footprint.  We have an understanding of our Cumbria demographic and in particular the issues being faced by people with Mental Health problems.  We will incorporate a more substantial section on the needs assessment which is a fundamental part of the model of care. The headlines being:   * higher than average number of suicides * higher admissions for self-harm * high levels of unemployment in pockets across the county, with employment status being a key determinant of mental health problems * significant pockets of deprivation, again being a key determinant of mental health problems * a large predicted increase in older people with mental illness, driven by demographics.   To support this Mental Health Strategies are undertaking bed-modelling based on three years retrospective activity across community and hospital services. The change in demography and future anticipated increased need is factored into the work. We will model the impact of different options for bed reconfiguration. A copy of the modelling proposal, due to report on 12th May 2016 is embedded. |

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| **Clinical Senate Recommendation** | **Success Regime Response** |
| 7.1.2 Ensure that Mental Health is integrated within the Success Regime programme and informs all other clinical plans.   * Further develop work to achieve “parity of esteem”, for example, by including primary mental health expertise within the physical health team integration development. * Ongoing work also should also extend to Child and Mental Health Services (CAHMS). * Consider and take account of how the strategy will impact on other health care providers including A&E, social services, carers, staffs, public health, ambulance services, and pharmacy | We will ensure a holistic approach to the mental health planning and will, again through the model of care development, confirm parity of esteem as a fundamental aspect.  We have also agreed to inform the Integrated care community development work how mental health should be maintained across the community and taking the local population needs into account and aligning service development against the needs assessment.  We will work with our children, families and colleagues to ensure we are able to reference the pathways more succinctly as they interrelate to those in the Children and Families Proposition. By working in partnership in this way we can be consistent and therefore work as a more effective ageless Mental Health model.  The crisis assessment model has more detail regarding the impacts on the wider organisations but we will demonstrate this across the whole programme. |
| 7.1.3 Model flows through the crisis response model for all ages, to gauge impact on in-patient and primary care flows. | This will be clear through the work being carried out across the options proposed in the Mental Health Strategies simulation model (see above). Once the outputs are know we will build into the proposal. |
| 7.1.4 When developing the concept of more treatment at home, when undertaking the review of estates, there is a need to be sensitive to evidence where family pressures can exacerbate rather than support mental health difficulties.   * It is important to identify how primary care or home care will address the complexities of patient care rather than seeing it as a solution to low staffing ratios, geographic complexities and limited finance | We are building a social response alongside the crisis pathway and also looking at alternative solutions for people who seek support.  There is also further work underway which will describe our models of recovery, self-management and prevention. The expected outcomes will be built into the proposal to support this.  All mental health assessments currently consider presenting need and social circumstance. |
| **Clinical Senate Recommendation** | **Success Regime Response** |
| 7.1.5 Prioritise the building of resilience for services to children and families as part of overall mental health plans, particularly the transitional years. | We will work with our children, families and colleagues to ensure we are able to reference the pathways more succinctly as they interrelate to those in the Children and Families Proposition. By working in partnership in this way we can be consistent and therefore work as a more effective ageless Mental Health model. |
| 7.1.6 Consider further the remodelling on in-patient flows as a direct response to primary mental health and crisis response outcomes, particularly where the re-distribution of funding may negatively impact elsewhere in care pathways.   * For example, there is a need to ensure effective CAMHS and ED support at Whitehaven to avoid admissions | We will explore this in more detail as it relates to a specific site and the identified needs there. The proposal has a county wide view and is strategic but may need to evidence specific local issues in the case for change.  We will review the outcomes of the modelling simulation configure scenarios around CAMHS. |
| 7.1.7 Investigate the need to provide effective support for self-harming at Whitehaven to avoid admissions. | We will assess the business intelligence around this and ensure we consider the impact of any developments we are modelling. |
| 7.1.8 Develop system clinical outcome measures that will enable benchmarking of strategy roll out. | We have developed clinical outcomes as a framework but will ensure this can be better described in terms on quantifying. |
| 7.1.9 Use findings from past service challenges to understand their impact on clinical outcomes. | We will build in past evidence and reports to evidence progression and service improvement. The strategic vision was a response to past challenges, which we can refer to in more detail. |
| 7.1.10 Where areas of strategy are built around “proof of concept”, focus on clinical outcome measures in this proof. | We have mapped some of the clinical outcome assumptions and we will express them more clearly in the proof of concept section. |
| 7.1.11 Consider more critical analysis of existing practice and identify the changes that need to occur that will help both staff and patients. | We explore this in more detail and ensure we evidence the findings clearly in the proposal. |
| **Clinical Senate Recommendation** | **Success Regime Response** |
| 7.1.12 Consider in greater depth how bed management strategies can address the needs of patients and their carers as well as well as the resourcing issues of the NHS. | As part of the bed modeling process we will consider this as part of the scenario planning and report back on the outcomes through the proposal. |
| 7.1.13 Encourage hospital clinicians to work and/or be involved more in the community care centres. | The OD plan will encompass the way of working and specifically look to this issue. A&E representative are part of our Crisis Centre Project Steering Group and associated sub-groups. |
| 7.1.14 Build a core clinical governance theme based upon routine acquisition of patient/carer/family experience. | We are acquiring patient and service user views/experiences currently and will have a more detailed analysis of this going forward and also determine the level of frequency to ensure we are fully informed of the patient and career experiences and are able to respond. |
| 7.1.15 Use a baseline workforce assessment to test the feasibility of new service models. | We have recently acquired the baseline assessment so this will be analysed and incorporated into the plans. The WRaPT workforce planning tool is being used to support this. |
| 7.1.16 Evaluate innovative recruitment strategies e.g. The Millom initiative. | There are other initiatives we wish to explore also and these have been picked up by the Success Regime Workforce Enabling Workstream. |
| 7.1.17 As part of modelling new services, evaluate competency impact of moving staff into new roles and build an integrated training support model to mitigate skill gaps. | This is part of the workforce planning approach, competency based modelling, we will make this clear in the paper when relating to the Workforce Enabling Workstream. |
| 7.1.18 Exploit current initiatives to extend contribution of IT solutions and staff training to engage local populations. | We have contributed to the Digital Roadmap for Cumbria and ensure our requirements are known. We will summarise this in the proposal. |
| 7.1.19 Consider the training all staff in the management of challenging behaviours to promote parity of esteem. In addition, all staff should make every contact count, for example, smoking cessation and CVD risk reduction. This will ensure that Mental Health teams address basic medical issues as well as | Part of the health and wellbeing layer in the model of care builds on this principle but would benefit from further comment and explanation. |
| **Clinical Senate Recommendation** | **Success Regime Response** |
| physical teams addressing basic mental health issues. |  |
| 7.1.20 Consider a rapid response team for all mentally ill patients going through a crisis episode for all ages in A&E Departments. | This is part of the crisis assessment centre model. |
| 7.1.21 Review further, initiatives to involve competencies for third and voluntary sectors in building workforce resilience | We are exploring this initially through a crisis pathway however there is an opportunity to expand this across the whole model of care. |
| 7.1.22 Build on the existing strategy to ensure the general public are core to engagement processes that seek to understand preferences for how services should be delivered | We have commenced the options appraisal process for inpatient services, however the principles are good and we will be developing this as a framework to support this recommendation. |
| 7.1.23 Consider how best to integrate communication systems into new models, particularly in relation to connecting people with services and supporting individuals and their families | Our network of third sector and service users can contribute to this recommendation as they are a critical partner in delivering the Mental Health programme. They have some innovative ideas, which we can build into the work we are currently doing. |
| 7.1.24 Test how the new models can be built around specific population areas with sensitivity to both native population, geography and skill recruitment | We can use the needs assessment to guide this and respond to the identified requirements. |
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| **Any Additional General Comments** | |
| Thank you for this comprehensive feedback, it is a really useful prompt to ensure a more robust end result.  The mental Health Strategy for Cumbria which forms the Mental Health Transformation programme superseded the Success Regime and has a Cumbria wide focus. The challenge is to embed the vision and model of care across the emerging proposals from the existing strategy. We will enhance the LD element of the proposal.  Reviewing the recommendations has been helpful and will assist the development of the proposed models. There are some areas where we have constructed the proposal from our Vision and Model of Care, in particular the 10 elements of the Kings Fund **‘Bringing together physical and mental health: A new frontier for integrated care’** (March 2016)’ as well as the 5 year forward view for mental health. These will be further developed to reference against the proposals. | |

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| **7.2 Integrated Care Clinical (ICC) Model (including Community services)** | |
| **linical Senate Recommendation** | **Success Regime Response** |
| 7.2.1 Consider the creation of robust governance arrangements which include key stakeholders, for example through the use of an Accountable Healthcare System or other partnership model with all partner organisations. | We will develop detailed governance arrangements as part of the implementation of the early adopter sites.  We have used the AQUA framework for integrated working for health and social care systems to look at readiness across 8 dimensions for a successful accountable system. |
| 7.2.2 Identify and stratify the risks across the health and social care system and use the results to inform the development of the ICC programmes and footprints. This could be achieved by creating a map of patient journeys to learn about and appreciate the existing problems and identify the improvements that will have the biggest positive impact for patients and staff. | We will use a risk assessment framework as part of the implementation plan for ICCs and risk registers will be managed as part of the implementation governance.  As discussed above patient journey mapping is one of tools promoted by CLIC and is part of the OD plan for mangers and clinical leads in all of the workstreams. |
| 7.2.3 Visit and learn from other health economies which have had success at achieving integration (examples above). | We have already benefitted from input from Pete Colclough (former Chief Executive of Torbay PCT) and have also discussed the approach being taken in Leicestershire.  Both the Medical Director Derek Thomson and Director of strategy in NCUHT developed the HRRP/LINS programme in Northumbria therefore have experience in this. |
| 7.2.4 Develop and measure achievement of standards and improved outcomes, through the implementation of an audit programme to inform | We will develop key metrics as part of the benefits realisation plan to support the implementation plan for ICCs. |
| **Clinical Senate Recommendation** | **Success Regime Response** |
|  | We are using the experience from Millom to look at novel targets as defined by the patient, for example total miles travelled to get care. |
| the ongoing changes. Also consider the use of other service evaluation tools such as patient reported outcome measures (PROMs) and clinician reported outcome measures (CROMs). | Thank you for the recommendation about PROMs and CROMs and will ensure these are discussed by the emerging leadership teams by the early adopter sites. |
| 7.2.5 Engage with stakeholders to co-design plans and proposals to meet the needs of the population within the resources available.   * Consider integrating services that offer a logical fit and where the impact will be greatest based on the local population and geography. | The development of the proposed ICC footprints has been based populations of between 20,00 and 80,000 based on GP lists and natural communities to take account of the local population and geography.  The work to establish each of the ICCs will involve considerable engagement with local stakeholders. |
| 7.2.6 Develop a communication plan and robust governance arrangements for the pilots and other adopters. | We will develop a communication plan for the implementation of the early adopter sites and the later phases of implementation. |
| 7.2.7 Undertake further work to develop a robust and realistic workforce plan which addresses the following:   * models the proposed workforce roles and numbers and testing the assumptions re potential financial savings * Clarifies the age profile and turnover of the staff * Clarifies the assumptions which have been made about the recruitment of new staff into the area and whether the anticipated numbers are realistic. * Clarifies the assumptions which have been | We are developing a workforce plan for the early adopter sites. We will ensure that the plans are robust and realistic and take account the factors suggested by the Clinical Senate. |
| ***Clinical Senate Recommendation*** | ***Success Regime Response*** |
| made re the flexibility of the workforce and whether these are realistic   * Builds on the results of a risk assessment of staffing numbers and clarifies the proposed governance arrangements to manage the identified risks * Outlines plans for the ongoing training and development of staff * Describes how professional isolation will be addressed * Embeds Quality Improvement into work force training and CPD * Describes the extent that local commissioners have been engaged in the development of the workforce plan |  |
| 7.2.8 Develop an integrated IT plan (with appropriate training) which embraces telemedicine in order to address some of the patient access issues. | We have an IT Enabling Workstream, which is fully engaged with the ICC planning as a key interdependency. |
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| **Any Additional General Comments** | |
| We appreciate the need to articulate the concept and concrete benefits of Integrated Care Communities more clearly. | |

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| **7.3 Children’s Clinical Model** | |
| **Clinical Senate Recommendation** | **Success Regime Response** |
| 7.3.1 Make timely decisions and decide concurrently on models of care for both maternity and children & families in order to maintain the viability of any future services.   * The requirements of a consultant led obstetric unit are such that the paediatric model of care needs to be robust to support it. This was considered by Dr Shortland in his review. * The Senate Review Team recommend that his opinion is considered further i.e. a 14 hour SSPAU at the WCH site may be a more achievable and sustainable option | The interdependencies between Maternity and Paediatric services are fully recognized both in the propositions and the options appraisal and evaluation processes that are in place. Recommendations on Models of care will part of the PCBC in line with the Success Regime timelines. |
| 7.3.2 Consider the following issues when modelling the effects of each option, reviewing achievability and making a decision:   * cross-border activity (e.g. the number of patients that would move to Barrow) * Interim arrangements in terms of both staff resources and financial costs and likelihood of meeting target configuration | We know from activity modelling and evidence of activity having already moved that the flow is likely to be east to Tertiary Centres rather than south to Barrow due to accessibility & road networks.  Evaluation criteria was used in the shortlisting of options for inclusion in the PCBC, includes reference to the likelihood of achieving and sustaining models of care taking account of both staff resources and financial costs. |
| 7.3.3 Further develop a robust and realistic workforce plan which addresses the following:   * models the proposed workforce roles and numbers and tests the assumptions re potential financial savings * Clarifies the age profile and turnover of the staff | Realistic and robust workforce contingency plans are already in place.    The Success Regime Workforce Workstream have also developed a 10 Point Action Plan for workforce and recruitment, with specific focus on the development of new roles and innovative approaches to education and training, based on the outcomes of the emerging clinical strategy. All activities are integrated across the partner organisations. |
| **Clinical Senate Recommendation** | **Success Regime Response** |
| * Clarifies the assumptions which have been made about the recruitment of new staff into the area and whether the anticipated numbers are realistic * Clarifies the assumptions which have been made re the flexibility of the workforce and whether these are realistic * Builds on the results of a risk assessment of staffing numbers and clarifies the proposed governance arrangements to manage the identified risks * Outlines plans for the ongoing training and development of staff * Describes how professional isolation will be addressed * Embeds Quality Improvement into work force training and CPD * Describes the extent that local commissioners have been engaged in the development of the workforce plan   Also See General Recommendations in Section 4.3 | Key actions within the plan relate to:   * Engagement with HEE, local universities and colleges (including both Deaneries) * Innovative recruitment and retention approaches. These have already been launched with plans for further work going forward * Working with schools and colleges specifically in respect of work experience * Preparation for the introduction of the apprenticeship levy   The workforce repository and planning tool (WRaPT) is being deployed across all the clinical workstreams with support from the central team regarding analysis and modelling.  Implementation plans have been developed and will reflect the recommendations suggested by the Clinical Senate. |
| 7.3.4 Employ novel recruitment models once a clear vision for the future of the service has been established. Suggestions include:   * Movement of clinical leaders between sites * Secondments of senior well established clinicians who may also provide additional clinical leadership * Working alongside universities to provide academic units | With support from the Workforce Enabling Workstream, innovative recruitment models are currently being trialed and we will continue to look for new opportunities to develop attractive job plans that will create greater interest for people to live and work in Cumbria. The details can be found in responses to recommendation in section 4.3. |
| **Clinical Senate Recommendation** | **Success Regime Response** |
| 7.3.5 Consider CAMHS and other service interdependencies throughout the decision making process and when putting in place transitional arrangements. | The Children and Families Workstream has taken a whole system approach to review of services and this includes CAMHS. There has been continuous and robust representation of CAMHS services in the Children and Families Workstream and this will continue. |
| 7.3.6 Ensure that a whole systems approach is maintained by considering community services and general practice at the heart of the decision making process. | The Children and Families Workstream has taken a whole system approach to the review of services, this is centered around the integration of services and supports the concept of Integrated Care Communities.  The Children and Families Project Group includes representation from Primary Care (GPs), Community Nursing, Acute Care, Social Care and Public Health, Hospice and third sector as well as commissioners. |
| 7.3.7 Support the Trust to continue to build upon its exiting successes such as telemedicine. | Through our continuing engagement with children, young people and their families we know that the increased use of telemedicine is welcome. We are committed to increasing the use of telemedicine and are encouraged by the progress made by the Success Regime IM&T Workstream in developing the digital roadmap. |
| 7.3.8 Ensure that a robust engagement plan which builds on Sam’s House is developed and implemented. It also needs to address and explain the reasons why changes are required. | The Children and Families proposition document details communication and engagement activities that took place before the Success Regime was established. The engagement programme for the Success Regime began in December 2015 and engagement with service users and stakeholders have been captured within the engagement programme. The details can be found in responses to recommendation in section 4.1. |
| 7.3.9 Further develop the standards and quality measures for the service. | The standards for Children’s services are centered around the RCPCH standards. Quality measures and benefit realisation plans are being developed as part of our implementation plans. |
| 7.3.10 Undertake an audit of likely number of patient transfers if the SSPAU model was implemented. | An acuity audit was undertaken in January 2015, which identified the likely number of patient transfers from West Cumberland Hospital (WCH) to Cumberland Infirmary (CIC).  In December 2015 a comprehensive audit of all inpatients on paediatric wards at CIC and WCH was undertaken. The audit reviewed patient pathways in relation to preadmittance/admittance/length of stay/discharge/post-discharge. This audit is in a process of being analysed and will be shared to inform the implementation plans by the end of May 2016. |

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| **Any Additional General Comments** |
| Reviewing the recommendations has been helpful and will assist the development of the proposed models. Cumbria CCG is also involved in the Better Care Together Programme in South Cumbria and are fully aware of the configuration of paediatric services in Barrow and related issues. |

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| **7.4 Maternity Clinical Model** | |
| **Clinical Senate Recommendation** | **Success Regime Response** |
| 7.4.1 Ensure that the proposed clinical models build on NICE guidelines and quality standards. | Agree |
| 7.4.2 Consider the clinical co-dependencies involved during the development of the proposals for maternity services. Sources of useful information about the process for identifying clinical co-dependencies are:   * The South East Senate report on clinical co-dependencies * The Making It Better and Healthier Together Programmes * The GM Devolution Specialised Services co-dependency assessment framework * The Healthy Liverpool Programme | The clinical interdependencies for maternity services has been fully acknowledged in the consideration and development of our proposals. We have undertaken a significant literature review and created an evidence base including national and international examples of best practice and innovation. We will review the evidence highlighted by the Senate and ensure that it is included in our evidence base. |
| 7.4.3 Consider and take account of the critical interface between maternity services and paediatrics in the further development of the proposals. | The interdependencies between Maternity and Paediatric services are fully recognized both in the propositions and the options appraisal and evaluation processes that are in place. |
| 7.4.4 Clarify how Cumbria responded to the concerns of the CQC. It would be helpful to see evidence of how the concerns raised from previous reports have or are being addressed. | The response to the CQC report was not public the time this review was conducted. However, CQC response document has been used to update to our narrative and key messages. The document is available on the Success Regime website and has been sent to stakeholders personally to keep them informed. |
| **Clinical Senate Recommendation** | **Success Regime Response** |
| 7.4.5 Undertake further work to develop a robust and realistic workforce plan which addresses the following:   * models the proposed workforce roles and numbers and testing the assumptions re potential financial savings * Clarifies the age profile and turnover of the staff * Clarifies the assumptions which have been made about the recruitment of new staff into the area and whether the anticipated numbers are realistic. * Clarifies the assumptions which have been made re the flexibility of the workforce and whether these are realistic * Builds on the results of a risk assessment of staffing numbers and clarifies the proposed governance arrangements to manage the identified risks * Outlines plans for the ongoing training and development of staff * Describes how professional isolation will be addressed * Embeds Quality Improvement into work force training and CPD * Describes the extent that local commissioners have been engaged in the development of the workforce plan | Realistic and robust workforce contingency plans are already in place.    The Success Regime Workforce Workstream have also developed a 10 Point Action Plan for workforce and recruitment, with specific focus on the development of new roles and innovative approaches to education and training, based on the outcomes of the emerging clinical strategy. All activities are integrated across the partner organisations.  Key actions within the plan relate to:   * Engagement with HEE, local universities and colleges (including both Deaneries) * Innovative recruitment and retention approaches. These have already been launched with plans for further work going forward * Working with schools and colleges specifically in respect of work experience * Preparation for the introduction of the apprenticeship levy   The workforce repository and planning tool (WRaPT) is being deployed across all the clinical workstreams with support from the central team regarding analysis and modelling.  Plans will also take into account the factors suggested by the Clinical Senate. |
| 7.4.6 Clarify further the Enhanced Neonatal Nurse/Midwife roles in terms of:   * Training numbers * Plans for supervision and ongoing training * Proposed level of ongoing support from the wider staffing infrastructure to reduce professional isolation * Proposed level of professional responsibility and accountability etc. | We welcome the senate’s comments and will continue to clarify and develop these roles. |
| **Clinical Senate Recommendation** | **Success Regime Response** |
| 7.4.7 Develop robust quality metrics and standards which can be used as a marker of progress and or success. | Following the RCOG Maternity Services Review, a Maternity Dashboard has been implemented which includes robust quality metrics and standards and will be used as a marker of progress and success. The dashboard is also enabling robust benchmarking against peer group organisations at both a local and national level. |
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| **Any Additional General Comments** | |
| Concern has been expressed in relation to the following statement on criteria for MLUs. It is unclear what is implied in the statement. The Director of Midwifery at NCUH is very clear that MLUs are purely for low risk labour and birth.  “The potential to expand birthing units should be explored further, although the Review Team urge caution in the light of population expectations as in Penrith the number of births is increasing. In addition, if a woman wants an epidural, this cannot be provided on an MLU. If, especially in remote areas, there is a desire to expand the use of MLUs, the Success Regime Team should be encouraged to review the literature to understand whether categories presently excluded, could safely be managed on MLUs” | |

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| **7.5 Proactive and Emergency Care Clinical Models** | |
| **Clinical Senate Recommendation** | **Success Regime Response** |
| 7.5.1 Co-design and communicate a clear vision which focuses on future development, quality improvement and the achievement of clinical standards that will ensure reliable care and includes a much stronger evidence base with identified safety, quality and effectiveness metrics.   * Focus communications on high level aspirations which describe how best to improve the outcomes for the population and describe what the system could look like in the future. * Communicate the ongoing benefits for the population which will result from service change e.g. improvements in mortality and morbidity should be monitored and reported regularly by the Success Regime | Whilst the acute urgent care elements of proposals have primarily been designed by acute professionals, primary care and CCG involvement has occurred at key stages and co-ordination has been provided through the multiagency Proactive & Urgent Care Board. We recognize that more will need to be done to involve patient and members of the public and will take this forward as the detail of the model develops. However, the Success Regime pre-consultation public engagement has clearly identified a strong desire in the West Cumbria population to see the continuation of Acute & emergency Medicine at WCH – and our proposals deliver that public aspiration. We, of course, recognise that we need to do more in communicating the model, with a strong vision and a clear quality improvement message, all underpinned by a sound evidence base. Whilst the latest Pre-Consultation Business Case draft has addressed some of these issues, we will work to ensure that further drafts, consultation documents and other core communications make this story far stronger.  We have already agreed, as an immediate priority, the need (for the Success Regime as a whole) to identify the outcomes anticipated to meet our overall success criteria linked to the interventions proposed, develop specific metrics and understand our initial baselines as soon as possible. We intend to pick this up for all workstreams through the Programme Executive and Clinical Advisory Group. |
| 7.5.2 Ensure that the proposed clinical models build on relevant guidelines and quality standards, suggestions as follows: | The Success Regime work has necessarily focused in on addressing major fragilities and challenges in key areas, so has not attempted to cover all specialties, pathways and services. However, for those areas we have considered and re-designed, we have taken into account the |
| **Clinical Senate Recommendation** | **Success Regime Response** |
| * Recent NICE guidelines * The Keogh report (which identifies evidence-based robust emergency care pathways) * College guidelines and standards for ED * Greater Manchester Primary Care standards NICE quality standards addressing hospital admission outcomes * The South East Clinical Senate and the GM Devolution Specialised Services clinical co-dependencies frameworks * Reference evidence and learning from other sparsely populated areas | need to meet College Guidelines, NICE Guidance etc. – for example in relation to staffing competencies and levels as well as best practice pathways in developing integrated emergency floors, building our use of Acute Care Physician model. We have also researched approaches in other areas such as Cornwall, Scotland, Wales as well as abroad. However, we fully recognize that there is little explicit reference to this work and that it will provide an importance evidence base in ‘selling’ our proposals – we will therefore now systematically gather the guidelines, standards and research evidence we have used and ensure this is well communicated. |
| 7.5.3 Further develop a robust and realistic workforce plan which addresses the following:   * models the proposed workforce roles and numbers and testing the assumptions re potential financial savings * Clarifies the age profile and turnover of the staff * Clarifies the assumptions which have been made about the recruitment of new staff into the area and whether the anticipated numbers are realistic. * Clarifies the assumptions which have been made re the flexibility of the workforce and whether these are realistic * Builds on the results of a risk assessment of staffing numbers and clarifies the proposed governance arrangements to manage the identified risks * Outlines plans for the ongoing training and development of staff * Describes how professional isolation will be | A high-level plan outlining the requirements for development and implementation of the proposed new model has now been internally approved by the Trust along with the governance arrangements to take forward the work with UCLan and provider/commissioner partners. We will ensure that the workforce detail recommended here is built into the subsequent detailed workplans to provide robust assurance on deliverability and timelines and mitigate associated risks.  Overall Success Regime work using the WRaPT tool will enable development of a whole-system workforce plan – this will include secondary acute/emergency care; the baseline analysis is now completed. The overall work is being led by the Workforce Enabling Workstream but has involved senior managers and clinicians in the acute Trust as well as other providers.  We welcome the useful checklist that the senate proposes here as we develop our models. |
| **Clinical Senate Recommendation** | **Success Regime Response** |
| addressed o Embeds Quality Improvement into work force training and CPD   * Describes the extent that local commissioners have been engaged in the development of the workforce plan.   Also See General Recommendations in Section 4.3. |  |
| 7.5.4 Further clarify the role of Physician Associate in terms of:   * Training numbers * Plans for supervision and ongoing training o Proposed level of ongoing support from the wider staffing infrastructure to reduce professional isolation * Proposed level of professional responsibility and accountability etc. | The composite workforce strategy requires that we model training & competency development requirements for existing Advanced Nurse Practitioners (ANPs) plus future Physician Associates PAs) & Advanced Clinical Practitioners – Medicine (ACPMs). Early stage planning is already underway between NCUHT & UCLan.  We are in the process of modifying the clinical / professional supervision and line management arrangements for existing ANPs to better facilitate new competency development, provide optimal support and improve accountability for ANPs as well as new PAs and ACPMs.  We are already clear in our plans that PAs in first will work at FY1/2 level, whilst, with suitable training and experience, ANPs / ACPMs will be able to work up to ST3 level. |
| 7.5.5 Develop an integrated IT plan (with appropriate training) which embraces telemedicine in order to address some of the patient access issues. | It is recognized that considerable further work is required in this area and this will be taken forward jointly with the IT Enabling Workstream. |
| 7.5.6 Clarify how the emerging clinical plans are drawing on the knowledge and expertise of the local System Resilience Group (SRG). | Cross-membership and internal Trust mechanisms ensure full alignment with the local SRG. |
| 7.5.7 Provide more clarity in relation to patient transport across the system. In particular, the triage and decision-making process for transfer to an acute centre for surgery. The access to services should also describe how patients will be repatriated. | A separate Transport Workstream has set out the vision, principles and priorities for whole system health and care transport issues; this has not been previously shared with the Senate during the Review Process but can be if desired.  Specifically, a Transfer Policy jointly agreed in 2015 with North West Ambulance Service FT sets out transfer arrangements including triage and decision making process, required |
| **Clinical Senate Recommendation** | **Success Regime Response** |
|  | documentation and repatriation. Work continues between the two Trusts to both monitor transfer activity and policy compliance, and to develop new pathways to enable direct diversion of patients at community source where clinically appropriate (e.g. stroke, some trauma and cardiac pathways etc.). Improvements are also being made to elements of communication and documentation following a full clinical case note review of transfers, which will be included in a further revised policy over the next couple of months. Modelling has been undertaken to identify the impact on ambulance and PTS journeys for all options and also travel impact analysis. |
| 7.5.8 - Identify solutions which are more creative. | We will continue to strive to be creative in our thinking as we develop our future models. We believe we have exhaustively considered possible options in working with the North East Clinical Senate and other external advisors to develop a very creative solution for the acute medical workforce challenges at WCH. The North East Clinical Senate concurs with our view that this appears the only viable option to maintain service provision.  We would however be very pleased to consider other creative opportunities that Senate Colleagues may have in mind. |
| 7.5.9 Clarify plans for the development of infrastructure e.g. 24/7 radiology access which will support local diagnostics to inform access to Specialised and other services. | Where we have identified gaps in clinical support services through seven day standard audit these are in general part of ongoing work with commissioners and through individual workstreams. Some provision has been made for them in the high-level financial planning. The Trust has a good understanding of the key diagnostic challenges, and will ensure that the detail of requirements is built into the detailed implementation phases. |
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| **Any Additional General Comments** | |
| The benefit for patients and careers from the overarching model aimed to achieve organisational and operational effectiveness is the continuation of local Emergency & Acute Medical care at WCH – rather than the closure of the service and transfer of patients (approximately 75 mins plus) to Carlisle.  We have an enabling group for Transport work area with a management lead from North West Ambulance Service. The partnership working is taking place and NWAS are members of the Programme Board. | |

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| **7.6 Elective Care Clinical Model** | |
| **Clinical Senate Recommendation** | **Success Regime Response** |
| 7.6.1 Meet with the Manchester Healthier Together Team and the Healthy Liverpool team to explore their approaches to the identification of evidence-based clinical standards, patient and clinical engagement, communicating the vision for future improvements in patient outcomes and reduction in mortality etc. | Included in our action plan:   * Develop local standards (similar to those developed by the Manchester Healthier Together Team and the Healthy Liverpool team) * Explore the approaches of the Manchester Healthier Together Team and the Healthy Liverpool team to identify evidence-based clinical standards * Use the standards to support patient and clinical engagement, communicating the vision for future improvements in patient outcomes and reduction in mortality. |
| 7.6.2 Consider the clinical and operational co-dependencies involved during the development of the proposals for elective care including, inter alia, Primary Care and the Ambulance Service. Sources of useful information are:   * The South East Senate co-dependencies report * The Healthier Together Programme * The GM Devolution Specialised Services co-dependency assessment framework * The Healthy Liverpool Programme * Reshaping Surgical Services: Principles for Change, The Royal College of Surgeons of England January 2013 | We will   * Invite the ambulance service to participate on the project work stream steering group and in all future mapping events. * Review all the recommended sources of information. * Compile a diagram/a list of possible co – dependencies for each key pathway. * Include all the above in our action plan. |
| 7.6.3 Ensure that the proposed clinical model build on NICE guidelines and quality and safety standards, RCS and GMC Recommendations. Develop robust quality metrics and standards and a performance framework which can be used as a marker of progress and/or success | Each work area will determine appropriate quality indicators based on NICE guidelines and quality and safety standards, RCS and GMC Recommendations.  Each work area will develop appropriate performance indicators. |
| **Clinical Senate Recommendation** | **Success Regime Response** |
|  | Measure a baseline quality and performance and measure at regular intervals.  Include all the above in our action plan. |
| 7.6.4 Co-design coherent pathways for referral (with primary care) and for transfer and transit. Involve actively the Ambulance Service in the development of the proposals. | Include all the above in our action plan. |
| 7.6.5 Undertake further work to develop a robust and realistic workforce plan which addresses the following:   * models the proposed workforce roles and numbers and testing the assumptions re potential financial savings * Clarifies the age profile and turnover of the staff * Clarifies the assumptions which have been made about the recruitment of new staff into the area and whether the anticipated numbers are realistic. * Clarifies the assumptions which have been made re the flexibility of the workforce and whether these are realistic * Builds on the results of a risk assessment of staffing numbers and clarifies the proposed governance arrangements to manage the identified risks * Outlines plans for the ongoing training and development of staff * Describes how professional isolation will be addressed o Embeds Quality Improvement into work force training and CPD * Describes the extent that local commissioners have been engaged in the development of the workforce plan. | Link with the Workforce Enabling Workstream with regard to the elements contained in point 7.6.5.  Liaise closely with the Workforce Enabling Workstream with regard to pathway redesign where additional training or different forms/grades of staff are required.  Include all the above in our action plan. |
| **Clinical Senate Recommendation** | **Success Regime Response** |
| 7.6.6 Clarify how the IT infrastructure will support the operation of the centre, particularly access to radiology and other imaging results. | Develop an independent IT Infrastructure plan for WCH to support enhanced telemedicine opportunities and to meet access or imaging issues.    Develop an independent business case to support the IMT strategy at WCH which includes consideration of information sharing, information governance, resources and professional training.  Include all the above in our action plan. |
| 7.6.7 Clarify the subspecialty use, case mix and transfer and transit arrangements for the proposed centre. Use this information to assess whether the proposed model is fully optimized to serve the population. | Develop clarity around subspecialty use, case mix and transfer and transit arrangements for the proposed centre.  Assess the information against population post code data and assess if the proposed models match population demands.  Include all the above in our action plan. |
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| **Any Additional General Comments** | |
| It will be beneficial to a number of the Success Regime work streams to meet with the Manchester Healthier Together Team and the Healthy Liverpool team to explore their approaches to the identification of evidence-based clinical standards, patient and clinical engagement, communicating the vision for future improvements in patient outcomes and reduction in mortality.  We will explore the possibility of organising the Success Regime visit to meet the Manchester Healthier Together Team and the Healthy Liverpool team.  As the name “Centre of Excellence” means different things to different people we will investigate a new name which people can more easily identify with - such as one suggestion for a new name is - “Surgical Treatment Centre”. The aim will be to build a strong reputation for delivering high quality care. | |