

**A response to the Care Quality Commission on a
safe and sustainable future
for West, North and East Cumbria**



Version 1.0

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Foreword

This document is our response to the Care Quality Commission's (CQC) requirement for both a sustainable clinical strategy for West, North and East Cumbria (WNE Cumbria) and assurance that the issues highlighted in relation to services provided by North Cumbria University Hospitals NHS Trust (NCUHT) are being addressed.

We confirm the actions being taken to stabilise the most fragile acute hospital services and to improve performance against key constitutional targets including A&E performance and waiting times.

These actions are being taken in the context of our ambition to position WNE Cumbria as an area recognised for its expertise in delivering integrated health and care for people living in rural, remote and dispersed communities. This will require our services to be underpinned by a comprehensive approach to public health and prevention and characterised by strong clinical networks across health and social care within WNE Cumbria and beyond.

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.

Our work to develop a whole system clinical strategy is demonstrating the extent and breadth of the cultural and behavioural challenges across the system and we know that willingness to change is not the same as ability to change. Our focus is now upon turning talk into action and to make WNE Cumbria's ambitions a reality, we will:

- **Take a system-wide approach.** We know that transformation of the scale outlined in this document will only be achieved if national and local leaders take a different, system-wide approach to those taken previously, none of which have effectively delivered the expected improvements for patients and the public.
- **Focus on enablers for change.** To achieve the changes required we will require smarter workforce solutions, a different approach to transport, and optimisation of the opportunities offered by new technology. We will also need to consider the best organisational arrangements that will enable us to deliver services across WNE Cumbria.
- **Focus on relieving workforce pressures in the immediate term.** In the immediate term, due to workforce pressures, we know that some of our key services, including general practice and some hospital services, remain very fragile. This means that it is important that we move forward at pace and with purpose to address these pressures, and with contingency plans in place to ensure our communities can continue to access safe services, and our staff feel supported.

The actions set out in this document, while focusing on acute hospital services provided by NCUHT, are therefore being progressed within a wider context of an emerging clinical strategy which reflects local needs and future resource availability. We set out some of the

evolving clinical scenarios for our acute hospital services. It is, however, important to recognise that no decisions have been made. These scenarios will be developed and tested further through our engagement process to inform the development of a Pre-Consultation Business Case (PCBC), with proposals for change subject to full formal consultation with the public, staff and all key stakeholders later this year (Figure 1).

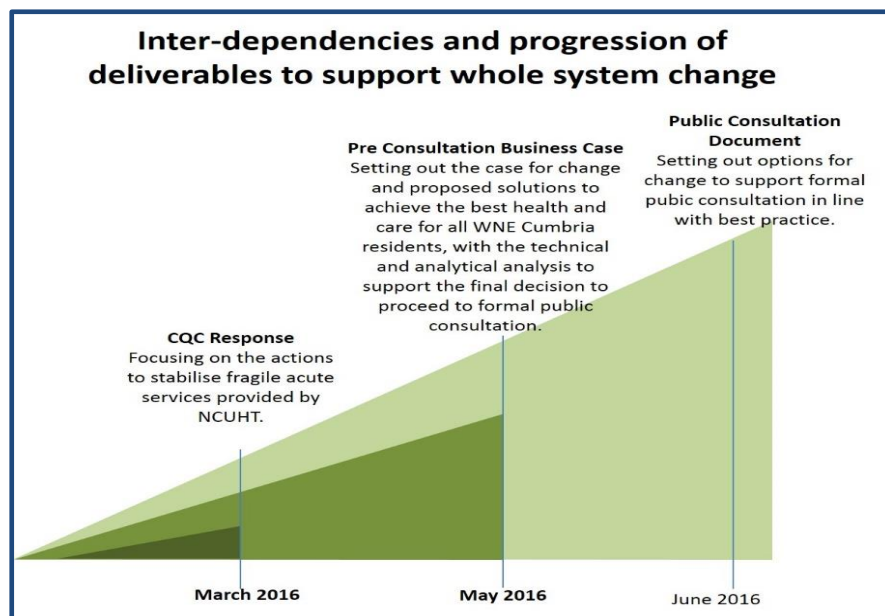


Figure 1. Relationship and timeline for key Success Regime deliverables

We have set out clear timelines and assurance processes to progress this work. This reflects our collective commitment to achieving our shared ambition, focusing on short-term actions while creating the conditions for successful long-term change in partnership with the community we serve. We know that strong leadership able to embed a culture of continuous improvement and ambition for excellence will be essential. In supporting this document we are confirming our commitment to the actions set out in support of NCHUT to respond to the CQC concerns. We recognise that there are important issues which sit out with the scope of this document, which are being progressed in parallel as we continue to work to achieve long term stability and improved outcomes for our population.

Neil McKay
WNE Cumbria Success
Regime

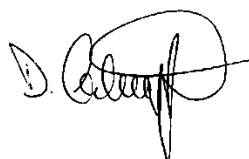
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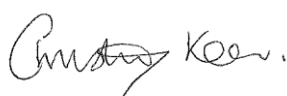


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Executive summary

This document is a system wide response to the request from the Care Quality Commission (CQC) to stabilise acute services provided by North Cumbria University Hospital Trust (NCUHT), and develop a sustainable clinical strategy for health and care delivery in West, North and East Cumbria (WNE Cumbria).

Chapter 1 sets out the **context for WNE Cumbria**. We recognise that the challenges for health care in WNE Cumbria are deep-rooted, long-standing and spread across the whole system. Over the years, many people have worked hard to improve health and care services in WNE Cumbria, and whilst there has been some success, the system still has significant cultural and behavioural challenges. The needs of our population are changing, with an aging population and comparatively high levels of ill-health prevalence. In addition, our geography adds further complexity, with communities spread over large distances. Making distance to, and between, key health and care sites challenging.

We also highlight the significant workforce issues impacting across the health and care system. This is resulting in an expensive large temporary workforce of doctors and key other professionals in our services, which is impacting on the cost and quality of services, and increasing pressure on already stretched health and social care staff.

A failure to drive efficiencies and productivity, diseconomies of scale associated with the current configuration of services and the area's geographical rurality, mean that our system is currently facing significant financial pressures with a projected overspend of c.£86m across providers and commissioners in 2015/16. The system will be even more stretched in the future, with our challenge potentially increasing to £163.8m in 2020/21.

We confirm some key principles that we believe are essential pre-requisites if WNE Cumbria health and care system is to be the best it can possibly be.

In **Chapter 2** we set out our plans to transform services across our whole care system through **strengthening out of hospital services**. It focuses on the work already progressing to improve population health and develop services that help people maintain their health and independence. We discuss the plans to establish Integrated Care Communities, which will bring together public health, general practice, social care, community services, mental health services and community assets to provide place based, coordinated care.

We believe that through these actions we can reduce reliance on acute hospital services and the need for long term care, and in so doing provide NCUHT the headroom to address quality and sustainability issues which are considered in **Chapter 3**.

In **Chapter 3** we set out the actions being taken to **stabilise acute services** in WNE Cumbria with specific reference to services identified by the CQC as being of particular concern. The significant issues associated with workforce are outlined, with plans for urgent and acute medicine, maternity and paediatrics focusing on both actions which aim to mitigate the workforce risks and actions which will support new models of care better able to meet needs. Given that some of the workforce issues reflect national shortages, we recognise that some of plans will be difficult and carry significant risk. Business continuity and contingency plans are therefore being continually reviewed to ensure that safe services can be maintained.

While working to stabilise fragile services, NCUHT is also clear that progress is made at pace to improve performance against **key constitutional standards**. **Chapter 4** confirms the actions that are being taken in relation to A&E and waiting times for elective care, diagnostics and cancer services.

In **Chapter 5** we acknowledge that while the actions to stabilise acute services and strengthen out of hospital services will improve quality, safety and patient outcomes, they carry significant risk and do not close the current system wide financial gap. We therefore acknowledge that we need to think more radically about how we plan and deliver health and care services. We have set out some **alternative scenarios for acute hospital services**, based on the principle of a single service across two acute sites. The scenarios are intended to help stimulate debate and discussion that will inform the development and assessment of options for the future that will be set out within a Pre Consultation Business Case prior to formal public consultation. We have set ourselves a clear timeline for this, recognising the need to provide greater certainty for our population and staff.

Chapter 6 summarises the work that has been progressing to **enable better care** focusing on workforce, finance, transport, clinical information and technology and organisational development. We also confirm the work that is progressing to consider the optimal organisational arrangements to support a sustainable health and care system in WNE Cumbria, and will have concluded this work by September 2016.

Finally in **Chapter 7** we set out the governance arrangements that we have put in place to support the development and delivery of our plans.

Summary of Response to Care Quality Commission (CQC) Requirements

CQC Requirements		Context	Response
Clinical Strategy	There must be a sustainable clinical strategy for WNE Cumbria by the end of March 2016	The CQC recognised that one of the biggest challenges faced by the acute Trust arises from the way in which local services are structured. Pressures are also increasing in primary, community, mental health, and social care services and this is impacting upon quality, sustainability and affordability. This requires a whole system response.	We are leading the development of the clinical strategy. This will require a major programme of engagement and consultation, building on the work of our clinical leaders. While some elements are being progressed immediately, such as Integrated Care Communities (ICCs), other opportunities will need to be tested and shaped with the input of our local communities. We will look to strengthen our clinical networking arrangements with other tertiary providers.
Acute Medicine	A clear plan to address medical care at West Cumberland Hospital must be agreed and implemented	The Trust is experiencing significant operational and financial pressures, with particular difficulties associated with the recruitment and retention of medical and nursing staff resulting in a heavy reliance on locum and agency staff. This in turn impacts on continuity of care and whole system working, clinical leadership and the ability to sustain service improvements. While levels of unplanned admissions are broadly in line with national averages, there is still scope to reduce these further and relieve the pressure on the Trust.	Early actions have been taken and further ones agreed, focusing on recruitment, support from a 'clinical taskforce', and the implementation of single specialist clinical teams across WCH and CIC. This will align with the development of the ICCs and strengthened pathways for acutely ill patients. Recognising the fragility of services as a result of staffing issues, detailed contingency plans are in place. Options for the longer term configuration of services will be tested as part of the wider engagement and consultation planned for WNE Cumbria.
Maternity Services	The lack of an agreed plan for maternity services needs to be addressed	There are approximately 3,000 births each year in WNE Cumbria with two consultant led obstetric units at WCH and CIC.	Actions have been progressed to strengthen cross-site working and midwifery leadership to address the immediate issues identified by the CQC. There has been detailed work by clinical teams with external advisors to develop and test the feasibility of four options for safe, sustainable maternity services. These will be further tested and refined as part of the wider engagement and consultation planned for WNE Cumbria.
Organisational Form	There should be a plan for the future organisation and management of acute services by 3rd September 2016	The organisations in WNE Cumbria (Cumbria CCG, NCUHT, CPFT and Cumbria County Council) currently operate as standalone entities with their own Boards and accounting officers. There are also 45 independent GP practices as well as community pharmacists, dentists and optometrists. There is recognition that the opportunity to review organisational form must be grasped to position the system to meet the huge challenges facing health and care services with a place-paced approach to future care delivery. .	Actions are progressing to formalise the buddying arrangement between NCHUT and Northumbria Healthcare NHS Foundation Trust, alongside strengthened partnerships with Newcastle and CPFT. In parallel, different organisational forms are being considered across WNE Cumbria to support the delivery of the clinical model of care and deliver improved population health.

WNE Cumbria is recognised internationally for its expertise in delivering integrated health and care for people living in rural, remote and dispersed communities. This will be underpinned by strong clinical networks across health and social care within WNE Cumbria and beyond.

1. The WNE Cumbria context

The challenges for health 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 June 2015 as one of the three areas to be included in the Success Regime, a new national initiative to help the most challenged health and care economies in England. Launched in Cumbria in September 2015, the aim of the Success Regime is to provide increased support and direction to these most challenged systems.

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

In September 2015 the CQC rated urgent and emergency services at NCUHT as “requires improvement”, with general medical services at West Cumberland Hospital (WCH) rated “inadequate”. As a consequence the Chief Inspector of Hospitals required the local health system to produce a clinical strategy by March 2016 and to begin the move towards a new organisational form by September 2016. The CQC recognised that the issues impacting on the Trust were in part due to the current configuration of services provided across two acute hospital sites, each serving relatively small, rural and dispersed catchment populations. We accept the conclusions of the CQC and we have addressed these concerns in greater detail, predominantly in chapter 3 of this response.

In addition, while WNE Cumbria has historically benefitted from high quality primary care services (specifically general practice services), these too are experiencing significant pressure associated with increasing workload, a challenging resource outlook and increasing workforce difficulties. Cumbria Partnership Foundation Trust (CPFT), which provides mental health, learning disability and community-based services across the area, is experiencing similar issues, as is Cumbria County Council. The recently published CQC report on CPFT gave an overall rating for the Trust as “requires improvement”, with particular concerns identified in relation to services for children, young people and families.

Despite the deep-rooted issues in the local system it is important to recognise that there have been some very positive and notable achievements. Some recent examples include:

- 96% of general practices that have been inspected to date have been rated “good” or better.
- While we cannot be complacent, there has been sustained improvement in some standardised hospital mortality indices across NCUHT.
- The establishment of the Cumbria Learning and Improvement Collaborative (CLIC) – a shared initiative which exists to drive a positive transformation in health and social care.
- There has been national recognition for *#seetheperson* - an initiative to change the culture in dementia care (It was shortlisted in the National Patient Safety awards and Nursing Times).
- The response of our staff to the 2015 floods, which has received national recognition.

- Achievement of 7 day 8am-8pm primary care across five GP practices in Workington offering “same day” GP appointments and a walk-in minor injury service.

In looking forward, we have reflected on the challenges we must tackle, aligned to the national Five Year Forward View, specifically in relation to culture and leadership, health and wellbeing, care and quality, and funding and efficiency. It is with these challenges in mind that the clinical strategy is being shaped.

High Level Overview of System Challenges

Culture and Leadership.

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 care economy is both challenged and fragmented.

We know that 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 we have fallen short in the past and demonstrate the right leadership behaviours, developing the capability to learn and improve.

Our work to deliver a whole system clinical strategy is demonstrating our commitment to work differently so that we can build a future health and care system that is sustainable.

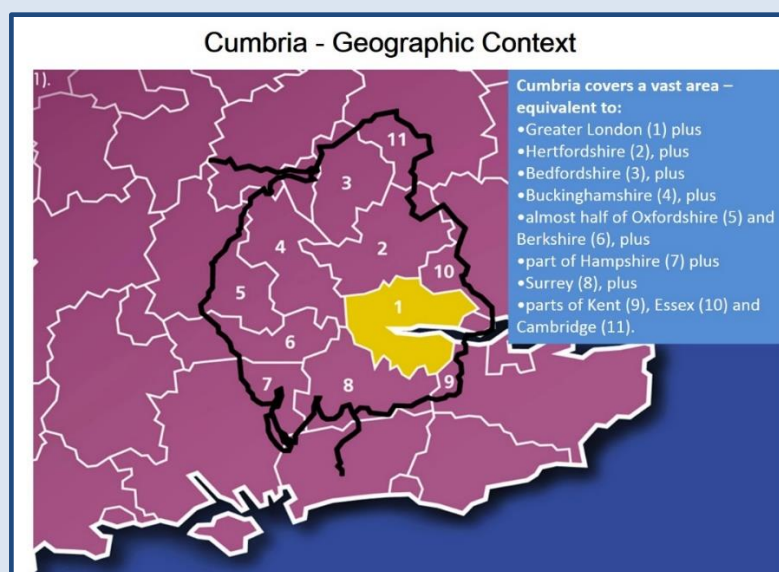
Health and wellbeing.

Our population is “super ageing”, with a higher than average growth in the proportion of older people year-on-year compared to the rest of England. By 2020, nearly 25% of the Cumbria population will be aged over 65. We report comparatively high levels of ill-health prevalence rates within our population, meaning that we have a high treatment burden in primary and secondary care. We therefore need to tackle primary prevention and address lifestyle risks, particularly in the more deprived pockets across WNE Cumbria.

WNE Cumbria’s overall performance on a range of health and wellbeing indicators disguises significant inequalities at district, lower layer super output area (LSOA) and ward level. There is a 19.5 year gap between the wards with the highest and lowest life expectancies in the county, with life expectancy in some wards being 8.4 years below the national average. Copeland has more than twice the prevalence rate for smoking as compared to Eden, implying an additional 9,500 smokers.

Our geography makes service delivery harder than average, with communities spread over large distances and isolation a key issue. WNE Cumbria is one of the most rural counties in all of England, with a population density of 74 people per sq. km, compared to 413 across England and 255 people per sq. km in the UK (Figure 2). This varies across districts from Eden having 25 people per sq. km to Carlisle having 104 people per sq. km.

Figure 2: Illustration of the geographic context of WNE Cumbria



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

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

Care and quality.

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

In WNE Cumbria, we know that we could be doing more to reduce the reliance on hospitals and care homes, providing better access to rehabilitation, reablement and support services which enable people to live more independently at home. This is especially the case for people who are frail or need multi-agency care, and people experiencing mental health distress.

Due to significant recruitment issues, the health and care system is currently utilising an expensive large temporary workforce of doctors and key other professionals. This is a major factor affecting the cost and quality of services in primary, secondary and social

care, and feedback from staff is that they are often not working optimally.

Our population deserves safe care delivered to high quality standards, and it is in this context that we set out plans to maintain the high quality of our primary care services, remodel our social care services and reduce the overall need for unplanned hospital-based care.

Finance and efficiency.

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

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

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

The WNE Cumbria Success Regime is determined to create the conditions that will enable us to achieve our ambition of being recognised for our delivery of integrated health and care services for people living in rural, remote and dispersed communities.

We have agreed some principles which we believe are essential prerequisites if the WNE Cumbria health and care system is to be the best it can possibly be:

- **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 West Cumberland Hospital and Cumberland Infirmary Carlisle have a clear future in providing safe, high quality care. This will require a commitment to the concept of **"single specialist clinical teams"** which may cross organisational boundaries.
- **Strong partnerships** with our staff and with our local communities will be promoted to enable them to help shape the future.
- Specialised and specialist services must be provided through **strong network arrangements**.
- We must work collectively to focus on both the short term improvements and longer term changes, and this will require a level of **leadership and commitment** not previously seen.

While the actions being implemented to stabilise acute services, and plans to strengthen our out-of-hospital services, should significantly improve quality (which includes safety, patient experience and patient outcomes), we know that there will still be significant deliverability challenges and risks associated with workforce. Indeed, the plans and contingencies have the potential to place further financial demands on a health and care system that already lives beyond its financial means, and increase pressure on already fragile primary, community and social care services. While our priority is quality we must, of course, address the questions of sustainability and affordability and this will inevitably involve some tough decisions. We are engaging with patients, public and staff around the potential future shape of the service and our final proposals will go out to public consultation later this year.

The work we have undertaken to date highlights the complex challenges which we know are facing all health and care systems. There is no simple, quick or “perfect” solution – the choices for WNE Cumbria will need to reflect the best fit that is most acceptable to citizens and professionals.

2. Transforming services across our whole care system through strengthening Out of Hospital Care

2.1. Introduction and Context

In this chapter, we outline the work that is already progressing to strengthen our preventative services and out of hospital care to improve population health, reduce inequalities and support people to maintain their independence. This is summarised in Figure 3 below.

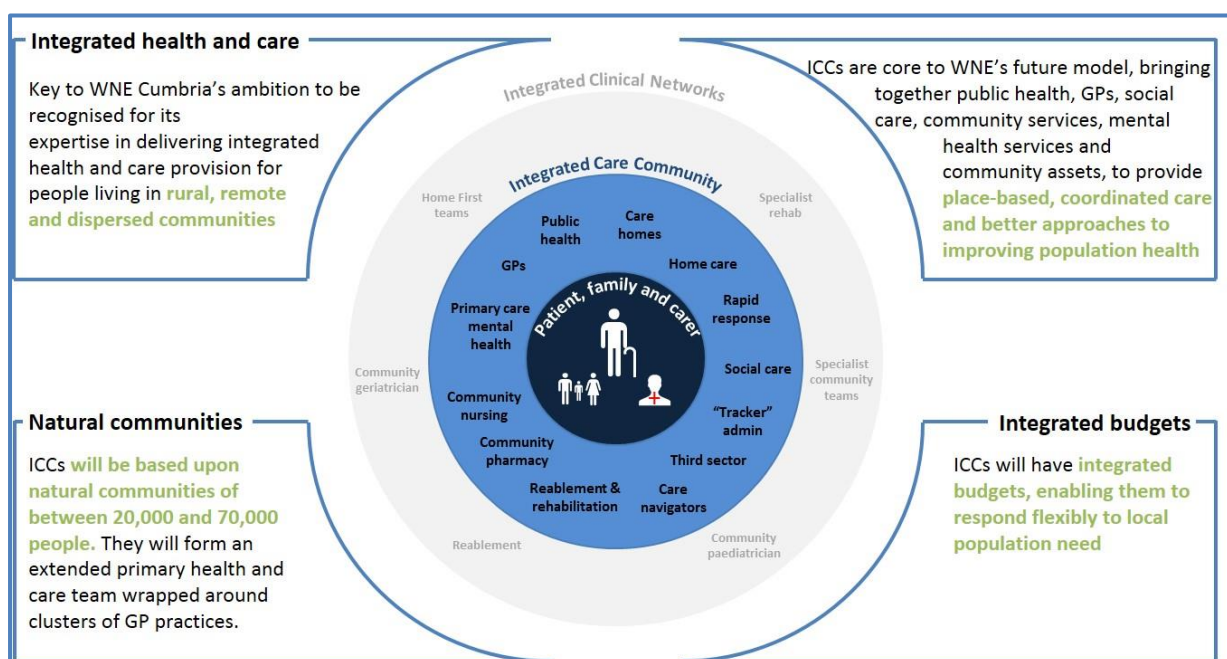


Figure 3: Summary of Out of Hospital Care Transformation

We are confident that these actions will reduce reliance on acute hospital services and the need for long term care, enabling us to better respond to individual need and manage demand. By doing do this it will also provide NCUHT the headroom to address quality and sustainability issues which will be considered in Chapter 3.

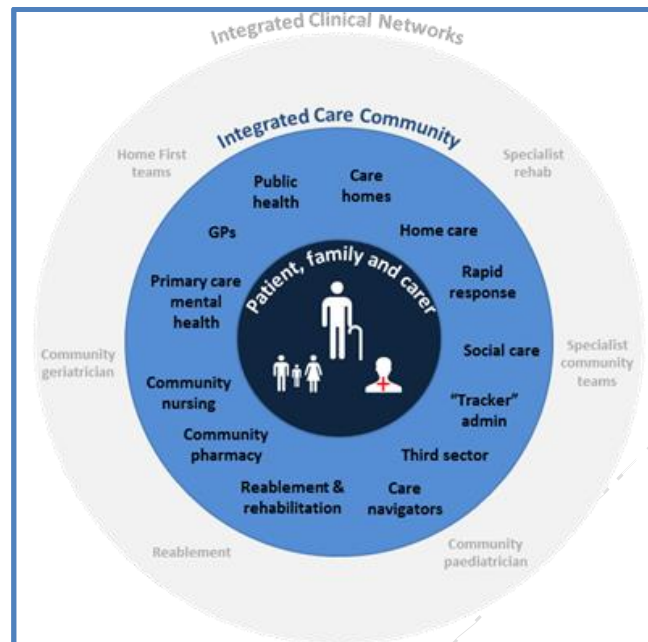
2.2. Integrated Care Communities (ICCs)

The implementation of ICCs is core to our future model care. Based on best practice from other parts of the country including Torbay and Northumberland, 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, to provide place-based, coordinated care and better approaches to improving population health. This is set out in Figure 4 below.

ICCs will also develop strong links with hospital-based specialists to ensure truly integrated physical and mental health care pathways, particularly for people living with frailty and long

term conditions. They will include services for children, young people and their families, specifically through strengthening the integrated children's workforce through a place-based approach.

Figure 4. Our model for Integrated Care Communities in WNE Cumbria



Based on natural communities of between 20,000 and 70,000 people, the ICCs will form an extended primary health and care team wrapped around clusters of GP practices. They will have integrated budgets, enabling them to flexibly respond to local population need. The success of the ICC model will draw on the skills, expertise and collaborative working from a range of different disciplines and services all working together to support the needs of the local community, with specific focus on those most vulnerable and complex.

We anticipate that the impact of ICCs will be to:

- Ensure that people are treated and supported at the **right time** and in the most appropriate setting.
- Ensure an increased focus on prevention, encouraging individuals and mobilising the population to take **personal responsibility** for their own health and wellbeing.
- Ensure an increased focus on prevention and greater use of **community assets** to support wider individual wellbeing.
- Focus more attention on **self-care/support**.
- Embed **person centred care** and shared decision making.
- Deliver more **care outside of hospital**.
- Ensure more care planning/**risk stratification** across the health and social care system.
- Improve **quality** through reduced clinical variation.
- Establish more **efficient** services with less waste.
- Deliver a positive patient experience that feels joined up and **seamless**.

By working seamlessly with strengthened ambulatory care, frailty services and rapid access clinics, we are seeking to achieve a reduction in admissions of frail elderly patients and reduce length of stay. Our initial estimates are that we will reduce admissions of frail elderly patients by up to 12% and reduce length of stay for the frail elderly in inpatient and community hospital beds by around 3 days on average. This equates to an overall reduction

in bed usage of around 10%. However, based on evidence from the Millom in South Cumbria, we believe that a 20% reduction in bed days could be achieved within 5 years.

Millom Case Study

Millom has successfully established place-based systems of care, in which providers, including the third sector, work together to improve health and care for the population they serve. The Millom Alliance is a partnership between all providers of health and social care plus the community itself. Millom's approach is to build a population health system that goes beyond integrated care and service delivery. Below are a number of key interventions that are central to the model:

- The clinical model integrates GPs, community staff (including community paramedics), social care, and specialists.
- Co-located general practice with the hospital.
- Capacity in the community to manage more complex patients e.g. IV patients.
- Digitisation of the patient pathway (for example, PACS, video consulting links, telehealth).
- A process of continuous learning and improvement.

Since 2013/14, Millom has achieved 261 fewer emergency admissions, 229 fewer elective (planned) admissions, and over 2,000 fewer journeys for outpatients and tests. In the last 12 months Millom has reduced the number of emergency bed days spent by Millom patients in the acute hospital by 29%.

We have confirmed that three ICCs will be mobilised in April 2016 (early adopters), with a further three 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 initiative.

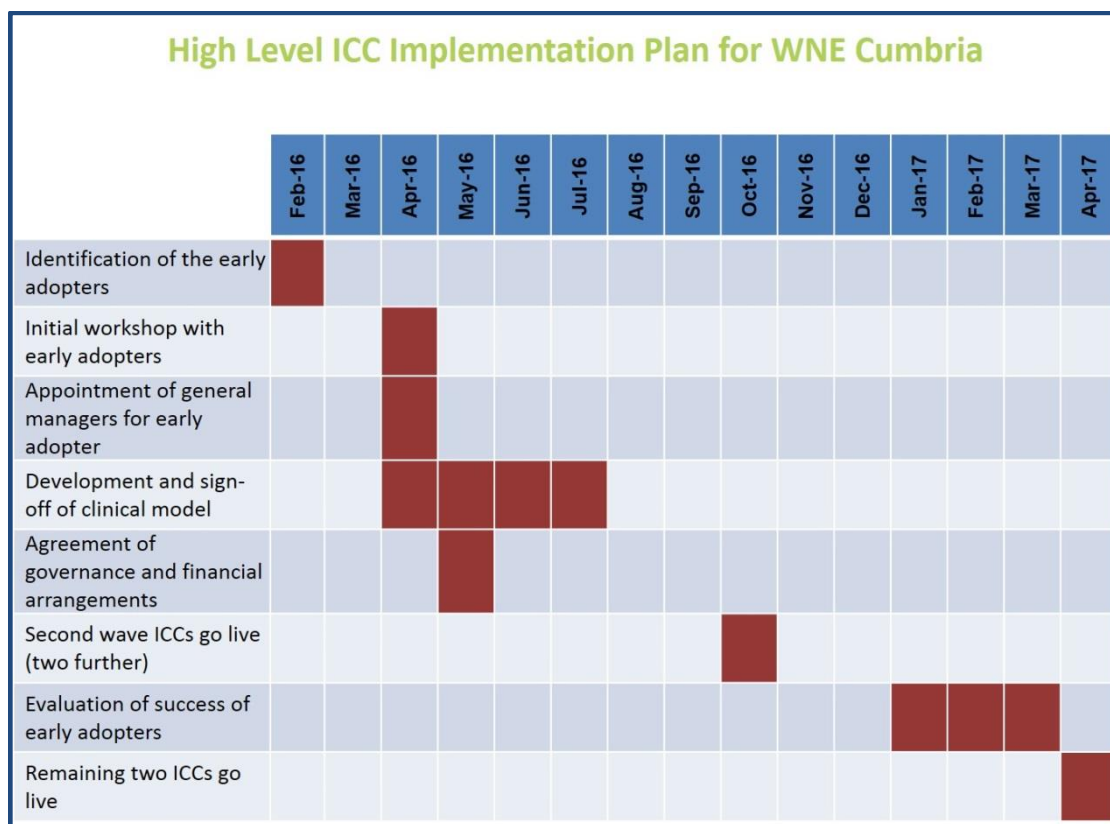
The role of the early adopters will be fourfold:

- To start to integrate in "shadow form" before any major change programme is initiated reflecting a new employing organisation.
- To work together to find solutions to the enabling areas i.e. governance, financial delegation, information sharing, interoperability, estates, workforce, etc.
- To improve patient care by developing new pathways, e.g. frailty pathway.
- To improve use of resources. ICCs will mean less duplication and increased shared understanding, pooling knowledge and resources.

We are planning for each ICC to have access to a gain-share agreement, whereby improved financial efficiency, prescribing and diagnostics will enable ICCs to reinvest a proportion of savings made into alternative community services. Activity data on usage of all health economy services will be monitored following a baseline collection to assess the impact of the ICCs.

The high level implementation plan for the ICCs in WNE Cumbria is summarised in Figure 5 below.

Figure 5: High level implementation plan for WNE Cumbria ICCs



2.2.1. Public health and prevention in the context of ICCs

A number of key indicators suggest that WNE Cumbria has an underlying health and wellbeing gap that could be partially addressed through improved public health measures:

- **Smoking** is a key underlying driver of poor health and chronic obstructive pulmonary disease (COPD) illnesses. Copeland (28.4%) has a much higher prevalence of smoking than the UK average (19%), as does Carlisle (22.2%).

The **Stop Smoking Service** for residents of Cumbria aged 16 years and over is provided through pharmacies across Cumbria. They offer one to one opportunistic support and advice to people who want to give up smoking. If necessary, the pharmacy also facilitates access to, and where appropriate supplies, appropriate stop smoking drugs and aids.

Access routes to this service are:

- self-referral (opportunistic)
- pharmacy referral as a result of the 'Promotion of healthy lifestyles (Public Health)' or 'Signposting' Essential services;
- signposting from the central booking telephone call centre
- signposting from GP practices

- Prevalence of **childhood obesity** is high, with 10.2% prevalence in Allerdale, and 10.8% in Copeland (children in reception), next to 9.1% for England.

During 2015/16, £150,000 was made available via Cumbria County Council's **community grants programme** to support activities that promoted healthy weight in children aged 4-11 years.

Grants of between £500 and £3000 were awarded to community based projects which aimed to:

- Increase physical activity
- Encourage/educate people to eat a healthy diet
- Improves access to healthy food
- Support individuals to lose weight
- Build knowledge skills and capacity in the local community

The learning from the activities funded is being used to inform the development of the integrated 0-19 programme.

- Prevalence of active **dental decay in children** is higher in the North West than any other region. 35% of children in Cumbria have experienced tooth decay in their teeth by the age of five, compared with 31% in England. Each of those children has on average four decayed baby teeth.

Smile4Life is an oral health improvement programme to help adults and children improve their oral health that has been running in Cumbria for three years. It is targeted at parents, carers and people working with children and focuses on:

- Encouraging health eating and drinking
- Encouraging regular tooth brushing
- Encouraging the promotion of healthy lifestyles
- Encouraging regular visits to a dentist

<http://www.smile4life.org.uk/index.aspx>

The Cumbria Public Health Team is also supporting the Catfish study in West Cumbria – a longitudinal case control study to investigate the effect of fluoridated water on the number of filled, missing and decayed teeth in children.

- The prevalence of **diagnosed type 2 diabetes** in Cumbria is currently higher than the national average at 6.6%, but the actual prevalence is estimated to be even higher, at 7.6%. Contributing factors include the ageing population, levels of obesity, levels of physical inactivity and levels of consumption of fruit and vegetables that are below the national average.

The **Healthier You: NHS Diabetes Prevention Programme** (NHS DPP) is a joint commitment from NHS England, Public Health England and Diabetes UK.

It is a national programme, which aims to identify individuals at high risk of diabetes and provide them with an evidence-based behaviour change programme to help reduce their risk. Cumbria has been identified as one of the first wave areas,

To reduce demand and reliance on health and care services we will build on the work to date to promote health and wellbeing and place a stronger focus on prevention in the context of each individual ICC population needs. We will also work to build capacity within communities for self-care and resilience. Currently, our health and wellbeing services comprise a number of separately commissioned services, with little structured prevention system and no defined, clear pathway between services.

The ICCs offer the opportunity to redesign the service model, with a phased implementation over an 18 month period (April 2016 – September 2017). This will include the following interlinked components:

- An online **'Wellbeing Cumbria' platform** that will enable wide ranging access to information, advice and digital support services, and that will enable all parts of the system to monitor outcomes in detail.
- A team of **Health and Wellbeing Coaches** (HAWCs) who will provide individual and family support to more vulnerable groups and those identified as most needing additional support to meet their individual goals or to prevent them needing to access other statutory services.
- **Place-based provision** of health and wellbeing activities to enable people to take opportunities to meet their own needs within their own local communities. The immediate focus of this place-based provision will be on services delivered through the third sector, but over time this component will grow to include other providers such as leisure services, pharmacy and other primary care services.
- **Focusing on early years** to ensure our next generation have the best possible start. Building on the 0-19 Healthy Child Programme and early help services, our priorities will include tackling childhood obesity, and strengthening our approach to young people's emotional health and wellbeing.

2.2.2. Primary care in the context of ICCs

We believe that primary care services are the foundation upon which our health system operates. It is a core building block of ICCs. Whilst General Medical Practice is the major component of the primary care system, it also includes a broader range of services: pharmacies, optometrists and dental services, as well as non-statutory community services all playing an increasing role.

There are 45 General Practices in NWE Cumbria, with a single GP Out of Hours provider (Cumbria Health On Call – CHOC). The recent CQC inspections of GP practices reconfirmed that GP services in WNE Cumbria are generally of a very high quality, with 96% of the 24 practices reviewed so far being rated outstanding or good. We know, however, that GP services are now very fragile.

- Over the last 3 years, the national pressure on general practice has 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 - 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 the acute hospitals, resulting in significant unplanned work.
- There are major issues impacting on 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.

Maintaining high standards of general practice is therefore a priority, as this will be fundamental to the success of the ICC model, and the sustainability of the health and care system more generally.

Working with NHS England and Health Education England (HEE), we are progressing a number of short term actions which aim to boost the number of GPs. 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.

In addition there are number of initiatives being progressed which are intended to support the wider recruitment and retention of the primary care workforce and address workload pressures:

- Commissioning an **extended range of services**, including services provided by GPs with a specialist interest (GPwSIs), which would have the benefit of improved access for patients as well as enhancing opportunities for recruitment and retention.
- Reviewing the provision of **urgent primary care** to support practices develop new approaches to meeting same day general practice demand, including 7 day access.
- Participating in the NHE pilot to introduce **clinical pharmacists** in to the general practice team (two practices are part of the pilot in Workington and Carlisle).
- 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 (see below).

- 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 National Primary Care Transformation Fund.

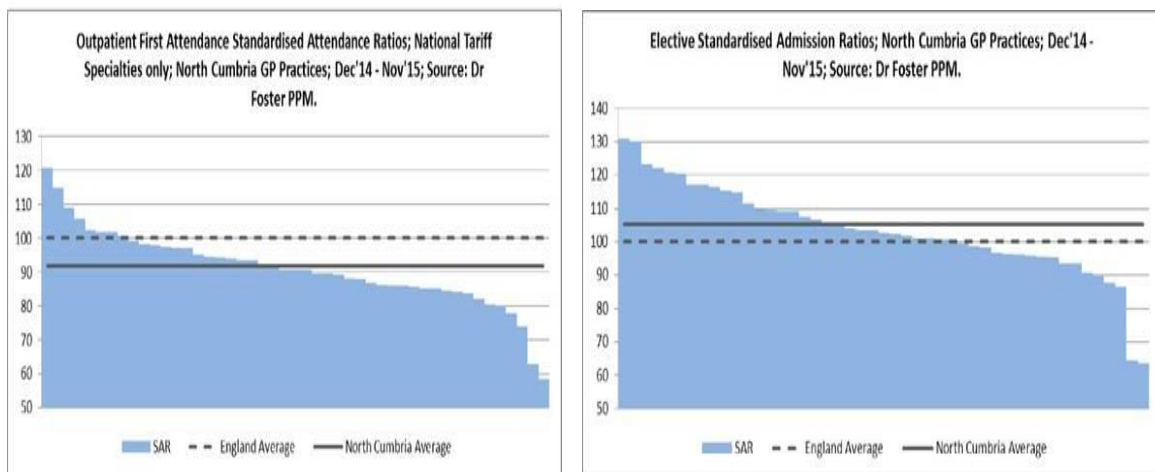
Community Pharmacy Schemes

The Community Pharmacy minor ailments scheme across South and West Cumbria created the equivalent of 638 appointments in December 2015. From January 2016 this scheme has been extended to Carlisle & Eden.

Piloting out of hours emergency supply of repeat medications. This scheme created 347 appointments across Cumbria from mid-December 2015 to the end of February 2016.

While the quality of our general practice is very good we recognise the importance of continuous improvement. In particular we will be working with practices to maintain and improve access and work to reduce unexplained clinical variation (Figure 6).

Figure 6: Elective admission and outpatient attendance ratios 2014/15



In support of this, Cumbria CCG is recommissioning the practice improvement scheme from April 2016 with a renewed focus on patient outcomes, quality and reducing unwarranted variation. Specifically, it will support practices to consider:

- Variation in referral and non-elective admission rates.
- Variation in recorded disease prevalence. Cumbria was above the national prevalence rate in 20 of the 21 measures and 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

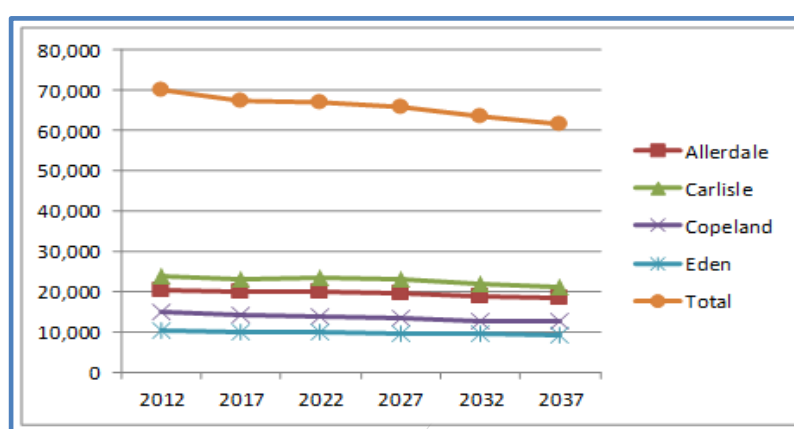
Ischaemic Attack, Cancer, Rheumatoid Arthritis, Palliative Care, and Dementia), with significant variation reported between practices, even when excluding extreme outliers. As an example, hypertension prevalence ranges from 9.43% to 25.67%.

- Variation in elective referrals and admissions.

2.2.3. Children's services in the context of ICCs

As well as the public health activities identified above, ICCs will also encompass services for children and families. This is in a context where the number of children aged 0-19 in the North Cumbria population is projected to reduce by 11.4% over the next 25 years (Figure 7).

Figure 7: Projections of the number of 0-19 year olds in North Cumbria



Changing epidemiology 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.

Expectations and behaviours have changed over recent years. Parents are more likely to present to NHS services, particularly with children under 2 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.

The underlying premise of our approach is that hospital is not the best place for the majority of children and young people, and indeed most children 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, through the ICCs, we aim to provide integrated and coordinated community support with rapid and appropriate assessment and treatment. (The implications for acute hospital services are considered in Chapter 3.)

One Team for children – integrating around the needs of the child

- A new, integrated clinical workforce, including a 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.
- A strong 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.
- Access to Short Stay Paediatric Assessment Units (SSPAU) delivering rapid assessment and treatment in support.
- Access to general and specialist expertise.

2.2.4. Community hospitals

There are currently nine community hospitals in WNE Cumbria, which are operated by Cumbria Partnership NHS Foundation Trust (CPFT). There is significant variation in size and scope of services provided – for example the number of inpatient beds in each hospital ranges from seven to twenty eight. Where there is a small number of beds, this is presenting significant challenges associated with recruitment, meeting safe staffing levels and providing medical cover. As a result there are frequent temporary closures and the cost of running the community hospitals is comparatively high. Some of the buildings are also ageing and pose significant operational challenges to meet the standards required.

We believe that community hospitals have the potential to be a significant asset in the delivery of integrated out-of-hospital care as part of the ICC model. It is, however important that we take the opportunity offered by ICCs to review their role and the services provided.

Engagement involving a wide range of health and social care stakeholders has started to consider how we might want to develop high quality sustainable care in community settings, including the role of the community hospitals. As a result of this engagement, a number of scenarios for the community hospitals have been described which will be tested through a further process of engagement and consultation. The scenarios relate to the number, location and scope of the community hospitals across WNE Cumbria, working as an integral part of the wider ICC model.

One emerging scenario would retain community hospitals as ICC hubs, providing the focus for integrated community based services, with a smaller number having inpatient beds, which could be “step-up” beds as an alternative to acute hospital admission, “step-down” beds as part of rehabilitation, part of a recovery plan following acute admission, or specialist beds, such as for palliative care.

2.2.5. Social care in the context of ICCs

Social care services will be core to the ICC model, supporting our most vulnerable individuals. WNE Cumbria's ageing population is likely to add additional pressures on social care services.

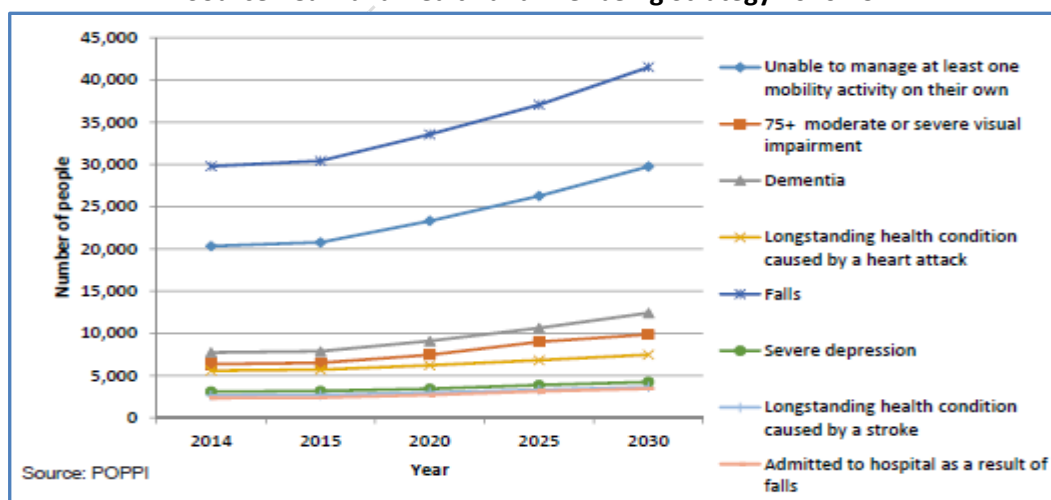
Over the past few years, the number of older people receiving person-centred care has increased more sharply than the peer group or national average (55% increase for Cumbria County Council between 2006 and 2010). The utilisation of long term residential and nursing care homes for older adults in social 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:

- The ageing demographics will impact on dementia prevalence, with the number of over 65 year olds with dementia expected to increase by 56% by 2030, from 7,858 to 12,410
- The projected number of older people accessing social care due to a physical disability, learning disability or a mental health problem is projected to increase over the next 5 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 need to be considered in the context of anticipated year on year reductions in funding available.

Figure 8: Cumbria: Health projections (65+ years population)

Source: Cumbria Health and Wellbeing Strategy 2016-19.



The plans developed by Cumbria County Council, which have been subject to consultation, support the ICC place based model and propose to target investment in services which prevent, reduce or divert demand, enabling individuals and activating communities to become more resilient, 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:

- 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.



These plans will be progressed in the context of ICCs, delivering a more integrated, person centred approach, reducing demand and more effectively managing risk.

2.2.6. Mental health in the context of ICCs

Mental Health Services for working age adults

We are now working to develop recovery focused, integrated community based services across the whole of Cumbria. Key to this will be the full integration of physical and mental health care delivered through the ICCs. In Cumbria, 14.28% of the population aged 16-74 are estimated to have a common mental health disorder (compared to 15.62% in England) and 7.2% of all patients on our GP registers have depression, above the England average (6.5%). Cumbria has a higher than the national average number of suicides per annum, which is seen as an indicator of underlying mental ill-health rates. The rate of suicide mortality and injury in Cumbria is 11.3 per 100,000, compared to 8.9 in England. There is recognition that the support to general practice must be strengthened ensuring that they can be confident in the support and expertise they have access to as they support people with mental health needs.

An engagement process has been led by the Cumbria Mental Health Partnership Group (a multi-agency body which oversees the development and delivery of mental health services across Cumbria) to inform the development of a model for adult mental health in Cumbria. It confirms the need to strengthen prevention and primary care, while also recognising the need to develop our specialist offer for users of services with complex and enduring mental health conditions during their journey to recovery.

To support a movement away from pathology, illness and symptoms to a focus on health, strengths and wellbeing, we are adopting the principles of Implementing Recovery through Organisational Change (ImROC). This will enhance our ability to recruit and employ service users in meaningful roles to support other's recovery journey. The implementation of these principles will also drive service change across our pathways and identify opportunities for further improvement. In 2015/16, through the Better Care Fund, Cumbria CCG invested an additional £1.4m to improve the psychiatric liaison service across Cumbria. The Liaison Service is based within the current Access and Liaison Integration Service (ALIS) operational management arrangements, with additional resource focussed on acute care, for people suffering acute mental health distress, and on older adults. The clinical leads provide daily leadership 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 pathway for older adults.

There has also been prioritisation of work to improve services for all people experiencing a mental health crisis (regardless of age) which recognises the need for strong interagency 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 Cumberland Infirmary Carlisle (CIC). It is anticipated that this model will be rolled out to support and optimise our ambition to provide better support and care outside of inpatient facilities, closer to home and integrated in communities. The third phase of the multi-agency assessment and crisis centre proposal will test out the impact of alternatives such as third sector provided short-stay crisis beds, safe haven and sanctuary cafes.

Multi-agency mental health hub

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

In developing strengthened community based services, we are reviewing the optimal configuration of inpatient mental health beds required to meet the needs of our local population. This work will be completed over the next few months to inform the development of options for the future, which may require formal consultation if changes are proposed.

Services for people with Dementia (and other organic mental health needs) and their carers

Work is also progressing to improve and develop support and services for people living with and caring for people with dementia, with recorded prevalence of people suffering from dementia in WNE Cumbria 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.

Early focus was given to 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 2015¹.

Care Home Education and Support Service

CHESS was launched in 2013 providing a rolling programme of mental health education combined with an outreach service to work alongside care home staff and inpatient services. The programme led to a reduction in inpatient admissions from care homes from 52% to 5% (2013) and a reduction in readmissions from 20% to 3%.

More recently, the implementation of the Cumbria Dementia Pathway is resulting in transformational changes across memory services. Working with the Alzheimer's Society and Age UK, CPFT is remodelling the memory services across Cumbria with the aim of developing more integrated, proactive, community based models, with open referral, carer interventions and the implementation of common screening tools. A key aim is to improve access to individualised, specialist comprehensive assessments and signposting to community based support which will include a range of "living well" initiatives and use of technology enabled support.

2.2.7. Elective care in the context of ICCs

The ICCs will enable us to transform a number of specific care pathways through the integrated team structure to create capacity to manage even more care in community settings, reducing the need for referrals to hospital and enabling shorter lengths of stay associated with elective procedures.

Initial care pathway redesign work is focusing on musculoskeletal, respiratory, ophthalmology and dermatology, to drive quality improvement and efficiency. This includes plans to establish a central referral hub for musculoskeletal services that will provide alternatives to surgery. In managing patients through a non-surgical pathway, additional capacity will be created within NCUHT to manage patients more locally, rather than out of

¹ Prime Minister's Challenge on Dementia 2020, February 2015, Department of Health

WNE Cumbria. This is a model we will be looking to develop across other specialties, building on evidence associated with shared decision making in enabling individuals to make informed choices about their care options.

Ophthalmology in an ICC Context

The current ophthalmology service at NCUHT relies heavily on locums. Through establishing a more integrated service the aim is to offer alternatives to hospital based provision and support patients closer to home in the community.

ICC will allow consultants to work in 'one stop' community clinics with opportunities for accredited GPWSIs and optometrists to provide diagnosis and treatment in the community. Conditions that could be managed within an integrated service include:

- Differential diagnosis of lumps and bumps in the vicinity of the eye
- Epiphora
- Eye problems related to herpes zoster
- Removal of suture
- Clinical ophthalmology opinion following unclear findings from optometry delivered repeat field tests
- Age related macular degeneration
- Post-operative cataract complications
- Raised Intra-ocular pressure
- Diabetic retinopathy
- Recent and sudden loss of vision including transient loss

GPWSIs and accredited Optometrists could also provide care for minor and less complex eye conditions including:

- Common eye conditions (including watery eye, dry eye, in-growing lashes etc.,)
- Cataract care (screening, assessment, post-surgery review)
- Glaucoma / Ocular Hypertension monitoring
- Paediatric screening

Through promoting greater integration between the acute hospital and primary care providers we are confident that improved referral management and pathways for general surgery can be achieved, reducing variation and strengthening adherence to agreed commissioning guidelines on elective care. This links closely with the General Practice Improvement Scheme referenced in 2.2.2. We believe that over 5 years, under a stretch scenario there is potential to reduce outpatient referrals by up to 16% and elective admissions by 14%.

2.2.8. Paramedic services in the context of ICCs

In recent years NWAS has developed some innovative ways of working within communities that have enabled a significant increase in the number of patients who would otherwise have required transfer to hospital following a 999 call. As part of this continuing journey of improvement, NWAS are working closely to maximise the opportunities to integrate services with the ICCS to ensure new pathways are developed to support care to be provided closer to home. This will build on the learning from the placement of specialist community paramedics which proved successful in enhancing health education, implementing new pathways and promoting partnership working. It will also support the progress already made by NWAS to develop alternatives to hospital conveyance including:

- **“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.

Modelling from across the UK suggests that with sufficient staff training, utilisation and access to alternatives, more than 40% of calls could be dealt with through “see and treat” and “hear and treat”, which for WNE Cumbria would equate to 45 patients each day. NWAS is currently 27% of calls through “see and treat” and “hear and treat”.

The development of Community First Responders across WNE Cumbria is also being progressed, creating a cadre of volunteers able to deal with a wide range of potentially life threatening conditions and provide support to the regular ambulance service. These individuals have the potential to play a wider role in the context of ICCs.

2.3 Summary

This section confirms that much work is already underway to strengthen all types of out of hospital care, focusing on improving population health, reducing inequalities and supporting people to maintain their independence. Integrated Care Communities will be at the very heart of this approach, bringing together public health, general practice, social care, community services, mental health services and community assets including community hospitals to provide place based, coordinated care and better approaches to improving population health.

We know that fundamental to the success of our out of hospital care will be a strong, vibrant and successful primary care services, with particular reference to general practice. There are a range of actions being taken forward which aim to directly support our general practice teams to help reduce the significant pressures and risks that, without urgent action, will compromise our ambition to be an area recognised internationally for its expertise in delivering integrated health and care provision for people living in rural, remote and dispersed communities.



3. Stabilising acute services in WNE Cumbria

3.1. Introduction and Context

This chapter confirms the actions that are being taken to stabilise acute services in NCUHT. It should be considered in parallel with the NCUHT Quality Improvement Plan (QIP) which is being managed by the Trust in response to the CQC recommendations, and which is now being overseen by a Quality Improvement Board convened by NHS England with representation from the CQC. The NCUHT QIP is attached at Annex 1.

3.1.1. A North Cumbria Hospitals University Trust perspective

NUHCT is operating acute services in a geographically large, rural and remote system, with a coastal boundary to the West. It has two acute hospitals designed to operate as traditional District General Hospitals, each with relatively small catchment populations: WCH has a catchment population of approximately 150,000 and CIC of approximately 170,000.

The Trust is experiencing significant operational and financial pressures, with particular difficulties associated with the recruitment and retention of medical and nursing staff, and a heavy reliance on locum and agency staff. This in turn impacts on continuity of care and whole system working, clinical leadership and the ability to make service improvement. The Trust has fewer doctors in training than in the past, further adding to the need for substantive staff and different ways of working.

Despite ongoing and additional effort, which has at best stabilised the workforce issues, we recognise the need for more fundamental change within the Trust in the way we recruit and deploy the workforce we can recruit and retain in order to best support local healthcare needs. Early priorities include ensuring more visible, local support for medical recruitment, implementing consistent approaches to cross site working and a single team approach, as well as developing innovative academic partnerships in rural clinical specialisms and promoting wider clinical networks with other Trusts, including tertiary providers. We also recognise the need to look again at the configuration of services across the two acute hospitals (which is explored in more detail in Chapter 5 of this document).

We know that access to services and “flow” once patients are admitted is not optimal as evidenced by recent Oak Group work. The Trust is consistently failing to achieve the majority of access targets; these include the A&E 4 hour waiting target, with knock-on impact on the 18 week referral target for treatment (RTT) for admitted and non-admitted pathways, as well as cancer targets.

The major capital redevelopment at WCH and the implementation of a new Electronic Patient Record (EPR) are major enablers to support new ways of working across the Trust.

Developing strong networks with specialist centres is also a priority. Most of WNE Cumbria residents live at least an hour away from a specialised centre by car, and access is worst in the west of the region where public transport is limited. We believe that this in part explains the fact that the number of people living in WNE Cumbria accessing specialised services is significantly lower than the national average. We are in discussions with Newcastle Upon Tyne Hospitals NHS Foundation Trust, as the main tertiary services

provider, to explore opportunities for greater joint working, with particular reference to cancer services, children services and trauma services.

3.1.2. Care Quality Commission (CQC) Perspective

The most recent CQC reports for NCUHT were published in September 2015. The CQC recognised that improvements had been made in a number of areas, however it rated NCUHT as “requires improvement” overall and as such the Trust has remained in Special Measures.² At WCH, urgent and emergency services, maternity and gynaecology, and end of life care were rated as “requires improvement”, and medical care was rated as “inadequate”. At CIC, urgent and emergency services, medical care, maternity and gynaecology, end of life care, and outpatients and diagnostic imaging were rated as “requires improvement”. Importantly the CQC highlighted the lack of a system wide strategy.

The main area of immediate concern related to the Trust’s challenges with recruiting and retaining medical and nursing staff and the subsequent impact these difficulties were having on the quality and timeliness of services provided to patients. CQC noted that despite the Trust’s recruitment efforts, there were still numerous vacant consultant, medical and nursing posts. Although recognising locum doctors were in place to cover vacancies in some areas, the CQC noted that the high vacancy rate was affecting service responsiveness (including referral to treatment times) and meant that junior doctors were not fully supported in some core services. CQC also observed that there were times when wards and departments did not have adequate nursing staff, which presented risks to patient safety. The CQC therefore required the Trust to make improvements in the following areas:

- Ensuring that medical staffing is sufficient to provide appropriate and timely treatment and review of patients at all times including out of hours.
- Ensuring medical staffing is appropriate at all times including medical trainees, long-term locums, middle-grade doctors and consultants.
- Improving ward staffing levels and skill mix particularly in medical care services.

² The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve.
- Provide a framework within which CQC can use its enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide before further action will be taken, for example to cancel their registration.

3.2. Service Stabilisation Plans

In the subsequent sections we describe our stabilisation plans in urgent care and acute medicine, maternity, children and families, and specialised services.

3.2.1. *Stabilising urgent care and acute medicine*

In an open letter from NCUHT, Cumbria CCG, NWS, CPFT and NHS England (NHSE) on 18th November 2015 we stated that, although it is a significant challenge, we are all fully committed to finding a way forward that would enable the continued delivery of an Accident and Emergency service at WCH. We also confirmed no further changes to any of the clinical services currently provided at WCH would be made until the clinical strategy has been developed and public consultation had taken place.³

3.2.1.1. *Current position*

Over recent years, a number of changes have been made to develop a single service model across the two acute sites:

- In 2012, high risk surgical pathways were transferred from WCH to CIC following a public consultation process.
- In June 2013, the transfer of major and significant trauma including hip fractures from WCH to CIC was implemented in line with public consultation.
- 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 the 24/7 specialist teams. These included patients with gastrointestinal bleeds, some types of myocardial infarctions (noting 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, NWS now transfer patients directly to CIC.

Subsequent clinical audits following the changes between 2012 and 2014 have identified improved outcomes in terms of reduced mortality and morbidity, attainment of best practice tariff targets, improved patient satisfaction, as well as enabling recurring annual saving of £500,000 (noting that some of these savings have been offset by increased costs of ambulance transfers).

There remain, however considerable challenges within acute medicine across the Trust, and these are particularly significant at WCH due to workforce vacancies across medical, general nursing and allied health professional disciplines. Following the withdrawal of most medical

³ 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.

trainees at WCH, the junior rotas at WCH are particularly fragile, with 53 vacancies out of 80 for non-consultant staff. As a result, at WCH, the projected full-year locum junior, middle grade and consultant overspend in medicine is running at £3.0m as of February 2016 (£1.4m for junior and middle grade; £1.6m for consultants).

3.2.1.2. Actions being taken

Early actions have been taken and further actions are planned focusing on workforce and new models of care.

Workforce

There are three key areas of focus to help stabilise the urgent care and acute medicine workforce:

- a) Refocussing and innovating in our efforts to recruit and retain staff
- b) Championing an NHS Doctors in Partnership Scheme
- c) Designing a new clinical workforce model

a) Recruitment and retention

We have developed a 10 point workforce plan which seeks to address the short and longer term challenges we face as a system. This is described in further detail in Chapter 6 – Enabling Better Care.

There has already been progress. The Trust has recently benefited from the appointment of 2 new acute physicians and nurse recruitment has been enhanced through strengthened partnership working with the University of Cumbria.

Nurse Recruitment

The Trust is continuing to focus on nurse recruitment, particularly for qualified nurses.

This is building on the successful approach with the University of Cumbria resulting in recruitment of 44 newly qualified nurses in September 2015, and substantive post offers to a further 31 students in advance of their training completion in September 2016.

The programme anticipates the appointment of 150-170 qualified nurses over a 3 year period, replacing the international recruitment campaign. This number is expected to meet qualified nursing requirements taking into account natural turnover and career progressions.

Closer working between the University of Central Lancashire (UCLan) and WCH is also a key priority with a number of important initiatives being progressed. This includes physician assistant training, with 12 placements to be located in WCH (See section 6.1).

b) NHS Doctors Partnership Scheme (DPS)

DPS is an innovative idea to enable the formation of a “bespoke” clinical team (of medical staff in the first instance) capable of immediate deployment to assist a failing health system

or organisation in crisis. The DPS Team will work alongside local clinicians to support system stabilisation and transformation. We believe that DPS has the potential to be analogous to the Territorial Army - something that is expected, respected and encouraged by the NHS for the NHS.

We believe that an NHS DPS in WNE Cumbria could serve as a pilot for the NHS and could become a model to be used in other critical situations that may arise if system or organisational resilience reaches crisis point.

Doctors in Partnership

DPS participants will be quality-assured clinicians, working according to standard operational protocols tailored to local need. All personnel will have appropriate professional expertise, leadership skills and the ability to develop others; they may be drawn from other parts of the NHS or possibly other bodies such as the military, reservist, or charity. A deployment plan and exit strategy will be agreed for the team in advance, with the host organisations, regulators and local system leaders. It will be important that the receiving system does not become dependent on this clinical task force for future viability.

DPS is an innovative approach and will require national leadership and support. Our discussions to date have confirmed strong support for the concept, however we recognise that there is a risk that health economies will be more interested in receiving support than releasing the calibre of clinical leaders required given national workforce pressures. Because of this, we think the earliest a DPS could be in place to support WNE Cumbria would be September 2016.

c) New clinical workforce model

It is proposed that the accident and emergency department (A&E), intensive care unit (ICU), and acute medicine clinical teams will organise themselves to work as a fully integrated team at WCH. This single team “composite workforce” concept will take full advantage of the new emergency floor layout at WCH. Consultants at WCH have confirmed a commitment to work with the Trust and its partners to implement this model, which has been tested and supported by the Northern Clinical Senate. It will build on experience already gained in WCH, with Advanced Practitioners are working in paediatrics, A&E and acute medicine.

The proposed composite workforce model at WCH

A minimum of ST3 clinical competency will be provided 24/7, in each of the following 3 key specialties: Acute Medicine, A&E and ICU/Anaesthetics. Clinical competency, up to and including ST3 capability, will be delivered by clinicians of any clinical background who are appropriately trained and experienced, such as:

- SpR Trainee / Trust Doctor
- Advanced Nurse Practitioner (ANP)
- Advanced Paramedic
- Physicians Associate
- GPwSI/GP

This multi-disciplinary team will have the requisite clinical competencies to replicate the traditional SHO and “Senior Resident Decision Maker” or Medical Registrar. This offers a staffing model with flexibility across traditional skill sets and will comprise:

- Substantive general internal medicine (GIM) consultant cover 8am-10pm, ensuring that routine interventions are completed and treatment escalation plans have been agreed earlier in the day.
- Substantive GIM consultant non-resident on-call, with overall responsibility for medical care decision making at WCH out of hours (nights & weekends).
- Resident cover at SHO (CT2) and Registrar (ST3) provided by Advanced Nurse or Paramedic Practitioners, Physicians Associates, GPs, GPSI trainees, Trust Doctor or SpR Trainee.
- Team working with WCH A&E and Intensive Care “middle grade” ST3 doctors.
- 24/7 remote specialist support for Cardiac/GI bleed/Stroke and Renal specialists.
- WCH Critical Care Outreach (CCO) team and Advanced Critical Care Practitioners.

With appropriate co-ordination, clinical and operational governance, we are confident that this model will be able to draw upon all available resources and expertise across all WCH speciality teams working as an integrated whole.

The Composite Team in Practice

Current Model: A cardiac failure patient is seen in A&E, triaged to an A&E doctor or Advanced Practitioner, seen by them and then transferred to the Acute Medical team (duplicated processes and time lost).

Composite Model: A cardiac failure patient arrives in A&E, immediate care is initiated and triage would flag the patient immediately to the acute medical team who would see them. The patient care would be provided in the most appropriate environment (A&E / EAU / CCU / ICU) and receive interventions from those within the team with the necessary skills.

We recognise that this model will require NCUHT to work at the leading edge of non-medical staff clinical education, working with educational partners to develop high level clinical competencies in staff groups not traditionally expected to operate at these levels. However, this model is not without precedent. NCUHT already has extensive experience of Advanced Nurse Practitioner roles, and is in contact with other Trusts with similar aspirations and experience. Senior clinical leaders from within NCUHT have also been identified to lead the implementation and UCLan colleagues have indicated their enthusiasm to assist. The Trust is also working with NHS Improvement and NHS England as a national ‘trailer’ for the reinvention of the acute medical model in small district general hospitals in line with *Five Year Forward View* proposals.

Composite workforce model implementation plan

Stage One: ANP workforce development plan.

By the end of 2018 all 28 Nurse Practitioners will have achieved Masters / Advanced Nurse

Practitioner (ANP) status and be able to cover the HO / FY1&2 role, including prescribing, with minimal supervision. This is on track for completion with a number of Nurse Practitioners already fully qualified, and the remainder registered to complete training by 2018.

Stage Two: ANP & AP workforce development plan to cover SHO / CT2 roles.

NCUH is developing, with educational partners, a training pathway for selected current ANPs and recruited Advanced Practitioner (AP) candidates, which will equip them with the clinical competencies to work at SHO / CT2 level.

Stage Three: ANP / AP workforce plan to cover Registrar / ST3 role.

NCUH will develop, with educational partners, a training pathway for selected ANP, Advanced Practitioner (AP) and GPSI candidates, which will equip them with the clinical competencies to work at Medical Registrar / ST3 level.

The implementation plan is being led by the Trust with strong support from the Medical/Clinical Directors at both sites and the Deputy Director of Nursing.

New Models of Care

The composite team in acute medicine will also be supported by the introduction of new models of care which aim to provide proactive, anticipatory care, reducing the need for unplanned interventions. Some examples are outlined below.

a) Enhanced Ambulatory Care

We will be offering enhanced ambulatory care, providing clearer pathways for common conditions, in particular deep vein thrombosis, pulmonary embolism, syncope and cellulitis, alongside more regular, consistent clinical service provision. This will be supported by an experienced Senior Medical Physician, who will stream and triage patients deemed “ambulatory” into this pathway from the A&E department as well as receiving referrals from clinicians in the community. Our ambulatory care units will provide rapid initial assessment in order to increase the proportion of patients treated and discharged without requiring an A&E attendance and/or an emergency admission.

b) GP rapid access to outpatient clinics and clinical advice

Hot clinics will be established to support GPs in managing patients who require urgent specialist advice or assessment to enable care plans to be agreed without the need for hospital admission. Alongside hot clinics/appointments there will be significantly extended opportunities for community clinicians to access consultant advice and support from Specialist Nurses with particular focus on respiratory, care of the elderly, stroke, renal, cardiology and gastroenterology. There is evidence that this approach can significantly reduce the need for admission and hospital attendance, and is valued by the GP community.

c) Frailty Services

The purpose of these services are to reduce admissions and support GPs and the ICC teams to manage patients at home and outside the acute hospital. The Frailty

Assessment Service (FAS) will provide timely senior assessment of vulnerable older patients, more rapid access to specialist care and faster turnaround for diagnostic tests.

d) Best practice patient pathways

As noted above, a number of care pathways have already been implemented for specific complex conditions including gastroenterology (GI Bleed) / cardiology / respiratory medicine, as part of the Trust's plans to simultaneously improve patient outcomes and manage risk. In essence, specific conditions are fast tracked from WCH to CIC to ensure optimal care. Further work is underway to achieve similar arrangements for acute stroke based around a single Hyper Acute Stroke Unit (HASU) based at CIC and a care pathway for deteriorating patients, both of which may require public consultation.

e) Managing capacity across the two acute sites

NCUHT has established a strong relationship with NWAS to continuously review capacity and agree catchment adjustments to ensure optimal flows between the two hospitals. The degree of diversion support depends on the pressures being experienced and diversions can be flexed as required.

We are committed to making early progress in implementation so our staff and the public are confident in our ability to make change. A detailed implementation programme is in place with key milestones agreed as summarised below.

Urgent and Acute Medicine Stabilisation Implementation Plan Summary

Actions	2012/13 to 2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
High Risk surgical pathways Implemented						
High risk medical pathway for GI Bleed and MI, Respiratory						
Nurse Recruitment Programme with University of Cumbria						
Higher risk (best practice) patient pathway: Deteriorating patients.		Ongoing				
Enhanced Ambulatory Care. Implemented		By Q3				
GP rapid access to OP "Hot clinics" & clinical advice.		By Q3				
Doctors in Partnership Pilot		From Q3				
Higher risk (best practice) patient pathway: Stroke.		From Q4				
Composite Model: ANP workforce plan.				By Q3		
ANP & AP workforce cover for SHO / CT2 role in place.					By Q3	
ANP / AP workforce cover for Reg / ST3 role in place.						By Q3

3.2.1.3. Short term business continuity plans

The actions described above are designed to secure safe and stable acute medical care services in WNE Cumbria, while also supporting strengthened out of hospital care. It is, however, acknowledged that due to workforce pressures, particularly the reliance on locum middle grade and consultant staff, acute medicine services at WCH remain fragile. It is therefore essential that business continuity plans are in place to maintain patient safety and support our staff.

As the example below confirms, clear processes are in place, with agreed trigger points and escalation arrangements at each acute site, with a specific focus on middle grade rota (ST3 and above), and a junior doctors (FY3). The arrangements for West Cumberland hospital are summarised below.

- a. If one ST3 post is vacant for longer than 4 weeks, the Trust will work to secure locum cover depending on the length of the vacancy. If no locum cover can be found, the competency of FY3 equivalent doctors will be assessed to provide cover. If that is not possible, the issue will be escalated to the Medical Business Unit and the option of consultant acting down will be discussed with the wider team.
- b. If two ST3 posts are vacant for more than 5 days, the Trust will continue to work to secure locum cover. In addition the Trust will assess the competency of FY3 doctors to provide cover, discuss potential cover arrangements with anaesthetics and ED and consider options for consultants to provide short term cover in an acting down capacity. If there is not sufficient cover, the service response would be to cancel all outpatient clinics and inform GP practices of potential long waits for outpatient appointments.
- c. If two ST3 posts remain vacant despite actions set out above, the Trust will seek mutual aid across the wider health economy. If that is not forthcoming, then the Trust will call a major incident to request NHS England to activate a regional plan to deliver mutual aid to provide at least one ST3 level doctor to provide cover at WCH for a short term period.
- d. If the above does not **secure sufficient** additional medical cover, the following major incident plan will be activated. WCH will close to admissions out of hours with patients requiring admission (c. 5-7 per night) being transferred to CIC. Referrals to ED at WCH will be **assessed and** transferred to CIC **if admission required**. Some admissions to CIC might also need to be transferred to neighbouring hospitals to ensure sufficient capacity to accommodate patient diverted from WCH. Additional ambulance capacity will be put in place to transfer patients.

3.2.2. *Stabilising maternity services*

3.2.2.1. *Current position*

In 2014/15 there were 3036 births in NCHUT with 1,703 deliveries in Cumberland Infirmary Carlisle, 1264 in West Cumberland Hospital and 69 in the midwifery led unit in Penrith. A small number of women also required very specialist tertiary services outside Cumbria due to complications of mother or baby and there are strong links Newcastle Upon Tyne Hospitals NHS FT for tertiary and level 3 neonatal facilities to support these women.

In April 2015 the CQC concluded that while the maternity service at CIC 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.

In February 2016, a Healthwatch Cumbria report⁴, Maternity Matters was commissioned to understand what women felt was most important to them from maternity services.

Maternity Matters – Healthwatch Cumbria Report

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 were as follows:

- a) The importance of continuity of care** throughout pregnancy, labour, and the post-natal period
- b) The importance of holistically well trained health care staff**, which are respectful to the women and families served, and sensitive to their needs – which may require a movement away from agency staff
- c) The importance of choice.** Services need to be accessible, and offer a choice to reflect the varying needs of patients, in terms of travel, support and place of birth. In turn, patients and families need to be supported and sufficiently informed to make a decision
- d) The importance of communication**, both between the staff themselves, and between staff and women and families.

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

- A programme of work has been progressed to strengthen midwifery leadership and developing the midwife led pathway.

⁴ <http://healthwatchcumbria.co.uk/wp-content/uploads/HW-Maternity-Matters-FINAL.pdf>

- A new tier of resident anaesthetist is in place at CIC
- An audit has been completed to review the theatre model at WCH, which has confirmed the current arrangements are appropriate.
- High quality consultant candidates have been appointed in obstetrics and gynaecology (however, efforts to secure non-consultant specialist appointments at WCH remains a major challenge.)
- The Trust has worked with the Consultant Obstetricians to develop the underpinning principles in relation to their roles, particularly focussing on cross site approaches to governance, clinical guidelines and continuing professional development.
- The maternity dashboard has been standardised across Cumbria to ensure that a consistent suite of quality metrics are monitored and the Trust Board have received regular progress reports via the Safety and Quality Committee.
- The Trust has continued to build relationships with users of the service and the wider local population.
- Epidurals are now available at both CIC and WCH (in place since October 2015).
- Plans are being progressed to establish, providing greater choice for women.
- the Trust has introduced a Fetal telemedicine link between WCH and Newcastle, which is being rolled out at CIC.

In parallel with these actions, it has also been recognised that the lack of a clear, agreed plan for maternity services at the Whitehaven site is not sustainable. We have therefore been working to develop options for the future, taking into consideration independent review undertaken by the Royal College of Obstetricians and Gynaecologists (RCOG), the advice from the local Maternity Services Liaison Committee and the Strategic Clinical Network.

The publication of the Five Year Forward View for maternity care⁵ has also informed our thinking. It recognises the particular challenges in providing safe and sustainable maternity services in remote and rural areas.

Key Findings of the Five Year Forward View for maternity care in relation to the provision of services for rural and remote areas

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, but 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

⁵ <https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf>

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 units

As a result of the work to date, four possible service models are being considered and tested in terms of deliverability and sustainability. It is recognised that the model for maternity services must also take account of the key interdependencies with other key services, specifically paediatrics and anaesthetics, both of which are experiencing significant pressures associated with workforce availability.

The ability to appoint permanent anaesthetic staff is an extremely important consideration in providing a safe and sustainable service. To continue to run two consultant led obstetric units, there would be a requirement to recruit to the current anaesthetic vacancies at consultant and middle grade based at WCH with an expansion in staffing to provide reliable obstetric anaesthetic cover. Failure to meet these recommendations in full is recognised, identified and kept under review on the Trust risk register.

Paediatrics is specifically considered later in this document (section 3.2.2).

Potential models for obstetric services in WNE Cumbria.

- I. Keeping services as they are now (with co-located MLIs) and stepping up attempts to recruit staff to fill middle grade medical vacancies.
- II. To implement a “Consultant led, Consultant resident-on-call” system at both WCH and CIC, with co-located MLUs. This model will require 10 additional consultants, but fewer middle grade staff.
- III. A reduced consultant led unit at WCH, with the identification of anticipated higher risk births to take place in a Consultant-led service at CIC, both with co-located MLUs.
- IV. The provision of a Midwife-led unit only at WCH with all other births booked for delivery in CIC.

Discussions to date with the consultant obstetricians in NCUHT suggest that models II and III are not considered favourably, with a strong preference for model I, and if this is cannot be delivered then model IV should be pursued. We note that this is the opinion of the consultant body, and any decisions would require engagement and consultation with the public.

3.2.2.2. *Actions being taken*

NCUHT is now working to test the feasibility of delivering model which able to safely support two CLUs (with co-located MLUs). This would require the ability to secure a substantive workforce to support a 3 tier model which would comprise:

- Tier 3: Consultant non-resident on-call (currently all 5 posts are substantively filled).
- Tier 2: Middle Grade – 7 Speciality Doctors (currently only 1x substantive).
- Tier 1: FY2/GPST (future: GPSI/ AMPs) – (currently 3x posts of which 2 are substantively filled).

Obstetric Medical Staffing 3 tier Model – Testing Feasibility

NCUHT are now progressing a range of actions to test the feasibility of securing the necessary workforce to delivery this model. Specifically actions include:

- **Innovative middle grade recruitment:** Middle grade posts are to be advertised as a 'Specialty Doctor with an Educational Component'. The Trust will offer full and part-time posts with a training element to be supported by the University of Lancaster, University of Cumbria (UoC) or University of Central Lancashire (UCLan), providing training opportunities that candidates will be able to select from a menu of options. Discussions to finalise training arrangements with the Universities and the Deanery are underway.

The following training options / Advanced training skills modules (ATSMs) have been identified:

- Ultrasound training
- Acute gynae & early pregnancy ATSM
- Advanced antenatal practice ATSM
- Advanced labour ward practice / labour ward lead ATSM
- Colposcopy BSCCP certification +/- ATSM
- Subfertility & reproductive health ATSM
- Urogynaecology & vaginal surgery ATSM

Further training options are in development.

- **Advanced Midwife Practitioners.** NCUHT will support the training of Advanced Midwife Practitioners (AMPs) who will, with sufficient experience and relevant training join the 1st tier rota and in the medium term could join the middle grade team.
- **GPwSI** - The Trust has also recently confirmed a plan to develop a GPwSI training scheme as an additional year to the existing 3 year GP training programme in West Cumbria. It is intended that Obstetric GPSI trainees will also be available to contribute

to the 1st tier Obstetric rota and with additional experience and relevant training may also be able to join the middle grade rota.

It is important to note that this model reflects the emerging view of clinicians, whilst the work to test the feasibility of these models is continuing, we are clear that a preferred option needs to be determined and that this happens within the time line for the PCBC.

3.2.2.1. Short term business continuity plan

While the current obstetric and associated anaesthetic services are stable, the fragility of urgent and acute medicine services (as set out in 3.2.) and paediatric services (as set out in section 3.2.3) are recognised as risks to business continuity for maternity services. A business continuity plan has been developed to confirm the actions that will be taken in the event that there is a failure in one of the services upon which the maternity service depends. This is summarised below.

Obstetrics & Gynaecology Service Summary business continuity plan in the event that there is no Paediatric support at West Cumberland Hospital

Service affected	Impact to service	Action required	Impact/Risks
Ante-natal clinics, WCH	None, service to continue at WCH		
Outpatients (Gynaecology)	None, service to continue at WCH		
Day Assessment Unit (Obstetric)	None, service to continue at WCH		
Delivery suite	No change for women who meet the Midwifery Led Unit (MLU) criteria. Women who do not meet the MLU criteria to be transferred to CIC to give birth	Create 4 additional delivery rooms at CIC by: <ul style="list-style-type: none"> • Moving colposcopy room • Use of 3 cubicles currently used by Aspen Ward 	Loss of 3 beds for women surgical patients
Ante/postnatal beds	MLU postnatal beds only. No antenatal beds at WCH	Create 13 additional ante/postnatal beds at CIC on Aspen Ward.	Cancellation of some routine elective work at CIC
Elective Sections	No elective sections undertaken at WCH	Re-provide 2 elective section lists on the CIC site using current maternity theatre, CIC	
Obstetric emergencies	All obstetric emergencies transferred directly to CIC	Dedicated Ambulance at WCH for obstetric & neonate transfers and obstetrician and anaesthetic rotas to be	Cancellation of some elective work at CIC

		reviewed. Second maternity theatre at CIC established.	
Gynaecology emergencies	All Gynaecology emergencies to be managed at CIC	NWAS to be made aware of necessity to transfer patients to CIC from WCH Create additional bed capacity at CIC by cancelling routine elective surgery as necessary	Cancellation of some elective surgery.
Workforce	Staffing Models	Re-evaluate staffing rotas to ensure additional areas at CIC are covered.	Potential HR issues if staff cannot work on the CIC site

3.2.3. Improvements in Children and Families services

3.2.3.1. Current position

During the CQC inspection, the Trust's paediatric services were rated as "good", however longer term sustainability issues in paediatrics have been noted as a challenge to our system for some time and the Royal College of Paediatrics & Child Health (RCPCH) requirements for senior assessment and emergency cover are only partially met on the two sites.

In WCH the senior assessment and emergency cover is achieved through a combination of specialty doctors, one APNP and consultants providing an incomplete resident service using a hybrid on-call rota. In CIC, where there is only one specialty doctor, consultants generally remain on site until 10pm on week nights. On both sites consultants will remain on site or return to the hospital depending on clinical need. This is resulting in onerous on-call rotas that are viewed as unattractive to prospective consultant applicants or to those already in post. This is in the context of the commitment to move to 7 day working and a national shortage across the paediatric medical workforce.

Current paediatric workforce

West Cumberland Hospital

- Consultants: 5 substantive positions; one will be filled from May, with locums for remainder.
- Middle Grade: 4 posts; 2 currently filled with substantive staff and 2 locums.
- 1 APNP: works almost exclusively on medical rota.
- 3 SHOs: 2 GPVTS and 1 Paediatric ST1; currently 1 ST1, 1 Trust doctor, 1 locum.
- 2 FY2: training posts, both currently filled.

Cumberland Infirmary Carlisle

- Consultants: 6 substantive positions; of these 5 currently filled plus 1 long term locum.
- Middle Grade: 1x 0.8 WTE-filled substantive post.
- SHO: 6 posts – 4 GPVTS, 1 Paediatric ST1, 1 Trust Grade; all locum/Trust positions currently.
- 1 APNP providing support to the junior doctor rota for ward cover.

3.2.3.2. Actions being taken

As referenced in Chapter 2, the plan for children and families in WNE Cumbria is to progress an evidence-based sustainable service model that focuses on integration, so that children, young people and their families experience services that are responding to their needs via one team.

As our challenges in the paediatric medical workforce model are currently particularly acute, there are a number of additional initiatives in progress to protect this fragile service. These include workforce issues and consideration of new models for hospital based care.

Workforce

As with acute medicine there are three key areas of focus:

- a)** Refocussing and innovating in our efforts to recruit and retain staff
- b)** Championing an NHS Doctors in Partnership Scheme
- c)** Designing a new clinical workforce model

a) Recruitment and retention:

Significant efforts are being put in place to deliver robust plans for recruitment and retention. Long term locums have been secured in order to provide services whilst the Trust prepares to recruit to vacancies.

The plans in paediatrics are consistent with the key areas in the 10 point plan (see section 6.1), and include:

- Redesigning job descriptions and recruitment processes
- Developing a cadre of specialist nurses
- Recruiting longer term locums and looking internationally to recruit into unfilled posts.
- Forging closer working relationships and joint appointments with The Great North Children's Hospital (GNCH) to reduce the risk of professional isolation.
- Forging closer working relationships with CPFT to explore opportunities for joint appointments and integrated practice.

b) NHS Doctors in Partnership Scheme

As noted in the above section on acute medicine, paediatrics would also look to benefit from the proposed pilot.

c) Implementing a new paediatric medical rota

The medical workforce model proposed by local clinicians would result in the removal of the middle grade posts and move to a fully consultant delivered service (recognising that most areas are moving to a semi-resident model). It would require 15 consultants (against a current establishment of 11), working across both sites with resident on-call at WCH and consultant presence until 10pm at CIC. The rota would provide cover for the acute services including maternity, daily rapid access clinics on both sites, GP access to a dedicated consultant for advice, provision of a child protection service on both sites and other important services.

We recognise that this model represents a considerable challenge, particularly given the national position with regard to recruitment.

New Models of Care

The establishment of a fully integrated acute and community model is the foundation for new models of care. A fundamental part of this model is providing access to Short Stay

Paediatric Assessment Units (SSPAUs) to provide rapid assessment for children who require a specialist assessment or period of observation.

We believe that this model has the potential to support new configurations of inpatient care across the two sites, recognising 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.

3.2.3.3. Short term business continuity plan

Whilst the plans outlined above retain paediatric services at both hospital sites, working with community based services, it is recognised that there are a number of implementation risks, particularly in relation to medical and nursing recruitment and retention.

Business continuity plans are in place, with specific focus on the actions that will be taken in the event of unplanned reductions in medical staffing levels. The plans detail the escalation actions to be taken depending on the number of vacant consultancy posts as summarised below:

- a) If 1 consultant post is vacant, the Trust will work to secure locum cover depending on expected length of vacancy. If no locum is available, the on call rota will be covered from within the existing cross trust team and two outpatient clinics per week should be cancelled.
- b) If 2 consultant posts are vacant and locum cover is inadequate, GPs will be informed of potential increasing waits for outpatient appointments and a further two outpatient clinics per week may need to be cancelled.
- c) If 3 consultant posts are vacant and locum cover is inadequate, outpatient clinics will be further reduced and alternative arrangements for new-born checks considered. The trust wide paediatric team will need to provide 24/7 cover at CIC, with no overnight beds at WCH.
- d) If 4 consultant posts are vacant and the Trust does not have at least 2 WTE long term locums a major incident will be called with a request to NHS England to activate the regional plan to seek mutual aid.
- e) If the above does not deliver additional support and 4 consultant past are vacant and the Trust does not have at least 2 long term locums, the SSPAU and SCBU will be temporarily closed at WCH, leading to discontinued consultant led maternity services, and closing of inpatient paediatric admissions.

3.3. Specialised Services

Specialised services are extremely complex and mutually dependant 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.

The proposition being developed by the specialised work stream identified approaches to driving service and provider transformation in a way which is supported by collaborative commissioning with CCGs and which will demonstrate improvements in Quality and Access for the people of North Cumbria. Specific reference is made to improving performance to meet National Cancer standards, National Access standards, retention of specialised staff and improved patient satisfaction.

It is recognised that new models for the delivery of specialised services will be needed to ensure that the population of WNE Cumbria have equality of access to safe and sustainable specialised services. These may be provided via links with a specialised tertiary centre (such as Newcastle Upon Tyne Hospitals NHS Foundation Trust) using technology where possible and developing strong clinical networks. This will not only enhance service provision by giving clinicians in Cumbria 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.

Discussions are progressing to explore the opportunities to work with Newcastle Upon Tyne Hospitals NHS Foundation Trust to improve diagnostic pathways, efficiency and quality in chemotherapy delivery and, subject to procurement of new equipment, this has the potential to support advanced radiotherapy therapies and techniques.

3.4. Summary

There are clear actions in place to stabilise the most fragile acute services in NCUHT with specific reference to acute medicine, maternity and paediatric services.

The actions are focussed on both retaining and recruiting a skilled and flexible workforce as well as embedding new ways of working to boost performance and resilience with the current staff – such as through an innovate “integrated teams”. In parallel, the plans recognise the need for new models of care which support proactive, anticipatory care and reduce the need for unplanned care. This includes strengthening our ambulatory care services, providing rapid access specialist advice, and implementing frailty and specialist care pathways.

We recognise that these actions are not without risk, particularly in relation to workforce pressures. In order to safeguard the system against the risk that stabilisation plans fail, service business continuity plans are in place. These business continuity plans will continue to be regularly reviewed and tested, with the Success Regime Clinical Advisory Group providing oversight. This will include regular table top exercises to test our plans as a whole system.

4. Improving Performance

Chapter 3 considered actions being taken to stabilise fragile services. We recognise that in addition the CQC, our staff, and those we serve, must be assured that progress is being made to improve our performance against the key constitutional standards with particular reference to accident and emergency performance and waiting times for elective care, diagnostics and cancer.

This Chapter confirms that NCHUT is determined to make progress to improve performance against key constitutional targets with clear trajectories agreed. There have been some notable improvements over recent months, this in spite of significant challenges out with the control of the Trust specifically relating to the winter floods. There remain, however, real challenges, particularly in relation to A&E and cancer waiting times. The leadership team at the Trust will be continuing to maintain a clear focus on driving operational improvements, while also recognising the wider strategic changes that are referred to in this response document.

4.1.1. Accident and Emergency performance

4.1.1.1. Current position

Within the Trust, a number of targeted interventions are being progressed which aim to help meet performance standards by the end of 2016/17, supported by wider system initiatives to reduce demand on A&E services. The NHS England Emergency Care Improvement Programme (ECIP) team is also working with us to support a clinically led programme that offers intensive practical help and support.

Performance against the A&E target for four hour wait times was 79% in January 2016 and consistently performs below the national standard of 95%. NHS Improvement and commissioners have agreed NCUHT performance targets of 85% by the second quarter of 2016, and 95% by the end of 2017. Current performance is in line with the agreed recovery trajectory (Figure 9.)

Figure 9. A&E Four Hour Target Trajectory and Performance

	2015/2016			2016/2017									
Performance	M10	M11	M12	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10
Target/ Recovery trajectory (%)	78.9	80.1	80.14	80.1	80.1	83.9	83.9	83.9	85.1	88.0	90.0	91.0	90.0
Actual (%)	79.1	80.55											

4.1.1.2. Actions being taken

The improvement in performance has been driven by a clear and focused programme to improve patient experience and patient flow. Specifically:

- Whole team reviews now take place every 2-3 hours to review patient flow.
- Standardised, evidence based clinical pathways for common presentations, such as chest pain, upper GI haemorrhage and headache, are being implemented to reduce clinical variation.
- Access to the primary care core record has been enabled.
- New ambulatory care pathways are being implemented to reduce admissions.
- A minors stream is being piloted with the aim of reducing waiting time for all patients and improving performance against the 4 hour standard.
- Supported by ECIP, a multi-disciplinary accelerated discharge event (MADE) took place in January to identify and agreed actions speed up discharges and release beds at CIC, WCH and two community hospitals; another event is taking place in March.
- The introduction of a Medical Procedures Unit in September 2015 has accommodated an additional 17 patients per week, releasing 441 bed days.
- The expansion of the ambulatory care unit at CIC is seeing an additional 15 patients each week compared to the same period last year (and increase of 46%).
- Frailty assessment arrangements are seeing an average of 9 patients per week.

The Trust is also putting plans in place to deliver A&E services from a single, cross site team working to ensure common standards, ways of working and enable the most flexible use of workforce and other resources. Further actions being progressed are summarised below.

Target date	Key Action
By April 2016	<ul style="list-style-type: none"> • Agreed whole system definition of frailty, a comprehensive frailty assessment tool and when / who undertakes the comprehensive frailty assessment
By June 2016	<ul style="list-style-type: none"> • Consistent approach to handover to Assessment Unit/Ambulatory Care in place • Review of assessment capacity for patients referred from the community completed • New, consistent medical assessment service at the weekend in place • Establishment of home first team / discharge navigation team
By July 2016	<ul style="list-style-type: none"> • Prediction and planning tool in place enabling the ability to predict the profile of demand hour by hour to help inform how resources are organised to deliver care. Increase care for patients on ambulatory care pathways with the expansion of the unit on the CIC site • Development of clear sub-specialty pathways • Implementation of assertive case management plans for frail patients • Agreed arrangements for specialist in-reach to support the EAU
By August 2016	<ul style="list-style-type: none"> • Review and agree pathways for step down capacity with CPFT and Adult Social Care (ASC) (subject to agreement with CPFT and ASC)
By September 2016	<ul style="list-style-type: none"> • Expanded ambulatory care opening hours at CIC from Monday to Friday (delayed from March due to staffing issue) • Integrated medical record as well as a consistent approach to clinical risk assessment in place

	<ul style="list-style-type: none"> Consistency in medical assessment 7 days a week
By October 2016	<ul style="list-style-type: none"> Ambulatory care at CIC extended to seven days a week at CIC SAFER standards embedded across both hospital sites and CPFT inpatient units
By November 2016	<ul style="list-style-type: none"> Establish a short stay assessment and treatment facility within the hospital

The successful delivery of these actions and improvements will be enabled by a number of workforce changes, such as reducing variation in A&E shift management, better defining roles for nurses, ward clerks, Emergency Care Physicians in Charge, and wider clinical support staff as well as making best use of the available resource of acute physicians and optimising the contribution of other sub-specialty consultants. The development of an integrated medical record will also enable clinicians to access wider care plans and deal with patients more efficiently and effectively.

Some system-wide areas of work are also being progressed which aim to support improved A&E performance including:

- Reviewing the NHS 111 service and exploring the potential opportunities to develop an integrated model with primary care out of hours services, such as **developing a clinical advice hub** that brings together the Urgent Care Desk already in place for 999 and the clinical advisors for 111 to provide clinical triage.
- Continuing a **social media campaign**, highlighting A&E is for serious and life threatening injuries and conditions, and providing signposting to other NHS services including 111, GPs, pharmacies and self-care.
- The CCG has commissioned 3 beds at Kingston Court care home for patients to be transferred to who are awaiting **continuing healthcare** (CHC) packages; effectiveness of this will be reviewed and may be increased to 6 beds.
- Supporting NWS participation in the **Paramedic Pathfinder Decision Making Algorithm** which allows alternative management of patients reducing the need for transfer to hospital; NWS rates for Hear and Treat and See and Treat now total over 38% of calls.
- A review of **ambulance turnaround** processes to ensure a full handover is managed effectively: NWS have put Ambulance Liaison Officers into CIC A&E to assist with flow and release ambulances back onto the road
- A recognition of the need to harness the most effective clinical, **diagnostic infrastructure** to support the units, being developed through the diagnostic improvement plans (in progress).
- As noted in section 2.2.6 above, introducing an alternative A&E “front door” for **mental health urgent care**: over the next two years there are plans to introduce a multi-agency crisis assessment centre at CIC, at which various services including psychiatric liaison with new on call transport will be co-located.

4.1.2. Elective services

4.1.2.1. Current Position

NCHUT has been working to improve the efficiency and effectiveness of elective services through the consolidation of high volume, low risk surgery on the WCH site, creating capacity at CIC for unplanned and higher risk surgery. Progressing this work is a priority, recognising that NCUHT is currently 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.

4.1.2.2. Actions being taken - Referral to Treatment (RTT)

A number of short term measures are being implemented to improve RTT performance, which we are expecting to help us to achieve the 92% standard for all incomplete pathways by September 2016. The most recent recorded performance was 90.46% for February 2016, above the agreed trajectory of 89.9%. (Figure 10.)

Figure 10. RTT Elective Trajectory and Performance

	2015/2016			2016/2017						
Performance	M10	M11	M12	M1	M2	M3	M4	M5	M6	M7
Target (%)	92	92	92	92	92	92	92	92	92	92
Target/ Recovery trajectory (%)	89.7	89.9	90.23	90.6	90.6	91.35	91.7	91.7	92.1	92.5
Actual (%)	89.8	90.46								

Delivery of this recovery trajectory is based upon short, medium and long term measures:

- **Short term measures** to deliver performance of 90.23% by March 2016. We will run a full elective programme at both CIC and WCH, which should equate to a reduction in 50-70 admitted backlog cases each month. At the same time, we will agree on non-recurrent resources for orthopaedics to support elective operating at Hexham, supplemented by the independent sector (Medinet), reducing the orthopaedic admitted backlog by 8 cases per weekend (circa 34 per month). We have also agreed on non-recurrent resources for ophthalmology to help maintain performance.
- **Medium term measures** will help us achieve 92% compliance by September 2016. The basis for an effective recovery will be demand and capacity modelling at a speciality level, to inform contracting volumes for both normal run rate and backlog reduction. In order to hit the 92% target, non-admitted performance needs to be sustained at around 97%, equating to a backlog of just under 330 patients. This will require prioritisation of outpatient appointments and timely completion of clinic letter typing. Meanwhile,

NCUHT will continue to run a full elective service on both sites, which will continue to reduce backlog.

- **Long term measures** are focusing on productivity and efficiency gains across specialties. Each specialty has been tasked with identifying potential productivity gains, and the aim is a 1% reduction per month in Q1 in cancellations which are not rebooked. At the same time, external providers will continue to be used to provide activity over and above the contract (e.g. Hexham for T&O, Medinet for ophthalmology).

4.1.2.3. Actions being taken - Diagnostics

The operational standard for diagnostics is that less than 1% of patients should wait 6 weeks or more from referral for a diagnostic test. This standard was being met for 4 out of the 12 key diagnostic tests provided by NCUHT in December 2015 with 246 patients waiting over 6 weeks (5.1%) – an improvement from 17.86% (1214 patients) in September 2015. The Trust's overall position has continued to improve such that by February 2016 128 patients (2.63%) were waiting over 6 weeks from referral for key diagnostics tests. All plans are on track against agreed recovery trajectories.

NCUHT has plans in place to source additional diagnostic capacity from Medinet and Hexham General Hospital (part of Northumbria Healthcare NHS Foundation Trust) to ensure patients have access to earlier diagnostics. A performance improvement plan for diagnostic services is in place, and this also identifies significant opportunities for efficiency improvements.

4.1.2.4. Cancer

The Trust is currently meeting the 14 and 31-day cancer performance targets overall, however it is not meeting the 62-day target (Figure 11).

Figure 11: Summary of NCHUT Cancer Performance as at 8th March 2016

1. FEBRUARY(as at 8th March)

	Target %	2 week wait			Target %	31day First Definitive Treatment			Target %	62 day standard		
		%	Seen	Seen in standard		%	Seen	Seen in standard		%	Seen	Seen in standard
Breast	93	98.8	81	80	96	94.1	17	16	85	75.0	12	9
Head and neck	93	96.3	108	104	96	100	9	9	85	83.3	6	5
Gynaecology	93	96.9	98	95	96	100	1	1	85	33.3	3	1
Lower GI	93	89.6	125	112	96	87.0	23	20	85	61.5	13	8
Lung	93	100	30	30	96	100	14	14	85	40.0	5	2
Skin	93	87.8	98	86	96	92.9	14	13	85	81.3	16	13
Upper GI	93	99.1	113	112	96	100	10	10	85	75.0	8	6
Urology	93	88.0	133	117	96	100	12	12	85	92.9	14	13

The cancer plan previously submitted to NHS England and the Trust Development Authority (TDA), which expects recovery to the 62-day cancer target of 85% by September 2016, is being progressed focusing on:

- Improving the **referral process**, by focusing on encouraging earlier referrals from primary care, and improving patient information at point of referral to reduce “Did Not Attend” numbers.
- Improving **Multi-Disciplinary Team** performance by clarifying roles and accountability, supporting delivery of MDT work plans, and standardising Peer Review documentation and accountability to reduce inconsistencies and delays.
- Improving monitoring of **cancer pathways**, by improving data and technology usage, which is currently labour intensive – relying primarily on manual input – and therefore underutilised.
- Targeting particular cancer pathways to reduce **diagnostic, histopathology and imaging reporting times** and reconfigure **chemotherapy service** to shorten access times.
- **Improving management across the 62-day pathway** by agreeing trigger points on the pathway with tertiary centres so that lead times before transferring patients can be managed efficiently, and by introducing clinical supervision across the pathway, to offer peer support and development, driving up staff performance.

5. Alternative scenarios for future acute hospital services in WNE Cumbria

5.1. Introduction

While our actions to stabilise acute services and our plans to strengthen out of hospital and acute services should significantly improve quality, safety and patient outcomes, we know that there will be significant deliverability challenges and risks primarily associated with workforce. In terms of financial sustainability we also recognise that the plans set out in Chapters 2, 3 and 4 of this documents do not close the current system wide financial gap and indeed have the potential to place further financial demands on our health and care system. Therefore it is important that we consider further opportunities to deliver safe and sustainable acute hospital services.

To help stimulate discussion and debate on potential futures, our clinical leaders, through the Success Regime clinical working groups have been considering future models of care for acute hospital services.

In this chapter we outline a number of potential scenarios. These have been developed to help inform our thinking on the possible configurations for acute services in the wider context of strengthened out-of-hospital services should existing configurations prove unsustainable.

We are clear that the scenarios are not specific ideas for adoption. They do, however, set out some of the tough choices that may need to be considered by the WNE Cumbria health and care system with the full engagement of the local population.

Note: All the scenarios outlined below assume that outpatient services and investigations will continue at both acute hospital sites and that there will be a strengthening of specialised service networks. It is also recognised that any future model will need to be considered in parallel with the review of community hospitals outlined earlier in Chapter 2 and wider estates implications would need to be factored in.

5.2. The Scenarios

Building on work undertaken by our clinical work streams, we have set out six possible scenarios for acute hospital services focusing specifically on emergency care, integrated care, elective care, maternity and paediatrics.

In developing the scenarios, we have been mindful of the key design principles that we set out in Chapter 2.

- **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 West Cumberland Hospital and Cumberland Infirmary Carlisle have a clear future in

providing safe, high quality care. This will require a commitment to the concept of “**single specialist clinical teams**” which may cross organisational boundaries.

- **Strong partnerships** with our staff and with our local communities will be promoted to enable them to help shape the future.
- Specialised and specialist services must be provided through **strong network arrangements**.
- We must work collectively to focus on both the short term improvements and longer term changes, and this will require a level of **leadership and commitment** not previously seen.

Scenario 0: Core acute services at Cumberland Infirmary Carlisle and West Cumberland Hospital, enhanced by a modernised way of working

This is the service model that results from the various service level improvements set out in chapter 3, building on the “status quo” with initial implementation of a composite clinical workforce model.

24/7 accident and emergency services continue at both CIC and WCH with direct transfer of pre-agreed categories of emergency patients to CIC in line with agreed protocols.

Enhanced frail elderly assessment, anticipatory care and ambulatory care with inpatient beds are available at both acute hospitals, working with the ICCs.

CIC delivers acute and complex elective surgery, with increased volumes of low risk surgery at WCH.

Both sites have a consultant-led unit (CLU), special care baby units (SCBU) and co-located midwife-led units (MLU).

Inpatient paediatrics and short stay paediatric assessment units (SSPAU) are provided at both sites.

Scenario 1: Selected “blue light” cases and higher-risk maternity at Cumberland Infirmary Carlisle

In this scenario, 24/7 A&E continue at both CIC and WCH. Slightly more patients would be taken directly to CIC based on agreed pathways, including patients who require access to hyper acute stroke care.

Enhanced frail elderly assessment, anticipatory care and ambulatory care with inpatient beds are available at both acute hospitals, working with the ICCs.

CIC provides acute and complex elective surgery, with even more routine elective surgery provided at WCH as an “elective centre of excellence”.

There is a single CLU at CIC with SCBU and a co-located midwife led unit. There is a MLU at WCH.

Inpatient paediatrics is consolidated at CIC, with short stay paediatric units (SSPAUs) at both CIC and WCH, with low acuity beds at WCH.

Scenario 2: Selected “blue light” cases, reduced A&E hours and all maternity at Cumberland Infirmary Carlisle

24/7 A&E is consolidated at CIC with reduced hours A&E available at WCH and a 24/7 Urgent Care Centre (UCC).

Enhanced frail elderly assessment, anticipatory care and ambulatory care with inpatient beds are available at both acute hospitals, working with the ICCs.

CIC provides acute and complex elective surgery, with routine elective surgery provided at WCH as an “elective centre of excellence”.

All intrapartum maternity services are consolidated at Carlisle, with a consultant-led unit, alongside midwife-led unit and SCBU. There are no intrapartum care at West Cumberland Hospital; only antenatal services including a nurse led early pregnancy assessment service

Inpatient paediatrics is consolidated at CIC, with 14 hour short stay paediatric units (SSPAUs) at both CIC and WCH, and low acuity beds at WCH.

Scenario 3: All acute services consolidated and high risk maternity at Cumberland Infirmary Carlisle

24/7 A&E is consolidated at CIC with a 24/7 UCC at WCH.

There is a frail elderly assessment unit and ambulatory care provision with inpatient beds at Carlisle. West Cumberland has beds for non-acute care.

CIC provides acute and complex elective surgery, with routine elective surgery provided at WCH as an “elective centre of excellence”.

There is a CLU at CIC, with a SCBU and co-located Midwife Led Unit. There is a MLU at WCH.

All Inpatient paediatrics are provided at CIC, with 14 hour SSPAUs on both sites.

Scenario 4: All acute services, maternity deliveries and paediatric services consolidated at Cumberland Infirmary Carlisle

24/7 A&E is consolidated at CIC with a 24/7 UCC at WCH.

There is a frail elderly assessment unit and ambulatory care provision with inpatient beds at Carlisle. West Cumberland has beds for non-acute care.

CIC provides acute and complex elective surgery, with routine elective surgery provided at WCH as an “elective centre of excellence”.

All intrapartum maternity services is consolidated at Carlisle, with a consultant-led unit, alongside midwife-led unit and SCBU. There are no intrapartum care at West Cumberland Hospital.

All paediatric services are consolidated at CIC.

Scenario 5: All acute services and higher risk maternities at West Cumberland Hospital

24/7 A&E is consolidated at West Cumberland Hospital, with a 24/7 UCC at CIC.

Enhanced frail elderly assessment, anticipatory care and ambulatory care with inpatient beds are available at both acute hospitals, working with the ICCs.

WCH provides acute and complex elective surgery, with routine elective surgery provided at CIC as an “elective centre of excellence”.

There is a consultant led unit, SCBU and co-located midwife led unit at WCH and an MLU at CIC.

All Inpatient paediatrics are provided at WCH, with 14 hour SSPAUs on both sites and low acuity beds at CIC.

The above scenarios are set out in Figure 12 below.

5.3. Next Steps

As we work to develop our PCBC, we will need to develop options and assess these through a robust, open and transparent process, including formal public consultation where appropriate. This will include the development of evaluation criteria and an evaluation process that enables a formal appraisal to be undertaken.

Figure 12: Summary of scenarios for acute hospital services in WNE Cumberland

	Scenario 0 – <i>Maintain existing services at CIC & WCH, and add MLUs to both</i>	Scenario 1 – <i>Selected “blue light” cases and higher-risk maternities at CIC</i>	Scenario 2 – <i>Selected “blue light” cases, reduced A&E hours and all maternity</i>	Scenario 3 – <i>All acute services at CIC, MLU at WCH</i>	Scenario 4 – <i>All acute services & maternity/ paediatrics at CIC</i>	Scenario 5* – <i>All acute services and higher risk maternities at WCH</i>
Emergency care 	24/7 A&E services at CIC & WCH with direct transfer of pre-agreed categories of emergency patients to CIC	24/7 A&E services at CIC and WCH with more direct transfer of pre-agreed categories of emergency patients to CIC	24/7 A&E consolidated at CIC with daytime A&E at WCH. Direct transfer of pre-agreed categories of emergency patients to CIC	24/7 A&E consolidated at CIC with UCC at WCH. Emergency surgical & medical admissions to CIC	24/7 A&E consolidated at CIC with UCC at WCH. Emergency surgical & medical admissions to CIC	24/7 A&E consolidated at WCH with UCC at CIC. Emergency surgical & medical admission to WCH
Integrated care 	Frail elderly assessment and ambulatory units with inpatient beds at CIC & WCH working with ICCs**	Frail elderly assessment and ambulatory units with inpatient beds at CIC & WCH working with ICCs	Frail elderly assessment and ambulatory units with inpatient beds at CIC & WCH working with ICCs	Frail elderly assessment, ambulatory unit with inpatient beds at CIC. WCH has beds for non-acute care of the elderly	Frail elderly assessment and ambulatory unit with inpatient beds at CIC. WCH has beds for non-acute care of the elderly	Frail elderly assessment and ambulatory units with inpatient beds at CIC & WCH working with ICCs
Elective 	CIC delivers acute & complex elective surgery, increased low risk surgery at WCH	CIC delivers acute & complex elective surgery. WCH is centre of excellence for low risk surgery	CIC delivers acute & complex elective surgery. WCH is centre of excellence for low risk surgery	CIC delivers acute & complex elective surgery. WCH is centre of excellence for low risk surgery	CIC delivers acute & complex elective surgery, WCH is centre of excellence for low risk surgery	Complex surgery undertaken at WCH & out of area. CIC is centre of excellence for low risk surgery
Maternity & Paediatrics 	CLU with SCBU & co-located MLUs at both sites. Inpatient paediatrics and SSPAU at both sites.	CLU with SCBU & co-located MLU at CIC, MLU at WCH. Inpatient paediatrics and SSPAU at CIC. 14 hr SSPAU and low acuity beds at WCH.	CLU with SCBU & MLU at CIC. Inpatient paediatrics and SSPAU at CIC. 14 hr SSPAU and low acuity beds at WCH.	CLU with SCBU & MLU at CIC, with MLU at WCH. Inpatient paediatrics and SSPAU at CIC. 14 hr SSPAU at WCH.	CLU with SCBU & MLU at CIC. Inpatient paediatrics and SSPAU consolidated at CIC	CLU with SCBU & MLU at WCH and MLU at CIC. Inpatient paediatrics and SSPAU at WCH. 14 hr SSPAI and low acuity beds at CIC
Specialised 	Specialist services such as interventional radiology, oncology provided as part of a networked service e.g. w/ Newcastle	Specialist services such as interventional radiology, oncology provided as part of a networked service e.g. w/ Newcastle	Specialist services such as interventional radiology, oncology provided as part of a networked service e.g. w/ Newcastle	Specialist services such as interventional radiology, oncology provided as part of a networked service w/ Newcastle	Specialist services such as interventional radiology, oncology provided as part of a networked service e.g. w/ Newcastle	Specialist services such as interventional radiology, oncology provided as part of a networked service e.g. w/ Newcastle

*There may be variants of this scenario, making WCH the main site

**As part of a whole system bed model

6. Enabling better care

To deliver better care we recognise that there are a number of important enabling strategies that must be in place. Early focus has been given to workforce, transport, technology, organisational development and organisational form.

6.1. Workforce

The 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. Some of our proposals are summarised below:

- Championing the idea for NHS Doctors in Partnership (see section 3.2.1.2) and promoting WNE Cumbria as a pilot site. We have designed a DPS team comprising acute medicine personnel, paediatricians, obstetricians and General Medical Practitioners.
- Exploring a **single, local approach to the employment of temporary staff** to help radically reduce the current over reliance on locum staff.
- Developing an education, training & development plan that aspires to create the first **“Associated University Teaching System”** in the country supported by new centres of excellence for support staff and clinical networks. This will be complemented by the development of a new rural remote clinical school at UCLan with international prestige.

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

WNE Cumbria 10 Point Workforce Plan		
	Action	Summary of outputs/measurable impact
1	Produce a workforce and investment plan in support of the clinical strategy	<ul style="list-style-type: none"> • A new baseline workforce portrait for local system including for each clinical work stream by March 2016 • Modelling of the workforce implications of the clinical options developed for consultation by May 2016 • Workforce and investment plan developed by Sept 2016
2	Establish a new national clinical taskforce - Doctors in Partnership to be piloted in WNE Cumbria	<ul style="list-style-type: none"> • To pilot an approach, in partnership with NHS Improvement and IMAS (Interim Management and Support), to help clinical service sustainability and transformation on behalf of a national initiative; initially focusing on medical staff in key specialty areas. To be implemented by September 2016

3	Accelerate the development of extended and new roles/skills/behaviour	<p>Working closely with HEE, to encourage the support for developing, training staff</p> <ul style="list-style-type: none"> • introducing new and innovative roles which underpin new clinical ways of working • continuing professional development of current staff • to agree education investment by end of June 2016
4	Focus on “Growing Our Own” workforce locally through a new Centre for Excellence	<p>To ensure we maximise the potential for the whole of current and future workforce</p> <ul style="list-style-type: none"> • CPFT participated in “dream placement” Feb 2016, to encourage potential medical students into working in the NHS locally • HEE funded support mapped by end March 2016, to enable targeted work • Review proposals for other professional roles by end April 2016 to ensure a balanced workforce
5	Devise a prioritised ‘NHS in Cumbria’ reward and recognition strategy	<ul style="list-style-type: none"> • To develop a new ‘Offer’, based on best practice, feedback and innovative suggestions, for encouraging clinicians to want to live and work in Cumbria. Plan outlining options/proposals for short, medium and long term to be produced by 31.3.16 • Planned to be shared with Executive Teams for comment/Input – 5th April 2016 • Planned to be shared with consultant body including BMA members – by mid-April • Recruitment campaign <i>underway by 1st April 2016</i> • <i>Increase to vacant posts by 5%</i> • <i>Decrease of agency spend by 10%</i>
6	Develop the first national teaching system accredited by local education and national partners	<p>To help establish a ‘System of Excellence’ for education, training and development of all staff building on the associated university recognition of both local Trusts as well as the new UCLAN partnership by Sept 2016</p>
7.	Develop a recruitment hub (improving the quality of the recruitment experience)	<ul style="list-style-type: none"> • Gold standard recruitment process for medical and non-staffing to be designed by June 2016. • Candidate experience is improved with 90% of candidates saying experience was positive - - to be tested from November 2016
8	Promote Cumbria through an NHS covenant and Local Enterprise Partnership (LEP) commitment	<p>To test the local willingness to deliver a “covenant” for staff (paid and unpaid) working in Cumbria with regard to, for example, housing, schooling etc. by June 2016, to encourage staff into Cumbria NHS .</p> <ul style="list-style-type: none"> • Key components drafted for agreement by end of April 2016 • Initiate discussions with Cumbria CC May 2016 • LEP-led kick off session attended; LEP to confirm funding support in April 2016; used to support promoting Cumbria as a place to live and work, to tackle vacancies

9	Enhance the employer brand / employer of choice initiative	<p>To build on current approaches currently to staff engagement and satisfaction with a view to achieving national organisational accreditation / recognition as a great place to work; and improve on the staff engagement scores in the national staff survey.</p> <ul style="list-style-type: none"> • Staff survey results to be analysed, actions to improve staff satisfaction identified by mid-April 2016 • Map current engagement activities by end April 2016 • Share WWL best practice model with NCUHT, to agree a joint way forward, by end April 2016
10	Invest in leaders and talent	<p>To support and champion leaders at all levels in delivering new services through development programmes, coaching and mentoring, talent management and networks, to improve management capacity and capability.</p> <ul style="list-style-type: none"> • OD Workstream to map planned activities across SR by end of April 2016 • Explore potential to work with NHS Executive Search on a pilot to support Senior NHS Leadership Succession Planning, by end April 2016

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.

6.2. Finance

Our work suggests that, based on current models of care and levels of efficiency, by 2020/21, the health system in WNE Cumbria would have an anticipated overspend against its allocated budgets of c. £163m annually. This would represent almost 35% of the budget available.

Approximately half of this overspend (£83m) relates to the underlying deficit for 2015/16, with this increasing by a further £80m over the five years.

We recognise that the level of over-spend has escalated in recent years, largely as a result of the increased use of agency staff, and the inability to control costs and deliver efficiency savings.

Progress is being made to identify the opportunities to achieve savings across WNE Cumbria, considering both opportunities to improve efficiency and productivity, as well as releasing cost and delivery better value through new ways of working. The early indications from this work are that there is the potential to deliver savings through a combination of stretching efficiency measures and through implementing some of the new models of care which are set out earlier in this document. To reduce the financial gap, we recognise that we may need to go further and explore with staff, communities and stakeholders new opportunities that can release resource while enabling us to achieve our ambition for WNE Cumbria.

Alongside this, we are also developing more detailed plans to underpin the efficiency opportunities identified, which will include careful consideration of the options set out within the Carter Review.^[1]

As the Success Regime works to develop a plan to deliver clinical and financial sustainability, we expect that this will result in a bid for financial support whilst the measures to be put in place deliver the financial balance over five years are implemented. This will be set out clearly in the Pre Consultation Business Case.

[1] Department of Health, Operational productivity and performance in English NHS acute hospitals, June 2015
<https://www.gov.uk/government/publications/productivity-in-nhs-hospitals>

6.3. Transport

6.3.1. Overview

There are significant ongoing transport issues across WNE Cumbria for those using health and care services due to the challenges of distance to, and between, key health and care sites compounded by poor road infrastructure and high reliance on public transport in some areas. As a result, transport issues are cited by public, patients and staff as an area of both current and future concern.

Public transport can be difficult to access due to infrequent services and often lengthy journey times. Community transport is currently limited with only one of the four community transport organisations in Cumbria providing transport to hospital appointments and the local surgery. As a result, reliance on travel by private car is significant and car parking capacity is cited by the public as a major issue at both hospital sites. To address this issue, two new car parks at CIC providing a further 395 spaces will be operational by Christmas 2016 and NCUHT has detailed Travel (improvement) Plans in place for both sites and is working closely with community colleagues to deliver these plans.

NWAS provide emergency medical services and non-emergency Patient Transport services (PTS) in WNE Cumbria. The PTS contract for Cumbria has been recently re-awarded to NWAS and will be live from July 2016. It 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.

NWAS has struggled to meet national emergency standards in WNE Cumbria for a number of years. This is in part due to geographical challenges, workforce difficulties, and delays in turnaround times and increased activity, both from community source and in relation to inter-site transfers. It is therefore recognised that the impact of any changes on both emergency and non-emergency transport must be carefully modelled and managed.

6.3.2. Future plans

Looking forward, a key assumption underpinning the transport plan will be the opportunities associated with the delivery of care closer to home through the ICCs and the impact of new technologies which reduce the need for patients and staff to travel. This will release resources to further expand see and treat models and focus on improving response times for the most clinically urgent cases. Key strands of our strategy will include:

- Ensuring the system has a thorough **understanding of existing demand and capacity**.
- **Modelling solutions** and options to support each alternative scenario in terms of activity, workforce, finance along with lead-in times and risk-assessment
- **Maximising the use of technology** such as telecare and telemedicine and use of community based advanced paramedics to reduce the need for travel.
- Potential **extension of PTS** services to evening and weekends to facilitate discharges 7 days a week

- Consideration of the feasibility of **hopper bus** services between sites
- Ensuring adequate provision of **car parking** including “drop-off” and disabled facilities, as well as signposting and use of volunteers.

Helimedicine

We are also considering a radical proposal to establish a helicopter based Emergency Medical Retrieval Service (helimedicine) which would complement and work with existing air ambulance services.

This would be a regional service, to be initially trialled at WCH, which would provide patients in remote and rural areas of the North of England with rapid access to an emergency medicine or intensive care senior expertise, from vehicles equipped to provide lifesaving, specialist, and critical care. At the request of local doctors, nurses and ambulance staff, the team would fly to roadside and fell settings as well as to rural hospitals and practices to assess, resuscitate and/or stabilise patients before they were transferred by air to either an emergency department or to intensive care within a main hospital. As well as consultants, the team would include registrars and critical care practitioners (paramedics and nurses) with additional skills in critical care retrieval. This is expected to have a significant recruitment and retention benefit in offering an exciting local portfolio option for those with emergency medicine expertise.

The proposal has support from Keith Willetts, NHS England’s Director of Acute Care and we will be working to test the feasibility of different options, learning from other systems and third sector partners. We also recognise that it will need financial support as, without this, it will increase rather than, close our affordability gap.

6.4. Clinical Informatics and Information Technology

6.4.1. Overview

Clinical informatics and technology have been recognised as a major enabler of our vision for WNE Cumbria as a centre of excellence in the delivery of health and care in a rural and dispersed area.

Cumbria is already recognised as a national leader in the development of a system networked health care system. This offers significant opportunity to build on this platform to support integrated clinical models and create visibility of clinical information for quality, governance and improved performance. To build on this we have agreed seven cross system principles.

Our Seven Cross System Principles

- All providers of healthcare in WNE Cumbria will implement an **electronic patient record** :
- As a foundation for an integrated Electronic Patient Record (EPR) across Cumbria, solutions must be **interoperable** and must be accessible to patients.
- Interoperability will be extended to **care homes, hospices and voluntary sector providers**.
- Strata (**e-referrals and resource matching**) will be used as the prime electronic tool to support effective and high quality transfers of care between teams, services and organisations.
- Social care will use the **NHS number** to populate its social care system
- Integrated Care Communities will be exemplars in the use of **technology enabled care**.
- Use of **mobile technologies** will become the norm.

6.4.2. Creating a system fit for the 21st century.

Our ambition is that a person's relevant patient information will be available at all times, at the point of care. Clinicians and nursing staff will have access to the most up to date information, in the right format in the right place at the right time, leading to improved quality of care and reduction of medical errors. We believe that this provides the foundation for the development of truly integrated clinical care.

The roll out of Superfast broadband across Cumbria, allied to investment in patient facing technology, by the NHS and Councils, will support health and wellbeing initiatives. Technology enabled care will be facilitated through the use of mobile devices, with patient records accessible from mobile devices, expanding usage of the existing telecare and assistive technologies, from text prompts to remote monitoring of vital signs, and fully utilising videoconferencing tools for remote consultations with patients or for multi-disciplinary team meetings. Informatics will be used to ensure that we are able to plan our services to meet need with insight and access to evidence.

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

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

- Developing the Cumbria COIN, providing a sound, secure network across health and care organisations as a solid foundation for organisations and staff to use technology safely and effectively, and access their records from any health and care establishment across Cumbria
- Implementing comprehensive WiFi for both staff and the public across all our healthcare establishments
- Ensuring that by June 2016 all GP practices, community and specialist services in CPFT and all hospice / palliative care services will be using EMIS as their prime electronic patient record, offering an integrated patient record across our ICCs.
- Leading the way in the use of electronic referrals and resource matching software, (Strata) with all referrals to adult social care, from acute and community services, being sent electronically. This 'air traffic control system for patients' has streamlined the referral process in some cases from a couple of hours to 15 minutes and was shortlisted for a Health Service Journal (HSJ) Award in 2015.
- Standardising referral forms, thereby reducing variation in the quality of information and significantly improving timeliness and communications between staff across organisations
- Part of the Cumbria Rural Health Forum, a network of professionals taking a collaborative approach to digital health and social care as part of the rural solution.

Further planned and pipeline initiatives, to facilitate patient flow, improve timeliness, quality of care and efficiency are outlined in the implementation programme below

Actions	2013-15	2016/17	2017/18	2018/19
Majority of community nursing and community based specialist services staff, all hospice and specialist palliative care services and Cumbria Health On Call sharing information through EMIS				
Adult social care referrals from acute and community settings are sent electronically via Strata e-referrals and resource matching.				
MIG / Shared record viewer				
Children's Services EPR (RiO) go live		Q1		
All general practices across WNE Cumbria using EMIS Web		Q2		
NCUHT to refer patients electronically into community services via Strata e-referrals and resource matching		Q2		
Mental health EPR go live		Q3		
New telecare and assistive technology services in place		Q3		
All 5000 non-acute beds (ASC, community, hospice), will be booked electronically.		Q4		
E-referrals to third sector and care homes		Q4		
5000 people using telecare and assistive technology services			Q4	
NCUHT EPR / e-prescribing system (funding to be confirmed)				Q4
Ambulance service to be linked into MIG / Strata (timeline to tbc)				

Telehealth and Telecare

We currently have around 2,250 telecare users across the whole of Cumbria, and expect this to increase 5,000 users by 2018. Cumbria County Council will shortly be tendering for increased delivery of telecare and assistive technology services which include 24/7 remote monitoring, motion sensors, vision and hearing impaired equipment, medication prompting. Our intention is to include opportunities for telehealth initiatives alongside the telecare tender, to introduce monitoring of vital signs and utilise the expertise built up by the Council, in rolling this out through ICCs.

We are looking to work collaboratively with Scottish Centre for Telehealth and Telecare, the "market leaders" at developing these types of services for remote communities at scale. Such initiatives will enable more people to monitor their own conditions e.g. heart failure, diabetes and hypertension through readings sent wirelessly to nursing teams with the assurance that any changes will automatically be alerted to medical professionals.

6.5. Organisational development

While our local organisations and our people who deliver services have, over a number of years, worked hard to improve care and services in WNE Cumbria, the scale and size of the challenge now faced highlights the extent and breadth of the cultural and behavioural change required. We recognise that a different approach to change and improvement is required if we are to be successful in achieving and sustaining improvements in quality and financial performance. Specifically our clinicians and managers will be required to work together more closely, showing leadership and alignment to the system and working tirelessly in the interests of the people who use our services.

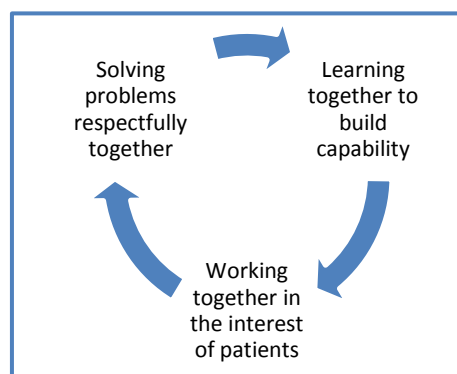
The five organisational development objectives

To enable us to succeed:

- We will build engagement, ownership and happiness amongst staff, patients and the public (The Success Regime communications and engagement plan)
- We will build leadership that consistently and unrelentingly shows, supports, directs and rewards the necessary change and development required
- We will develop a single culture (“the way we do things around here”), and shared sense of purpose, focused on improving outcomes with and for patients
- We will 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
- We will 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 (The Success Regime Workforce enabling work)

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

- A commitment to learn together through the Cumbria (health and social care) Learning and Improvement Collaborative (CLIC).
- 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.



An exercise to map the development programmes and OD resources that are currently in place across organisations has been undertaken to inform a system OD plan.

System OD Plan		
	Action / Initiative	Timescale
Learning together		
All staff	Continuation of CLIC improvement programmes <ul style="list-style-type: none"> • 0.5 day CPS awareness • 3 day CPS Practitioner Continuation of Forerunner clinical skills programme.	On going On going
Targeted*	Programme to support specific groups e.g. Board, SRO using established common tools and models.	Commencing April 2016
Working together		
All staff	Continuation of CLIC collective leadership programmes <ul style="list-style-type: none"> • 0.5 day Making an Impact • 3 day Improvement leaders. 	On going
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.	Commencing April 2016
	CLIC System leadership programme to support integrated care teams	Review April 2016
Solving Problems respectfully together		
All staff	Agree specific values and behaviours to define “how” we will work together to incorporate into development programmes (specific to systems and organisational programmes)	March 2016 - Completed
Targeted*	Coaching skills – 2 day programme	Started Feb 2016

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

6.6. Organisational form

6.1.1. Introduction

In progressing decisions in relation to organisational form, there will be a two staged approach – the first stage is aimed at achieving organisational stability for North Cumbria University Hospitals NHS trust, the second stage is aimed at achieving the most optimum organisational form for the WNE Cumbria system. Whilst these approaches are linked, they are not wholly dependent on each other and can run concurrently.

6.6.1. Background

The Success Regime has been tasked by the CQC with producing a plan for the future organisation and management of acute services by September 2016, with a clear implementation process agreed.

The formal merger of NCUHT and Northumbria Healthcare NHS Foundation Trust (Northumbria) has not progressed since the appointment of Northumbria as Preferred Bidder in February 2012 for a variety of reasons; including the need for significant financial support for a merger. There is a consensus that, as it currently stands, the original plan that Northumbria should acquire NCUHT may not be the only solution because of:

- The risks associated with the acquisition of an organisation with a major financial deficit
- Poor performance;
- Some services which are not sustainable in their present form;
- A recognition of the need for a solution which supports the delivery of our whole system strategy.

6.6.2. Current Arrangements – NCUHT

The Public Service Agreement (PSA) for the buddying arrangements with Northumbria continues and there are plans in place to strengthen this.

The Buddy Agreement

The “buddying agreement” between NCUHT and Northumbria has provided benefits for the NCUHT including:

- Improvement in mortality rates – particularly at the CIC site
- Clinical leadership through the secondment of clinical leaders from Northumbria including 2 medical directors
- Specific clinical support to the WCI site to sustain acute medical services
- Additional senior financial personnel
- Access to clinical and managerial training and development
- Access and provision of back office function support
- Senior leadership in communications and engagement

The support provided by Northumbria is paid for via a combination of a direct recharge for services provided, predominantly staff secondments and a fixed management fee payable by the TDA.

In order to stabilise and build on the existing partnership arrangements, it is intended to strengthen the “buddying agreement” with a more binding formal legal partnership between the two Trusts.

The means of doing this are under development and will utilise the freedoms Northumbria have through the establishment of their Acute Care Collaboration Vanguard proposal which is intended to lead to the formation of a Foundation Group.

The advantage of a more formal legal agreement is that it will unequivocally describe the responsibilities of the two Boards and the specific support Northumbria will provide to NCUHT who will be a member of the Foundation Group. It is likely to include commitment from Northumbria to be the provider for some specific clinical services, arrangements for joint clinical appointments, supporting clinical leadership development, the provision of support for Strategic and Operational leadership and management and access to full shared services.

This is likely to be supplemented by the involvement of Newcastle upon Tyne Hospitals NHS Foundation Trust (Newcastle), managing some other specialist clinical services which may include oncology, trauma and children’s services.

In considering steps towards the second stage, the key organisations in WNE Cumbria will be involved – these are Cumbria CCG, NCUHT, Cumbria Partnership Foundation Trust and Cumbria County Council. The governance arrangements in these organisations are different and these will need to be carefully considered in detail when looking at what may be the most appropriate new system-wide organisational form(s) which are consistent with the new integrated service models which will feature in the clinical strategy. Consideration of new forms will include the type of accountable care arrangements being pursued in South Cumbria, Northumbria and Salford, along with the development of the service chain concept.

6.6.3. Moving Forward

In progressing decisions in relation to organisational form, there will be a two stage approach but whilst linked are not wholly dependent on each other and can run concurrently.

6.6.3.1. Solidify the Buddying Agreement through contractual arrangements

As referred to previously, the first step in progressing towards a sustainable organisational form is to strengthen and formalise the current arrangements with Northumbria, in to a binding contractual arrangement with greater clarity of roles and with a view to incentivising improvements and taking further the principles enshrined within the PSA. This contractual arrangement will also need to include Newcastle given they will be managing some clinical services. This arrangement will be in place from 1st September 2016.

A more formal arrangement will build upon the freedoms already afforded to Northumbria through its Acute Care Collaboration Vanguard but will need to specifically:

- Unequivocally articulate the responsibilities of each organisation not just at Board level but clinically, managerially and operationally;

- Identify the remuneration structure of the arrangement – determining how each organisation will share in the risk and reward of the arrangement and be properly incentivised to deliver success and improvements across WNE Cumbria; and
- Outline the roadmap for a longer term organisational form that builds upon the collaboration of Providers and local commissioners.

6.6.3.2. *Determining the Organisational Form/s for WNE Cumbria*

A strong organisational form is critical to delivering change in WNE Cumbria. We recognise that the proposed acquisition may no longer be the only option. Given the size and scale of the clinical and financial challenge, consideration also needs to be given to other options. Key stakeholder in determining the organisational form will be Cumbria CCG, NCUHT, CPFT and Cumbria County Council.

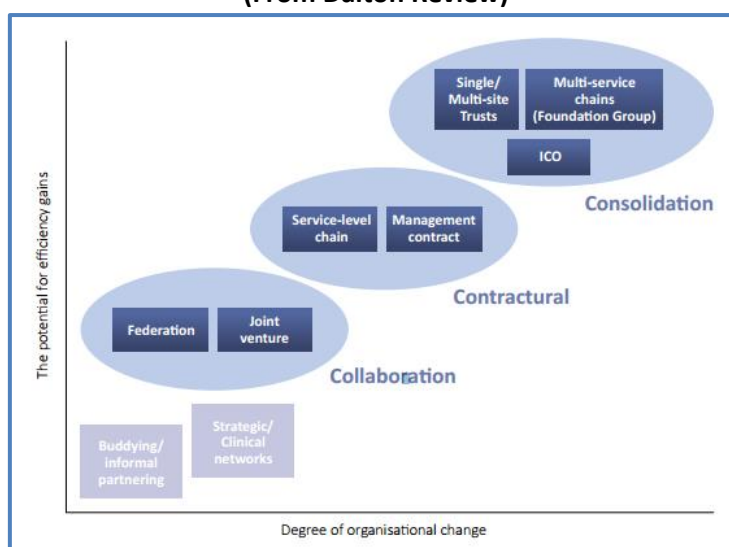
The development of our whole system clinical strategy which defines what success looks like for WNE Cumbria will also inform the preferred organisational form best able to drive forward the scale of change that is needed.

6.6.4. *Developing the options*

The determination of the most appropriate organisational form needs to be conducted through an inclusive robust, evidence based framework that results in a proposal in which all stakeholders have bought into and which can provide rapid and demonstrable improvements to clinical services, reputation and financial position.

There is interest in learning from the experience of the Vanguard sites and considering the ideas set out within the Five Year Forward View and the options set out in the Dalton Review: *Examining new options and opportunities for providers of NHS care*⁶. (Figure 13).

Figure 13. Different organisational forms and their potential ability to release efficiency gains
(From Dalton Review)



⁶ Kings Fund. The Dalton Review *Examining new options and opportunities for providers of NHS care* December 2014

Proactive stakeholder involvement throughout the process for determining organisational form will be critical to agreement of the final outcome.

6.6.5. Evaluation Framework

An evaluation framework to look at the most appropriate options for organisational form, and to appraise the list of option will be developed. The evaluation framework will draw from the clinical strategy and the objectives of the Success Regime and will be in the form of Multi Criteria Decision Making Analysis (MCDA), a tool for the objective assessment options for a robust evidenced based outcome.

The final framework and associated criteria will be agreed with all key stakeholders and include clinicians, operational and management representatives. The continued focus of all the evaluation framework will be the patient and how the respective organisational form can deliver benefits the population of WNE Cumbria.

The evaluation framework will include key quantitative and qualitative aspects and be aligned to the clinical strategy, for example:

- High level impact of the option on financial, clinical and operational sustainability, as well as on existing transformational opportunities;
- Fit with local commissioning intentions and the barriers (e.g. competition and reconfiguration requirements) that the health economy would face in implementing the solution;
- Expected impact on patients and quality of service;
- Social and regulatory impact;
- Alignment to vision and long-term strategy;
- Ease of implementation; and
- Flexibility and adaptability to changes in commissioning intentions and/or NHS policy.

6.6.6. Evaluation of options

Once the evaluation framework is agreed each of the options identified will be appraised accordingly and tested to ascertain which organisational form can most appropriately deliver the clinical strategy and deliver a long term financially sustainable solution.

The NHS organisations in WNE Cumbria (Cumbria CCG, NCUHT, and CPFT) currently operate as standalone entities with their own Boards and accounting officers. Joint working with Cumbria Council is also key.

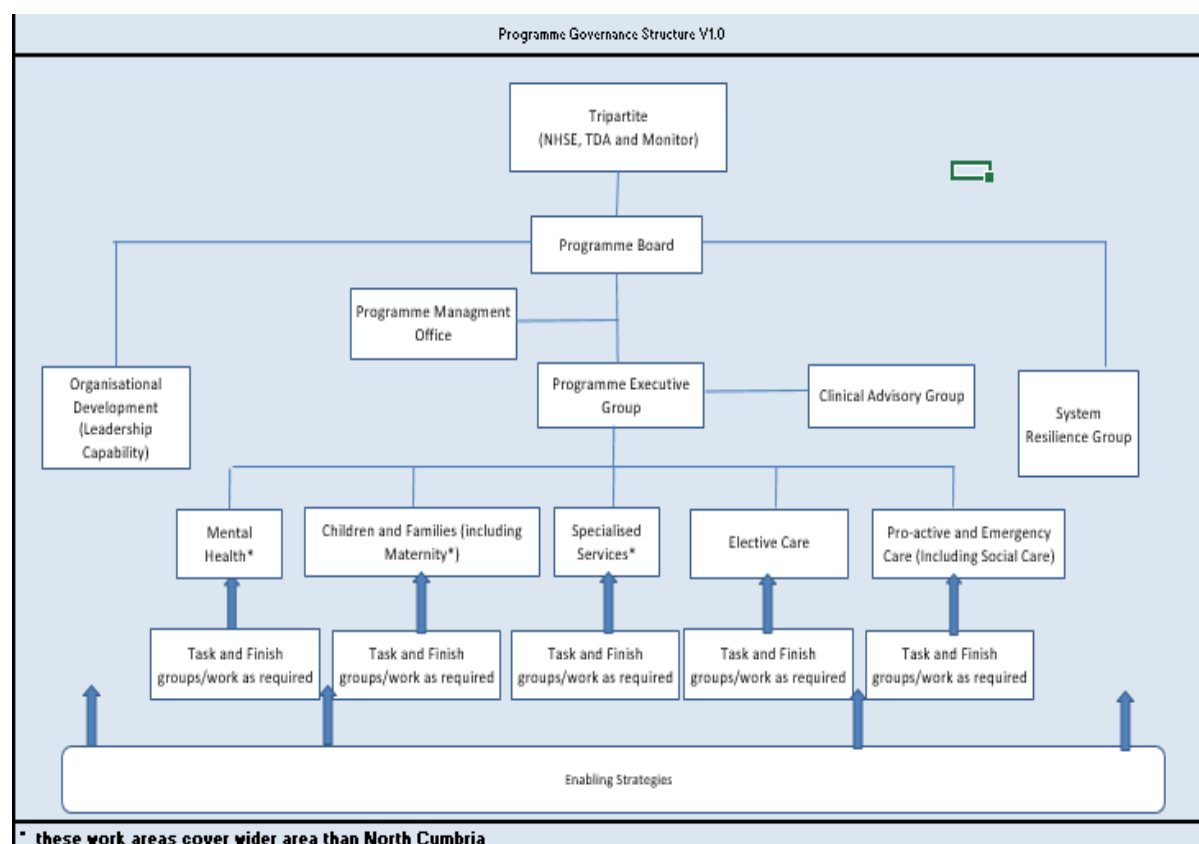
We know that, while it will be the people who will make things happen, organisational form must be considered as we work to deliver our vision for the future. This is particularly important if we are to attract the very best cadre of clinicians and managers to work in WNE Cumbria, giving confidence that they be working in an organisation which demonstrates strong leadership. We also recognise that an approach that relies solely upon new organisational structures, as the solitary solution to sustainability, is not realistic.

7. Developing and governing the forward plan

7.1. Programme Structure

We know that to deliver the scale of change required across the system, strong programme management arrangements will be essential, with co-ordinated, collaborative and consistent leadership.

The Success Regime is providing an overarching governance process and programme structure as set out below.



Accountability

The collective Programme Board is accountable to the regional leads – NHS England, Monitor and the Trust Development Authority – via the Programme Chair for the successful development and implementation of the Success Regime in WNE Cumbria. The regional leads are in turn accountable to the National Joint Oversight Group for the Success Regime.

The Programme Chair, Sir Neil McKay, is the Senior Responsible Owner (SRO) and is accountable for the overall programme.

Internal Assurance

There is a **Monthly Programme Board** that determines the strategic direction of the programme. It includes all major providers and commissioners across the full range of health and care services across WNE Cumbria. Every organisation has a responsibility to recognise the fundamental importance of collaborative working across the system in achieving future sustainability. We have fostered a culture where organisational leaders are committed to the delivery of the programme within their own organisation as well as having a shared responsibility for successful delivery of the overall programme across the system.

The **Programme Executive Group** is chaired by the Programme Director and has a clinical SRO from the CCG. The membership is drawn from clinical and management leads from each of the main organisations within the Success Regime and the group is responsible for overseeing the development of the clinical strategy, the PCBC and subsequent consultation.

Strong **clinical leadership** is provided through a clinical advisory group chaired by the Success Regime's medical director. This group provides quality oversight of the emerging clinical proposals being developed by the work areas within the Success Regime Programme. The evidence presented to the clinical advisory group has supported the development of the clinical strategy and will continue to support the future pre-consultation business case.

Senior Responsible Owners (SROs) are accountable for setting out the quality, care, and finance and efficiency challenges in their work area and for developing proposals for clinical models aimed at meeting the stated challenges. This role provides additional clinical leadership and direction throughout the programme and is being delivered within the following work areas – system resilience, proactive and emergency care (which includes integrated care communities), primary care development, elective care, maternity, children and families, mental health, specialised services, and adult social care commissioning.

External Assurance

The Success Regime has worked closely with the Northern Clinical Senate to receive independent clinical opinion on the proposed service changes as part of the NHS England assurance process. The Senate has reviewed a number of service change proposals against factors such as safety, clinical effectiveness and patient experience to ensure these factors have been appropriately considered. A final independent assurance review will be provided by the Greater Manchester, Lancashire & South Cumbria Clinical Senate during April and May to collect any final advice ahead of the development of a pre-consultation business case. Views and advice have also been sought from a number of other external clinical experts and the programme has worked with the Senate to ensure this work complements other arrangements for provision of external clinical advice and challenge.

A Health Gateway Review 0: Strategic Assessment will be carried out in April 2016 and a recommendation report produced against the following assessment areas:

- The scope and purpose of the programme has been adequately researched
- That there is a shared understanding of what is to be achieved by the key stakeholders
- That it fits within the CCG's overall policy or management strategy and priorities
- That there is a realistic possibility of securing the resources needed for delivery
- That any procurement takes account of prevailing government policies
- The work strands are organised (in sub-programmes, projects, etc.) to deliver the overall programme objectives, and that the programme management structure, monitoring and resourcing is appropriate

7.2. Engagement with staff, patients and the public

We have agreed some core principles, summarised below:

- The programme will be highly visible and anchored in best practice.
- It will involve all key stakeholders including patients, patient interest groups, elected councillors, third sector etc. and will seek to explore their views in some depth.
- The programme will adopt a largely qualitative, conversational approach rather than a quantitative approach.
- The programme will be assessed for legal compliance by Capsticks solicitors.
- Work stream leaders will receive regular feedback from the engagement process and will be expected to demonstrate how the feedback has impacted their thinking.
- The final engagement programme report will be independently peer reviewed / assessed.

We recognised that this an engagement programme not a PR exercise. Any large public meetings are chaired by an independent chair in order to increase public confidence in the independence of the process, to ensure members of the public have a proper chance to ask questions and express their views and to ensure that NHS speakers have a fair chance of explaining their position too.

7.2.1. The nature of the programme

The public engagement programme includes some traditional engagement activities such as public meetings, drop in events and focus groups, but also some innovative elements such as citizens' juries and budget exercises. A key element of the programme has been delivered independently by Healthwatch in the form of a highly visible, NHS branded vehicle fitted with a small discussion area that responded to requests to visit particular communities across WNE Cumbria on a well-planned programme of visits. Elected members often make suggestions of places to visit and this idea has ensured that we can literally go anywhere, even visiting 2-3 places per day, including towns, villages, extreme rural locations, shows, markets, fairs, schools, day services, community groups, events etc. Engagement will continue to take place with MPs, Cumbria County Council cabinet, the local Health and Wellbeing Board, the local Health Overview and Scrutiny Committee (HOSC), District Councils, NHS statutory boards, third sector organisations, trades unions, the local medical committee, West Cumberland Community Forum, the nuclear industry and others.

7.2.2. Activity to date

Engagement activity to date has included:

- 43 x mobile vehicle events.
- 5 x public listening events.
- 2 x focus groups.
- 12 x campaign and community group meetings.
- More than 50 stakeholder meetings, including meetings with MP, industry and union representatives.
- Regular clinical and workforce staff meetings and workshops.
- More than 70 maternity Healthwatch engagement visits to mums meetings, focus groups, “drop-in” sessions and public events.

7.2.3. Forthcoming activity

Following the publication of the Success Regime progress report, a number of engagement activities have been organised to take place over the next couple of months. These include:

- Public meetings at venues across WNE Cumbria.
- Patient/public focus groups.
- Citizens’ juries.
- Stakeholder events.
- An online qualitative engagement response facility (via the CSR website).

7.2.4. Staff engagement

A comprehensive staff engagement plan led by the partnership and acute Trusts and CCG, with support from the Success Regime, is running concurrently with the public engagement programme. This will continue to be rolled out through a number of activities, including staff presentations and “drop-in” sessions, an online survey, quick-read updates available online, comment boxes and postcards to feedback ideas and thoughts, as well as regular meetings.

7.3. Assurance, accountability and implementation

We know that we are working at an extremely challenging speed to produce a clinical strategy and we are pleased about the huge progress we have made thus far. Despite this pace, we have gone through a rigorous process of assurance to sign off this clinical strategy. And we will go through a similar process for the development of a pre-consultation business case from April until June. Below we highlight the key stages in the assurance process.

Development of CQC response

	Key Milestone	Target Date
1	SR Programme Board review of proposition documents	25 th and 26 th Feb 2016
2	Meeting with Tripartite	9 th March 2016
3	Discussion and sign off draft clinical strategy document at SR Programme Board	10 th March 2016
4	Send draft document amended in light of SR Programme Board discussion to Tripartite	14 th March 2016
5	Revised document in light of Tripartite feedback	18 th March 2016
6	Board discussion	22 nd March 2016 (NCUH) 23 rd March 2016 (CCG) 24 th March (CPFT) 24 th March 2016 (Private Cabinet presentation)
7	Extraordinary SR Programme Board meeting for final sign off	30 th March 2016
8	Send Draft CQC response to CQC	31 st March 2016

Development of PCBC

	Key Milestone	Target Date
1	Report progress to SR Programme Board meetings	April & May 2016
2	Initial discussions with Health Scrutiny re PCBC and consultation process	13 th April 2016
3	Trust Board Briefings and Discussions	Early May 2016
4	Review PCBC at Programme Board	By 10 th May 2016
5	CCG Governing Body	<i>To be confirmed</i>
6	Present to NHSE Finance & Investment Committee	<i>Papers due 16th May for 23rd May meeting (TBC)</i>
7	Formal stage 2 consideration by Health Scrutiny	16 th May 2016
8	Formal consultation starts	1 st June 2016
9	Consultation ends	31 st August 2016 (<i>potential additional 4 weeks</i>)
10	Consultation report and decision making process	September 2016
11	Final decision by CCG	October 2016

12	Formal stage 3 consideration by Health Scrutiny	13 th October (TBC)
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Assurance process

	Key Milestone	Target Date
1	Gateway Planning meeting	22 nd March 2016
2	Independent Clinical Senate TOR agreed with CCG and Senate Chair	30 th March 2016
3	Independent Clinical Senate review	April – Early May 2016
4	Gateway review	11 th and 12 th April
5	Gateway review feedback and report to Programme Board	13 th April 2016
6	Independent Clinical Senate review final report	9 th May 2016
7	Present to NHSE Finance and Investment Committee	<i>Papers due 16th May for 23rd May meeting(TBC)</i>
8	Second Gateway review	TBC

7.4. The 5 Year Sustainability and Transformation Plan

Delivering the Forward View: NHS planning guidance 2016/17- 2021, confirmed that every health & care system in England is required to come together to develop 5-year Sustainability and Transformation Plans (STPs). These are expected to provide an ambitious local blueprint for accelerating implementation of the Five Year Forward View.

As part of a Success Regime, WNE Cumbria has been agreed as an appropriate transformation footprint, we are now put in place arrangements to take this work forward.

We recognise that clear collaborative and capable leadership arrangements need to be articulated as distinct from the leadership arrangements related to the Success Regime, although undoubtedly there will be considerable elements of overlap. We want the STP arrangements to be fully locally owned and driven, demonstrating leadership capability for transformational change well beyond the lifetime of the Success Regime.

There is local agreement that the strategic leadership for the WNE Cumbria STP will be provided by our local Chief Executives and/or equivalents, working together as a single team:

Stephen Eames	Chief Executive, North Cumbria University Hospitals NHS Trust (NCUH)
Colin Cox	Director of Public Health, Cumbria County Council (CCC)
Claire Molloy	Chief Executive, Cumbria Partnership NHS Foundation Trust (CPFT)
Hugh Reeve	Interim Chief Clinical Officer, Cumbria Clinical Commissioning Group (CCCG)
Diane Wood	Chief Executive Cumbria County Council (CCC)

Stephen Eames is the overall STP lead for WNE Cumbria and is responsible for overseeing and co-ordinating the STP process, dedicating time and resource to this role.

To ensure effective alignment between the STP and the work associated with the success regime, we have set out respective areas of responsibility and initial operational lead arrangements which will be continually reviewed.

The Success Regime will be responsible for:	WNE Cumbria STP Team will be responsible for:
<ul style="list-style-type: none"> • Agreeing a whole system plan to create the conditions for success, specifically enabling the sustainable achievement of constitutional standards for A&E, Cancer and RTT waiting times, and a clear plan for resolution of the most immediate service fragilities and providing the foundations for long term sustainability. • Preparation of the Pre Consultation Business case (PCBC), on behalf of the CCG, for submission by the CCG to NHS England Investment Committee • Preparation of the public consultation document on behalf of the CCG, and supporting public consultation • Provision of other detailed material it has already developed which will support the production of the STP 	<ul style="list-style-type: none"> • Developing detailed plans to implement the agreed whole system plan, including increasing local organisational integration and working with acute care collaboratives • Leading work to ensure delivery of any national policy requirements not currently addressed directly through the Success Regime work.

Cross membership of key groups will ensure common understanding and communication between the discrete areas of work, in particular through the cross-membership of the Success Regime Programme Board and Chief Executive Forum, and through that of the Success Regime Programme Executive Group and Directors Meetings will be held back-to-back wherever possible to reduce diary challenges and allow rapid progression of issues within the most appropriate forum. .

8. Summary and Conclusion

The plans detailed in this document are intended to demonstrate how the whole health and care community in West North and East Cumbria has worked together to tackle the problems identified by CQC in their report in September 2015. The report identified a number of services which were assessed as requiring improvement and General Medicine at West Cumberland Hospital was deemed as being inadequate.

What needs to be done to get NCUHT out of Special Measures is clearly set out, as are the measures which will be used to gauge progress. Contingency plans are also set out - if there are any continuing challenges in the areas of concern, then additional remedial action can be taken swiftly

None of the immediate actions proposed in this document require public consultation and implementation is already underway on a number of fronts

Our work doesn't finish with this response to the CQC concerns. The challenges facing WNE Cumbria are deep rooted and longstanding and represent a set of the most difficult challenges seen anywhere in the country. The implementation of the plans in this document will make major steps towards providing the quality of services the population needs and of course deserve. To ensure the long term clinical and financial sustainability of all services it is likely that tough choices will need to be made. These choices will need to be the subject of public consultation and this is planned to start in June 2016.

Once this process is complete we are confident the platform will have been established to enable services in WNE Cumbria to become increasingly recognised as an exemplar for delivery of high quality health and care to remote, rural and dispersed communities.

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		
Year 6-8		General Practitioner
Year 9+	Consultant (total time in training: 8-10 years)	(total time in training: 5 years)
Optional	Training may be extended by obtaining an Academic Clinical Fellowship 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
62 day wait cancer metric	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.
ACO	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.
Ambulatory care	Ambulatory care is a patient focused service where some conditions may be treated without the need for an overnight stay in hospital.
ALIS	The Access and Liaison Integration Service (ALIS) provides assessment and support for people experiencing acute mental health distress and their carers
APNP	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.
Better Care Fund	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.
CCG	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.
CIC	Cumberland Infirmary, Carlisle
CLU	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.
CPFT	Cumbria Partnership Foundation Trust (CPFT) provides community and mental health services in WNE Cumbria.
CQC	The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England
CT2	Refers to the second year of the core training medical post.
DPS	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.
ECIP	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.
EPR	Electronic patient record
FFT	Friends and Family Test (FFT) is a quick and anonymous way to give your views after receiving care or treatment across the NHS.
Five Year Forward View	The Five Year Forward View sets out a vision for health 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.
Front and back of house	"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

	<p>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>
GPwSI / GPSI	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.
GPVTS	GP vocational training scheme (GPVTS) is a three year training that doctors must undertake to become an independent general practitioner.
Healthy Child Programme	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.
HEE	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.
ICC	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.
ImROC	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”.
LEP	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
Local Health and Social Economy	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 North Cumbria

	University Hospitals Trust and the Cumbria Partnership NHS Foundation Trust and Cumbria Council
LSOA	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.
Low acuity beds	Acuity refers to the level of nursing staff required to give good care to patients. Low acuity beds refers to beds designated for patients that have low nursing staff needs.
MBBS Training	Bachelor of Medicine & Bachelor of Surgery - an innovative approach to medical education for self-funded and sponsored international students (non UK/EU).
Middle grade doctors	A junior doctor (non-consultant) who has more experience than a senior house officer, but less experience than a consultant. Middle grade doctors include staff grade, clinical fellows and specialist registrars (ST1, ST2, and ST3).
MLU	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.
NCUHT	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
NWAS	North West Ambulance Service (NWAS) provides emergency medical services and non-emergency Patient Transport services in WNE Cumbria.
PCBC	A pre-consultation business case (PCBC) is a document that details proposals to reconfigure health and care services.
Primary Care Transformation Fund	Multi-year £1 billion investment programme to help GPs make improvements, particularly in capital assets (e.g. technology) and estates.
Primary Care Home initiative	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 trailing primary care homes at rapid test

	sites.
PSA	Public service agreement
PTS	Patient Transport Services
RTT	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.
SCBU	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.
SHO	A Senior House Officer (SHO) is a non-consultant hospital doctor, applying to the second and third year of a doctor's career. The name is no longer used officially in Great Britain, as it has been superseded by "Foundation Doctor" for the first two years, and "Specialty Registrar" for the third to fifth years.
"Single team" concept	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.
Six week diagnostic metric	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.
SpR trainees	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.
SSPAU	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
ST1/ST2/ST3/ST4/ST5	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.
Step up / step down	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.
TDA	Trust Development Authority (TDA) provides support, oversight and governance for all NHS Trusts.
UCC	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.
WCH	West Cumberland Hospital
WNE Cumbria	West North and East Cumbria comprises the districts of Allerdale, Copeland, Carlisle and Eden.
WTE	Working time equivalent

Annexe

NCUHT Quality Improvement Plan

DRAFT IN CONFIDENCE

Measurable Outcome/Action	Baseline 2015	Deadline	Trajectory 2016/17	Status
1.1 Improve the management of the deteriorating patient <i>Executive Lead: Dr Derek Thomson (Medical Director)</i> <i>Operational Leads: TBC</i> <i>Corporate Link: Dr Clive Graham (Assistant Medical Director)/Kathy Barnes (Head of Clinical Standards)</i> <i>Committee: Managing Deteriorating Patients Committee</i>				
• The NEWS Policy will be reviewed and updated in line with national best practice	-	December 2015	-	Complete - The policy was updated in December 2015 and is featured on the Trust intranet.
• There is a clearly defined training needs analysis (TNA) in place which is included within the trust wide TNA	-	December 2015	-	Complete - The TNA is encompassed within the NEWS Policy and has been mapped to the trust wide TNA.
• 100% of available staff will be trained in line with the TNA	94% as at September 2015	October 2016	100%	1813 staff are mapped against the TNA; 1738 have completed the training, 75 staff remain outstanding. Compliance is 96% as at 29 February 2016.
• Deliver additional training in line with the TNA targeting high risk areas/aspects of NEWS monitoring	-	March 2017	Ongoing	On-line training is already in place; this is to be mandated for all relevant staff by March 2017. Additional training for high risk areas/aspects will commence in 2016/17. Dedicated face to face training will commence in 2016/17 and continue into 2017/18.
• There will be a process in place to ensure that: <ul style="list-style-type: none"> Specific issues identified through mortality reviews (e.g. oxygen saturation and NEWS = 3 in single domain) are reviewed, acted upon and shared widely within Trust Specific trends and themes identified as a result of serious incident, and other investigations are reviewed, acted upon and shared widely within the Trust 	-	June 2016	-	Development of the process is being overseen by the Managing Deteriorating Patients (MDP) Committee.
• Where issues are identified in escalating NEWS, modification to training is made within the TNA and training monitored to ensure that all staff are aware	-	March 2016	>95%	Incidents will be reviewed by the Managing Deteriorating Patients Committee who will oversee.
• NEWS 5 red stickers to be rolled out	-	June 2016	-	Roll out will be commencing at the start of April 2016 and will be underpinned by a screensaver, launch literature and dedicated support.
• Review of NEWS audit process to be undertaken to ensure it is fit for purpose	-	September 2016	-	The NEWS audit is currently encompassed within the AuditR system and reports are provided to business

Measurable Outcome/Action	Baseline 2015	Deadline	Trajectory 2016/17	Status
				units on a monthly basis. However historically there have been challenges as the system configuration does not allow the entry of 'not applicable' or free text; therefore a N/A is reflected as a 'no' and falsely demonstrates a high non-compliance rate.
<ul style="list-style-type: none"> Review dissemination of NEWS score audits and agree optimal process moving forward 	-	September 2016	-	Development of the approach is being overseen by the Managing Deteriorating Patients (MDP) Committee.
<ul style="list-style-type: none"> Review NEWS assurance processes to make certain audit data is reviewed at appropriate committees and escalated appropriately 	-	September 2016	-	Development of the approach is being overseen by the Managing Deteriorating Patients (MDP) Committee.
1.2 Improve the recognition and initiation of treatment for patients with sepsis <i>Executive Director: Derek Thomson (Medical Director)</i> <i>Operational Leads: Dr Jon Sturman (Consultant Intensivist)</i> <i>Corporate Link: Dr Clive Graham (Assistant Medical Director)/Kathy Barnes (Head of Clinical Standards)</i> <i>Committee: Managing Deteriorating Patients Committee</i>				
<ul style="list-style-type: none"> Ensure Sepsis Policy is updated to reflect changes in recognition and management of sepsis 	-	September 2016	-	There is an existing policy in place.
<ul style="list-style-type: none"> There is a clearly defined training needs analysis (TNA) in place which is included within the trust wide TNA 	-	December 2015	-	Complete
<ul style="list-style-type: none"> 100% of available staff will be trained in line with the TNA 	96%	October 2016	100%	96% as at December 2015
<ul style="list-style-type: none"> Ensure on arrival a full set of observations are taken 	-	September 2016	-	Retrospective spot check audit to be undertaken. The concept of continuous monitoring of this action has been discussed and an IT solution, i.e. Symphony upgrade will provide this resolution. Confirmation is awaited from IT as to when this can go ahead.
<ul style="list-style-type: none"> Ensure any deficiencies in critical care outreach services are triangulated with mortality and other outcome data 	-	December 2016	-	The heat map is currently being considered as one mechanism by which this could be achieved; MDP will identify the way forward.
<ul style="list-style-type: none"> All patients diagnosed with sepsis to be managed on a care bundle as part of a care pathway, compliance to be audited on a regular basis 	-	July 2016	-	The sepsis bundle is in place but a review of the audit arrangements is required.
<ul style="list-style-type: none"> Agree a training programme in the diagnosis and management of sepsis for all new members of staff and all those working in admission areas or where deficiencies in recognition of sepsis have been identified 	-	June 2016	-	Dedicated study days for NEWS and Sepsis have been delivered. Training will be ongoing and feature as part of the Trust mandatory training programme and within the

Measurable Outcome/Action	Baseline 2015	Deadline	Trajectory 2016/17	Status
				TNA.
<ul style="list-style-type: none"> Confirm Jon Sturman as clinical lead for sepsis in accordance with NCEPOD report 	-	April 2016	-	Formal communication to be sent. Job plan to reflect responsibilities.
<ul style="list-style-type: none"> Review the sharing of information regarding sepsis with primary care and other organisations 	-	June 2016	-	Approach to be agreed within MDP.
<ul style="list-style-type: none"> Develop a patient information leaflet providing patient and their relatives on recognition of sepsis, long term complications, recovery and risk of recurrence. 	-	June 2016	-	Development will be overseen by MDP.
<ul style="list-style-type: none"> Ensure that sepsis is recorded on discharge so that it can be recorded in GP record 	-	December 2016	-	Retrospective audit to be undertaken.
<ul style="list-style-type: none"> Ensure that all sepsis deaths are reviewed and any lessons identified shared, sepsis should be recorded on death certificate 	-	December 2016	-	Ongoing mortality reviews and introduction of an audit of COD (cause of death) featured on the death certificate.
1.3 Reduce the variation in mortality between hospital sites and Embed the 7 day working standards <i>Executive Director: Debbie Freake (Director of Strategy)/ Helen Ray (Executive Chief Operating Officer)</i> <i>Operational Leads: Business Unit Directors</i>				
<ul style="list-style-type: none"> There is an approved clinical strategy between the trust and its partners in place within 6 months that provides safe and sustainable services for the health and social care economy of North Cumbria. 	-	October 2016	-	<p>The clinical strategy forms part of the Success Regime programme of work. The clinical strategy is currently under consultation, public consultation will commence in May 2016 and the final version of the clinical strategy is expected in October 2016.</p> <p>The internal Trust work is on track to provide the Trust elements of clinical strategy for inclusion in the detailed proposition documents and the quality impact assessments required by 11/02/2016 to allow final completion of clinical strategy by end of March 2016.</p> <p>The clinical strategy being designed is focussed on improvements in quality of care and outcomes on both sites and particularly focussed on the challenges at WCH.</p> <p>The Trust has identified a renewed comprehensive approach to affordable achievement of 7 day working standards as required within 2016/17 operational plan.</p>

Measurable Outcome/Action	Baseline 2015	Deadline	Trajectory 2016/17	Status
				The change team is refreshing self-assessment work and gap analysis.
2.1 Ongoing development of the Mortality & Morbidity Framework <i>Executive Director: Dr Derek Thomson (Medical Director)</i> <i>Operational Leads: TBC</i> <i>Corporate Link: Dr Clive Graham (Assistant Medical Director)/Kathy Barnes (Head of Clinical Standards)</i> <i>Committee: Managing Deteriorating Patients Committee</i>				
<ul style="list-style-type: none"> The HSMR needs to remain within expected limits and condition specific alerts will be referred to specialities for review 	102.6 (January 2014 – December 2014)	March 2017	Within expected limits	Draft Mortality data pack. 112.1 (Apr 2012 – Mar 2013) 107.6 (Jun 2013 – Jun 2013) 105.8 (Oct 2012 – Sept 2013) 102.7 (Jan 2013 – Dec 2013) 103.6 (Apr 2013 – Mar 2014) 104.0 (Jul 2013 – Jun 2014) 102.3 (Oct 2013 – Sept 2014) 102.6 (Jan 2014 – Dec 2014)
<ul style="list-style-type: none"> The SHMI will remain within 'expected limits' and condition specific alerts will be referred to specialities for review 	SHMI 1.0 (June 2015) SHMI 1.11 (September 2015) Range 0.9 – 1.11	March 2017	0.9 – 1.11	Collaborative working with TDA/CHKS to provide split site data is in progress in order to focus on site specific improvements.
<ul style="list-style-type: none"> All avoidable deaths will be considered by the Managing Deteriorating Patient (MDP) Committee; the MDP will identify any improvement required and subsequent action taken, feedback will be provided to the Safety & Quality Committee on a quarterly basis 	Hogan 4: 13 Hogan 5: 2 Hogan 6: 0	May 2016	Year on year reduction in number of cases categorised as Hogan 4 and above	Hogan 4 – 21 (2014), 13 (2015), 1 to date (2016) Hogan 5 – 3 (2014), 2 (2015), 0 to date (2016) Hogan 6 – 0 (2014), 0 (2015), 0 to date (2016) Ongoing development of feedback processes, further investigation and action plans to be developed as required.
<ul style="list-style-type: none"> Achievement of an overall improvement in mortality outcomes. 	-	March 2017	-	Monitored via the MDP, with a plan to introduce a mortality surveillance group in line with TDA advice.
<ul style="list-style-type: none"> A review of the arrangements for mortality will be undertaken via the MDP committee to include: <ul style="list-style-type: none"> The introduction of a mortality surveillance group A review of the terms of reference 	-	June 2016	-	The Safety & Quality Committee work plan has been amended to include a quarterly report from MDP with respect to mortality. The review of the arrangements around mortality has been prompted as a result of

Measurable Outcome/Action	Baseline 2015	Deadline	Trajectory 2016/17	Status
<ul style="list-style-type: none"> ○ A review of the membership ○ A review of the role and responsibility of the group ○ A review of reporting requirements and frequency to the Trust Safety & Quality Committee 				joint working with the TDA.
<ul style="list-style-type: none"> ● Review of the M&M Framework to include development of current reporting arrangements around neonatal and paediatric deaths and, new learning disability death framework. 	September 2015	October 2015	-	Complete - As of October 2015 this framework has incorporated a formal process for the review of deaths for people with a learning disability, following the recommendations within the Confidential Inquiry into Premature Mortality of People with Learning Disabilities (PWLD), 2013 (CIPOLD). A process for review of Paediatric and Neonatal deaths is also incorporated.
<ul style="list-style-type: none"> ● Complete the actions identified on the mortality action plan within the agreed timescales (MAT12/15 – WCH – SHOULD DO) 	-	December 2015	-	Complete
2.2 Physical Health: Acute Kidney Injury (AKI) <i>Executive Director: Dr Derek Thomson (Medical Director)</i> <i>Operational Leads: Dr Jim Shawcross (Consultant Physician)</i> <i>Corporate Link: Dr Clive Graham (Assistant Medical Director)/Kathy Barnes (Head of Clinical Standards)</i> <i>Committee: Managing Deteriorating Patients Committee</i>				
<ul style="list-style-type: none"> ● Review current data on management of acute kidney injury including use of care bundle and AKI guideline 	-	August 2016	-	The AKI guideline has been reviewed and is on the Trust intranet.
<ul style="list-style-type: none"> ● Review of discharge summaries to ensure stage of AKI is documented 	-	October 2016	-	Baseline and 2016/17 trajectory to be established by the Managing Deteriorating Patients (MDP) Committee in April 2016 following review of end of year CQUIN submission.
<ul style="list-style-type: none"> ● Review discharge summary to ensure medicine review is undertaken 	-	October 2016	-	Baseline and 2016/17 trajectory to be established by the Managing Deteriorating Patients Committee in April 2016 following review of end of year CQUIN submission.
<ul style="list-style-type: none"> ● Review discharge summary so agreed monitoring process is in place at discharge 	-	October 2016	-	Baseline and 2016/17 trajectory to be established by the Managing Deteriorating Patients Committee in April 2016 following review of end of year CQUIN submission.
<ul style="list-style-type: none"> ● Devise mechanism for monitoring which is sustainable 	-	June 2016	-	IT solution to be explored by the MDP.
3.1 Implementation of the Clinical Strategy <i>Executive Director: Debbie Freake (Director of Strategy)</i>				

Measurable Outcome/Action	Baseline 2015	Deadline	Trajectory 2016/17	Status
<i>Operational Leads: Business Unit Directors</i>				
<ul style="list-style-type: none"> There is an approved clinical strategy between the trust and its partners in place within 6 months that provides safe and sustainable services for the health and social care economy of North Cumbria. 	-	October 2016	-	<p>The clinical strategy forms part of the Success Regime programme of work. The clinical strategy is currently under consultation, public consultation will commence in May 2016 and the final version of the clinical strategy is expected in October 2016.</p>
<ul style="list-style-type: none"> Improve patient flow throughout both hospitals to ensure patients are cared for on the appropriate ward for their needs and reduce the number of bed moves, particularly in the medical division. Review and improve bed management. Stop moving patients during the night without a medical reason for doing so. <p>(T04/15 – TRUST – MUST DO) (MED06/15 – CIC – MUST DO) (SUR05/15 – WCH – SHOULD DO) (MED18/15 – WCH – SHOULD DO)</p>	-	March 2017	-	<p>The following meetings and operational functions continue to drive the teams to achieve the required standard of care:</p> <ul style="list-style-type: none"> Urgent Care improvement board System Wide Conference Calls (NECS) Bed management meetings Daily Ward / board rounds Delayed Transfers of care meeting SRG Operational Delivery to include identification of Estimated Date of Discharge, Medical and Surgical Outliers, Repatriation from CIC to WCH and CIC to WCH, Elective profile and estates development. <p>Work continues with regards to DTOCs with weekly sign off meetings taking place between agencies. A multi-agency task group continues to focus on the issues causing DTOCs to improve flow.</p> <p>The teams continue to be supported by ECIP (a further event for Cluster 2 held in month was attended by a multi- agency team) as work streams develop to embed improved care pathways; SAFER, Home First, early Older Peoples Assessment in ED, improved ambulatory care and frailty pathways.</p>
Addressing the operational elements of the must-do's to support the wider delivery of the clinical strategy:				
Medical Care/Urgent & Emergency Care <i>Executive Director: Helen Ray (Executive Chief Operating Officer)</i> <i>Operational Leads: Business Unit Directors</i>				

Measurable Outcome/Action	Baseline 2015	Deadline	Trajectory 2016/17	Status
<ul style="list-style-type: none"> Ensure that medical staffing (including medical trainees, long-term locums, middle grade doctors and consultants) is sufficient to provide appropriate and timely treatment and review of patients at all times including out of hours. (T01/15 – Trust – MUST DO) (T02/15 – Trust – MUST DO) 	-	April 2016	-	<p>Success Regime – Workforce and Leadership work stream:</p> <p>Emerging thinking for future of the workforce includes:</p> <ul style="list-style-type: none"> Development of a new workforce strategy (to be developed by April 2016) with an investment plan for next three years supported by Health Education England. National proposal for a clinical task force to be piloted in Cumbria called the Post Operational Support Team (POST). This will be a team of healthcare professionals who will be brought in to work alongside local teams to provide short term support and help design and deliver new models of care. Explore a single, local approach to the employment of temporary staff to help reduce current over-reliance on locums. An education, training and development plan complemented by development with UCLan.
<ul style="list-style-type: none"> Improve the routine review of medical patients receiving care and treatment on wards outside their speciality. (MED11/15 – WCH – MUST DO) (MED05/15 – CIC – MUST DO) 	-	April 2016	-	Complete - Outlier SoP completed with clear lines of accountability for consultant workforce.
<ul style="list-style-type: none"> Improve the number of substantive medical posts. (MED01/15 – WCH – MUST DO) 	-	April 2016	April 2016 - Strategy	The Trust is currently working with UCLAN to assist with recruitment. During Q3 there have been 3 trainee doctor posts and 2 middle grade posts recruited at WCH, reducing locum posts by 5.
<ul style="list-style-type: none"> Ensure equipment is stored correctly, decontaminated effectively and all single use items are within expiry date. (U&E04/15 – WCH – MUST DO) 	-	May 2015	-	Complete - Stock was checked on the day of the CQC visit and out of date stock was discarded immediately. A weekly checking process was implemented with immediate effect and compliance with this check is subject to ad hoc spot checks by both the matron and Operational Service Manager.

Measurable Outcome/Action	Baseline 2015	Deadline	Trajectory 2016/17	Status
<ul style="list-style-type: none"> Work towards JAG accreditation in endoscopy. (MED14/15 – WCH – SHOULD DO) 	-	March 2017	-	Issues related to the environment at WCH have now been addressed, but issues pertaining to staffing levels required by JAG are currently being reviewed.
<ul style="list-style-type: none"> Improve access to psychiatric review (MED15/15 – WCH – SHOULD DO) 	-	March 2016	-	This will form part of the clinical strategy.
<ul style="list-style-type: none"> Provide safe and secure storage for medication with limited access to qualified staff only. (U&E05/15 – WCH – MUST DO) 	-	May 2015	-	Complete - Drugs such as adrenaline (used in emergency resuscitation) were being stored in an unlocked drawer in the resuscitation room that could be accessed by all staff. The storage arrangements were reviewed by the Lead Pharmacist who is satisfied with the arrangements now in place. A 'coded access' lock has now been situated to ensure the resuscitation room remains secure. This arrangement remained in place for five weeks until relocation to the new build at WCH. All staff have been reminded of the importance of ensuring that the door is kept locked at all times.
<ul style="list-style-type: none"> Improve access to systems for newly appointed doctors and locums. (MED16/15 – WCH – SHOULD DO) 	-	June 2017	-	There is a project focused on introduction of a clinical portal and clinical document hub; promoting a move in the direction of an electronic patient record. The junior doctors' induction is currently under review.
<ul style="list-style-type: none"> Ensure that medical staff document in patients records appropriately. (MED13/15 – WCH – MUST DO) 	-	September 2016	-	The standard of medical record keeping was clarified in the Clinical Policy Group in 2015. Spot check audit to commence in 2016; recommendations from audit to be overseen by medical Director.
<ul style="list-style-type: none"> Improve the way in which medicines are stored (MED08/15 – WCH – MUST DO) 	-	May 2015	-	Complete - Medications for the minor's area were being stored in the eye/ear, nose & throat room which resulted in a disturbance to any patients being treated if drugs needed to be collected. The medication has now been relocated into two separate areas and this was confirmed by the CQC team at the time of inspection.
<ul style="list-style-type: none"> Improve performance in relation to the care and treatment of patients with diabetes (MED04/15 – CIC – MUST DO) 	-	August 2016	-	There has been agreement with CPFT to appoint an additional diabetologist and endocrinologist. A meeting will be held with CPFT and CCG to address diabetes services.

Measurable Outcome/Action	Baseline 2015	Deadline	Trajectory 2016/17	Status
<ul style="list-style-type: none"> Provide sufficient infusion pumps so that there are pumps always available for patient use. (MED09/15 – WCH – MUST DO: availability of infusion pumps) 	-	May 2015	-	Complete - 10 additional pumps were ordered for the ward areas and improvements as to availability have been noted as positive by the wards. 20 additional pumps have been delivered to CIC since the CQC visit.
<ul style="list-style-type: none"> Improved outcomes for stroke patients (MED12/15 – CIC/WCH – SHOULD DO) 	-	March 2016	-	A business case is being developed for hyper acute stroke unit (HAS). There is documented improvement in the sentinel stroke national audit programme (SSNAP) with WCH improving to C score from D. A business case has been approved by the Board and is awaiting approval from the Clinical Commissioning Group (CCG). Links to work with clinical strategy
<ul style="list-style-type: none"> In relation to NICE clinical guideline CG16 (Self-harm: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care) increase the number of patients who receive a clear risk assessment (currently 22%). (U&E03/15 – CIC – MUST DO) 	-	February 2016	-	An audit has been carried out on NICE clinical guideline CG16 Self-harm in primary and secondary care and an action plan put in place. A re-audit is due in February 2016.
<ul style="list-style-type: none"> Improve the rates for consultant led trauma teams being ready for patients with an injury severity score greater than 15 on arrival (currently 41%). (U&E02/15 – CIC – MUST DO) 	-	June 2016	-	A plan has been put in place to capture data on a real time basis. There is a requirement for a coder to assist with data. It has been stressed to staff to improve documentation completion. There will be a further audit carried out by June 2016.
Child Health <i>Executive Director: Debbie Freake (Director of Strategy)</i> <i>Operational Leads: Business Unit Directors</i>				
<ul style="list-style-type: none"> Agreement of the strategy for children's services to ensure adequate 24 hour consultant paediatric and junior medical staff provision. (CH03/15 – WCH – MUST DO) (CH05/15 – WCH – SHOULD DO) 	-	March 2016	-	<p>The internal Trust work is on track to provide the Trust elements of clinical strategy for children's services for inclusion in the detailed proposition documents and the quality impact assessments required by 11/02/2016 to allow final completion of clinical strategy by end of March 2016.</p> <p>The Trust is working with partners in the wider Cumbria health economy to develop an integrated</p>

Measurable Outcome/Action	Baseline 2015	Deadline	Trajectory 2016/17	Status
				North Cumbria children's workforce. Recent work has focused on the development of a partnership based approach with Great North Children's Hospital.
<ul style="list-style-type: none"> Recruit a ward manager and ensure oversight from a matron (CH04/15 – WCH – MUST DO) 				Complete - We have strengthened nursing leadership via the appointment of a chief matron and ward manager.
<ul style="list-style-type: none"> Improve the staffing position regarding the continued shortage of junior medical staff and the provision of 24-hour paediatric consultant presence on the hospital site which remained a concern as the service still offered a 24 hour emergency service for children and young people (CH01/15 – WCH/CIC – MUST DO) 	-	April 2016	-	<p>Work proceeding on whole-system plan which defines a vision for integrated children's health services including provision of care closer to home. Also work to progress partnership with Great North Children's Hospital. To some extent, children's services will be influenced by outcome of maternity services options. Emerging options include:</p> <ul style="list-style-type: none"> Creation of a single, integrated children's health team covering the whole of West, North & East Cumbria to enable much more care to be provided for children at home rather than hospital, Development of 14 hour short stay paediatric assessment units at both sites with inpatient beds at CIC and low acuity beds at WCH or Development of a 14-hour short stay paediatric assessment unit at both sites with inpatient/overnight beds at CIC only
<ul style="list-style-type: none"> Conclude the children's and young people's service review in order to better meet the needs of children and young people living in the area and to maximise the effective use of resources. (CH02/15 – CIC – MUST DO) 	-	March 2016	-	Paediatric Nurse practitioner development is underway. Two trainee Nurse Practitioners commenced training in September 2015. Linked to clinical strategy.
Maternity <i>Executive Directors: Helen Ray (Executive Chief Operating Officer)/Debbie Freake (Director of Strategy)/ Maurya Cushlow (Executive Director of Nursing & Midwifery)</i> <i>Operational Leads: Mr Matar (Consultant Obstetrician & Gynaecologist)/Head of Midwifery</i>				
<ul style="list-style-type: none"> Ensure clinical and other service requirements are fully explored and modelled with full clinical engagement in line 	-	April 2016	-	The RCOG recommendations not agreed, hub and spoke model is not practical. CCG review is ongoing.

Measurable Outcome/Action	Baseline 2015	Deadline	Trajectory 2016/17	Status
with RCOG Review recommendations.				<p>RCOG review to be concluded as part of success regime.</p> <p>Number of maternity options being considered which have been put forward by external experts such as RCOG as part of maternity review.</p> <p>The continuation of consultant-led maternity services at both sites is dependent upon a range of other clinical services being in place.</p> <p>Four main options under consideration:</p> <p>Keeping services as they are now and stepping up recruitment attempts – would recruitment improve enough?</p> <p>Implementation of a 'consultant-led, consultant resident on-call' system working as a single team across the Trust. This would require additional Consultants.</p> <p>Identification of higher risk births – would take place at CIC.</p> <p>The provision of midwifery-led care at WCH with all other births booked at CIC – question of access & transport need addressed.</p> <p>In addition, there are also some variations on the above.</p> <p>Ultimately the preferred option will need to be able to demonstrate it is capable of offering a safe service for mothers and babies and it will need to be a clinically and financially sustainable option for some years to</p>

Measurable Outcome/Action	Baseline 2015	Deadline	Trajectory 2016/17	Status
				Come.
<ul style="list-style-type: none"> Ensure out of hours surgical cover in Maternity Services to protect the safety of patients in a surgical emergency. (MAT03/15 – WCH – MUST DO) 	-	March 2016	-	Complete - There is out of hour's surgical cover in Maternity Services.
<ul style="list-style-type: none"> Ensure an epidural service is in place. (MAT01/15 – CIC – MUST DO) 	-	October 2015	-	Complete - Epidural services implemented on 26 October 2015.
<ul style="list-style-type: none"> Ensure staff are trained in the management of maternity emergencies. (MAT02/15 – CIC – MUST DO) 	-	December 2015	-	Complete - All staff attend the annual PROMPT study day. Compliance is currently 80% which is in accordance with the maternity services Training needs analysis'
<ul style="list-style-type: none"> Ensure a dedicated obstetric anaesthetist is available at all times. (MAT04/15 – WCH – MUST DO) 	-	September 2016	-	Anaesthetic cover is available at all times, however, the Business Unit are currently reviewing the situation to determine feasibility of dedicated obstetric anaesthetists. This is part of Success Regime.
<ul style="list-style-type: none"> Ensure that resuscitation equipment is appropriately checked in order that it is suitable for use at all times (MAT05/15 – WCH – MUST DO) 	-	May 2015	-	Complete - As part of handover SBAR documentation there is a handover that all equipment has been checked, a record of any identified issues that require escalation.
<ul style="list-style-type: none"> Ensure the safe management and storage of medicines in the maternity unit (MAT06/15 – WCH – MUST DO) 	-	May 2015	-	The keypad to the treatment room has been repaired as is working correctly. The keys for the cupboards have been ordered and are in use. Spot check of both wards medicines cupboards are undertaken and there were no strips of unlabelled medication on either ward. Weekly spot checks will continue.
<ul style="list-style-type: none"> Ensure medical and midwifery staff are up to date with the training necessary for their role (MAT07/15 – WCH – MUST DO) 	-	September 2016	-	<p>Midwifery staff training for PROMPT and professional issues is 80% in line with the Training needs analysis. Newborn Life Support (NLS) for all midwives is mandatory. Not compliant due to access to funding and available courses.</p> <p>Trust mandatory training monitored by the maternity training team.</p> <p>Review to be undertaken by HOM.</p>
<p>Improve the governance arrangements to: (MAT08/15 – WCH – MUST DO)</p>				
a) include investigation of the higher than target rate of	-	April 2016	-	There was an increase to 3.8% in Q3 from 2.8% in Q2

Measurable Outcome/Action	Baseline 2015	Deadline	Trajectory 2016/17	Status
unexpected admissions to the neonatal unit (Claire Moore, Chief Matron, December 2015);				of unexpected term admissions to SCBU. There is no transitional care unit on either site, and a report is presented monthly to maternity governance to monitor.
b) the potential wait for patients requiring a termination of pregnancy from referral to procedure, especially when medical staff were absent from work (Yvonne Fairbairn, General Manager, January 2016);	-	September 2016	-	Working party has continued with ongoing work and there is now a significant drop in waiting time.
c) the necessary measures to adequately manage patients with a high body mass index, multi-disciplinary clinics which should be routinely available for patients with complex needs or multiple health needs (Mr Matar/Denise Lightfoot, January 2016);	-	December 2015	-	Complete - The women with BMI of 40 or more at booking are seen in a joint anaesthetist/obstetrician clinic on each site. A plan is made for labour regarding special circumstances e.g. poor veins for cannula or back problems.
d) possible extension of the early pregnancy service to a seven day service (Yvonne Fairbairn, General Manager, December 2015),	-	November 2015	-	Complete - New nurse was appointed to gynaecology nurse specialist post in November 2015. This has released staffing to ensure a 7 day service.
e) the standardisation of the post-natal listening service across the trust (Denise Lightfoot, November 2015) and	-	November 2015	-	Complete - There is an equitable provision of the service on both sites.
f) Introduction of mechanism for monitoring the number of cancelled inductions of labour (Mr Matar/Denise Lightfoot, October 2015).	-	October 2015	-	Complete - Induction of labour (IOL) is now monitored through Euroking. Incident reports are submitted via Ulysses if significant IOL delays and is recorded as a 'red flag' on weekly staffing submissions.
<ul style="list-style-type: none"> Mitigate against the security and privacy issues in the maternity ward due to the layout of the environment (MAT09/15 – CIC – SHOULD DO) 	-	June 2016	-	This will be addressed when we start the MLU refurb as there will be doors to separate Aspen from the MLU and delivery suite.
<ul style="list-style-type: none"> Systems to protect the privacy and dignity of gynaecology patients accommodated on a mixed sex ward should be in place (MAT10/15 – WCH – SHOULD DO) 	-	April 2016	-	Complete - All rooms used by gynae patients at WCH are now single ensuite rooms.
<ul style="list-style-type: none"> Improve incident reporting, monitoring and mechanisms for sharing learning across the whole staff team on both sites. (MAT11/15 – WCH – SHOULD DO) 	-	December 2015	-	Complete - There is a well-established process in place across both sites in relation to reporting incidents. The maternity business unit governance dashboard is used as a tool for monitoring of number of incidents reported and trends on a regular basis, and these are reported to the trust Safety and Quality

Measurable Outcome/Action	Baseline 2015	Deadline	Trajectory 2016/17	Status
				committee meeting monthly. These trends and hot topics/learning points are cascaded to all staff in the maternity news magazine.
<ul style="list-style-type: none"> Improve the level of staff up to date with training in prevention and control of infection. (MAT13/15 – WCH – SHOULD DO) 	-	March 2016	-	Complete - Non clinical staff training is at 100% and clinical staff are at 98%.
<ul style="list-style-type: none"> Medical staff should be up to date with practical obstetric multi-professional training. (MAT14/15 – WCH – SHOULD DO) 	-	January 2015	-	All medical staff attended the PROMPT training day in January 2016.
<ul style="list-style-type: none"> Staff should have information and advice regarding the management of patients who may have received female genital mutilation surgery. (MAT15/15 – WCH – SHOULD DO) 	-	February 2015	-	Complete - FGM training is being undertaken for staff by the named midwife for safeguarding. A departmental guideline is being devised, and a named consultant has been allocated.
<ul style="list-style-type: none"> Make sure the pager system works in all parts of the hospital for all staff. (MAT16/15 – WCH – SHOULD DO) 	-	April 2016	-	No further reported incidents of pager not working.
<ul style="list-style-type: none"> Audits of clinical practice should include recommendations and actions where a shortfall in provision is assessed. (MAT17/15 – WCH – SHOULD DO) 	-	April 2016	-	Complete - Maternity audits 2016 have been allocated and are currently underway. The audit process is to be overseen by the maternity audit group, with support from the clinical audit department. This includes the monitoring and coordination of completion of action plans.
Surgery <i>Executive Directors: Helen Ray (Executive Chief Operating Officer)/Maurya Cushlow (Executive Director of Nursing & Midwifery)</i> <i>Operational Leads: Nick Strong (BUD)/Nick McDonough (Deputy BUD)</i>				
<ul style="list-style-type: none"> Robust strategic plan for surgical services. (SUR04/15 – CIC – MUST DO) 	-	March 2016	-	<p>The internal Trust work is on track to provide the Trust elements of clinical strategy for inclusion in the detailed proposition documents and the quality impact assessments required by 11/02/2016 to allow final completion of clinical strategy by end of March 2016.</p> <p>Progress has been made within the Elective Care work area and pathways of work identified. These have been discussed at EMT on 27/01/2016.</p>
<ul style="list-style-type: none"> Improve the recruitment of medical and nursing staff (SUR01/15 – CIC – MUST DO) 	-	March 2017	-	Success Regime Work Stream

Measurable Outcome/Action	Baseline 2015	Deadline	Trajectory 2016/17	Status
<ul style="list-style-type: none"> Ensure there is access to a consultant and middle grade anaesthetist out of hours who do not have on call responsibilities for other specialties such as theatres and maternity (CC01/15 – CIC – MUST DO) 	-	December 2015	-	Complete
<ul style="list-style-type: none"> Ensure there is access to a consultant and middle grade anaesthetist out of hours who do not have on call responsibilities for other specialties such as theatres and maternity. 	-	May 2015	-	Complete - Second tier resident middle grade speciality anaesthetists have been implemented as of May 2015.
Diagnostics <i>Executive Directors: Helen Ray (Executive Chief Operating Officer)</i> <i>Operational Leads: Fraser Cant (Deputy BUD)</i>				
<ul style="list-style-type: none"> Recruitment of senior radiologists in particular a senior MRI radiologist and ultrasound radiologist. (OPD03/15 – WCH – MUST DO) 	-	August 2016	-	<p>Radiologist posts have been advertised previously – with no success. The current locums are in place, and some of them have expressed an interest in substantive posts.</p> <p>Interviews in February 2016 are planned for two Bank Consultant Radiologists to work on a sessional basis during weekends. Recruitment Plan with Consultant Radiologists positions to be advertised externally in February 2016.</p>
3.2 Implementation of the Nursing, Midwifery and AHP Strategy <i>Executive Director: Maurya Cushlow (Executive Director of Nursing & Midwifery)</i> <i>Operational Leads: Business Units</i> <i>Corporate Links: Lesley Carruthers (Deputy Director of Nursing and Quality)/Anna Stabler (Deputy Director of Nursing and Quality)</i> <i>Committee: Nursing & Midwifery Board (NMB)</i>				
<ul style="list-style-type: none"> There will be a net increase in the number of filled qualified nursing staff posts. Review the nurse staffing ratio at times of high acuity of patients (MED02/15 – CIC/WCH – MUST DO) (T03/15 – TRUST – MUST DO) (CC02/15 – CIC – SHOULD DO) 	-	September 2016	-	<p>Workforce status is reviewed and reported to the Trust Board every 6 months, in addition, there are monthly reports which provided the Trust Board with an updated monthly position in relation to safe nurse and midwifery staffing, by % fill rate of planned staffing versus actual staffing and the report also informs the Board of performance against the heat map indicators by ward.</p> <p>6 monthly staffing paper will be presented in January</p>

Measurable Outcome/Action	Baseline 2015	Deadline	Trajectory 2016/17	Status
				2016 to Trust Board. The fill-rate papers continue to be presented every 2 months to Trust Board and now also include staffing and quality indicators such as numbers of pressure ulcers.
<ul style="list-style-type: none"> There will be a year on year reduction in patient harm, particularly in relation to: <ul style="list-style-type: none"> pressure ulcers falls medication errors as reflected in the safety thermometer <p>(MED03/15 – CIC – MUST DO)</p>	Average 92% harm free care	March 2017	Average 95% harm free care	The heat map detailing all safety thermometer information has been developed; this is used to inform the matrons 1:1 with the Deputy Directors of Nursing to ensure robust action plans are in place.
<ul style="list-style-type: none"> Efficiencies delivered through skill mix and staffing reviews. 	-	September 2016	-	<p>In partnership with University of Cumbria the Trust has interviewed the student nurses who are due to exit September 2016, 31 students have been offered and accepted substantive contracts with NCUH. In addition, work has been completed to look at the transformation of band 5 posts to band 4, 21 applications have been submitted to Health Education North West to support the training and back-fill from September 2016.</p> <p>The specialist nurse staffing review has been concluded and will be feedback at the Nursing & Midwifery Board.</p> <p>The main priorities are a standing item on the Nursing, Midwifery and AHP Board agenda which discuss the key components of nursing and midwifery information in order to provide a robust monthly assurance report on the ward areas at greatest risk in terms of their staffing, quality and safety indicators. In addition, there are weekly staffing meetings with all Matrons, Chief Matrons, Deputy Directors of Nursing, Executive Director of Nursing that review staffing issues.</p>
<ul style="list-style-type: none"> A leadership programme in place for band 7 and above. 	-	January 2016	-	Complete - A band 7 leadership development

Measurable Outcome/Action	Baseline 2015	Deadline	Trajectory 2016/17	Status
				programme has been developed for Nursing, Midwifery and Allied Health Professionals. The first cohort commenced January 2016 and a further 4 programmes have been planned.
<ul style="list-style-type: none"> A clearly identified leadership structure in place for nurse practitioners at West Cumberland Hospital and the Cumberland Infirmary. (MED07/15 – CIC – MUST DO) 	-	December 2015	-	<p>Complete - A structured career programme is in place for the Nurse Practitioners at WCH who will support the medical rota.</p> <p>Implementation of the career framework for support workers is being undertaken by Anna Stabler, Deputy Director of Nursing. Workforce reviews for Outpatients are complete, Specialist Nursing to commence in November 2015. A Matron from Bolton is coming to support clinical teams in reviewing current nursing workforce in conjunction with national requirements in Theatre.</p> <p>Senior nurse site arrangements for West Cumberland Hospital have been formalised.</p>
<ul style="list-style-type: none"> A review of all inpatient areas to ensure all wards have a ward manager. 	-	April 2016	-	Complete - All ward areas have a ward manager in place or are currently out to advert.
<ul style="list-style-type: none"> The Butterfly Scheme is in place on all relevant wards. (MED17/15 – WCH – SHOULD DO) 	-	December 2016	-	<p>Complete - Butterfly scheme documentation rolled out. Assurance that scheme is in place will be gained via inspection programme.</p> <p>Pilot Inspection programme starts in February 2016.</p>
3.3 Implementation of the NHS Constitutional Standards <i>Executive Director: Helen Ray (Executive Chief Operating Officer)</i> <i>Operational Leads: General Managers/OSMs/BUDs/Deputy BUDS</i>				
<ul style="list-style-type: none"> Staged improvement towards 95% and above patients will be seen, treated and admitted or discharged in less than four hours. (U&E06/15 - WCH – SHOULD DO) (U&E01/15 – CIC – MUST DO) 	80.55% (Feb. 2016)	March 2017	95%	<p>Multi-agency approach to management of flow. Support from Emergency Care Improvement Programme in place. There are 3 core work streams:</p> <ul style="list-style-type: none"> i) SAFER bundle ii) Discharge to assess / home first iii) Review of delayed transfer of care
<ul style="list-style-type: none"> Compliance with the 2 WW cancer standards. 	93.7% (Feb. 2016)	September 2016	93%	Revised trajectory to be agreed. Significant workforce gaps in dermatology and gastroenterology.

Measurable Outcome/Action	Baseline 2015	Deadline	Trajectory 2016/17	Status
<ul style="list-style-type: none"> Compliance with the 62 day cancer standards. 	77.7% (Feb. 2016)	September 2016	85%	Revised trajectory to be agreed. Significant workforce gaps in dermatology and gastroenterology.
<ul style="list-style-type: none"> 99% of patients will undergo diagnostic tests within 6 weeks (6 week diagnostic tests target). <p>(OPD01/15 – CIC – MUST DO)</p>	2.63% (Feb. 2016)	To be agreed with CCG & TDA	To be agreed with CCG & TDA	Trajectory for recovery agreed as end February 2016 utilising independent sector to support in challenging modalities.
<ul style="list-style-type: none"> Achievement of compliance with 18 week referral to treatment for the incomplete pathway standard. <p>(SUR02/15 – CIC/WCH – MUST DO) (OPD04/15 – CIC – MUST DO)</p>	90.46% (Feb. 2016)	September 2016	92%	Trajectory not met due to the impact of the fire in CSSD and the Cumbria-wide flooding in December 2015. Revised trajectory is 90% to be achieved by 31 March 2016.
<ul style="list-style-type: none"> Improve the number of patients whose operations were cancelled and were not treated within 28 days. <p>(SUR03/15 – CIC/WCH – MUST DO)</p>	7.76% (Feb. 2016)	March 2017	0%	The number of patients whose operations were cancelled and were not treated within 28 days has improved in the last 6 months and continues to be monitored.
<ul style="list-style-type: none"> Improve waiting times for outpatient physiotherapy which are commonly longer than four months for a routine referral and over three weeks for urgent referral against a target of one week <p>(OPD02/15 – CIC – MUST DO)</p>	-	September 2016	-	<p>An evidence based review of the service to identify an alternative model of delivery is planned for April 2016. This will include a review of capacity identifying duration of treatment appointments, frequency of follow up appointments, appropriate allocation of patients to correct grade of staff, utilisation of efficient working in group settings, Frequency of first appointment assessments, LEAN working, Identifying priorities in service delivery and Staffing levels/issues.</p> <p>Opportunities to modify the service delivery engaging with all stakeholders including referrers and service users will be explored. Following this event a new way of working will be identified and adopted to reduce waiting times.</p>
3.4 Estates, equipment and Facilities are fit for purpose <i>Executive Director: Mark Brierley (Director of Finance)</i> <i>Operational Lead: TBC (Associate Director of Estates & Facilities)</i>				
<ul style="list-style-type: none"> Undertake substantial and complex remedial works required in order to ensure the organisation is compliant with Fire legislation. 	-	March 2017	-	Enforcement notice served by the Cumbria Fire and Rescue Service (CFRS) in July 2015 was withdrawn on 23 October 2015. The CFRS now considers that the premises currently demonstrate suitable and sufficient measures to satisfy the requirements of the

Measurable Outcome/Action	Baseline 2015	Deadline	Trajectory 2016/17	Status
				<p>legislation. The measures undertaken have been:</p> <ul style="list-style-type: none"> • Fire Risk Assessments across our estate; • Fire Wardens identified in each service area and fire warden training implemented & completed; • Fire Floor walkers continuing to assess ongoing risk across the site on a 24 hour basis; • Fire Alarm system has been improved to achieve basic functionality. <p>This work continues to be monitored through the Health Management Carlisle (Ltd) (HMC) Fire Protection Outline Plan and at the Trust's fortnightly meeting with HMC and Interserve; where Cumbria Fire and Rescue Service attend to ensure continued compliance and assurance of the plan.</p> <p>On 19th November 2015 a washer caught fire in CSSD, the fire was controlled and contained in that area, although smoke damage was experienced vertically above. This meant the loss of the department for 2 weeks for complete refurbishment and replacement of washers. The contingency plans for maintaining theatres with an appropriate supply of sterile equipment were successful.</p>
<ul style="list-style-type: none"> • Review the equipment replacement programme process and the interaction with the business unit to ensure an effective and responsive system with clear escalation. Every service must have equipment that is fit for purpose. 	-	March 2017	-	<p>Equipment replacement programme process response:</p> <ul style="list-style-type: none"> • The Trust has a fixed asset register which is held by finance • Estates have an asset register for all other electric/electronic equipment • The Trust has a process for the replacement of equipment via the backlog maintenance programme and/or a business case optional appraisal request system • Small scale asset pat testing programme • Condition appraisal system and risk register

Measurable Outcome/Action	Baseline 2015	Deadline	Trajectory 2016/17	Status
				The Estates department including Medical Engineering manage the PPM programme as well as external maintenance contracts. Assets including the replacement programme is monitored by the Medical Device Committee & the Estates & Facilities Advisory Group.
<ul style="list-style-type: none"> Continue to work with our Facilities provider to conclude negotiations to improve cleaning standards in line with the national best practice. 	-	March 2017	-	<p>Proactive PLACE programme commenced in December 2015 which combines the weekly national cleaning specification audits.</p> <p>The PLACE programme consist of the following 3 elements:</p> <ul style="list-style-type: none"> Cleanliness of environment (domestics) Cleanliness of equipment (nursing) Physical environment (estates) <p>Currently national specification audits are achieving 95% of cleaning standards on both sites. These are monitored at the Infection Prevention and Control Committee and also reported to the Nursing, Midwifery & AHP Board.</p>
4.1 Embed a new system for clinical effectiveness <i>Executive Director: Dr Derek Thomson (Medical Director)</i> <i>Operational Lead: Business Units</i> <i>Corporate Links: Dr Fiona Graham (Clinical Audit Lead)/Kathy Barnes (Head of Clinical Standards)</i> <i>Committee: Safety & Quality (S&Q)</i>				
<ul style="list-style-type: none"> All business units will have an agreed clinical audit plan by 31 March 2015 	-	31 March 2015	-	<p>Reports are provided to each business unit on a monthly basis in relation to national and local audits as part of governance dashboards.</p> <p>The Clinical Director for Clinical Audit has been appointed to provide direction and support to the clinical teams and focus on compliance with NICE guidance.</p> <p>An exception report is submitted to the monthly Safety and Quality Committee.</p>

Measurable Outcome/Action	Baseline 2015	Deadline	Trajectory 2016/17	Status
				There are a few areas whereby prioritised work needs to be undertaken to improve performance, they relate to participation in HQIP national audits, compliance with NICE guidance (currently 76%) and the undertaking of risk assessments where the specialty are non-NICE compliant.
<ul style="list-style-type: none"> 100% of NICE guidance will be assessed for applicability on a monthly basis 	96% (December 2015)	Monthly	-	Work will be undertaken to increase the timeliness of the assessment approach and this will be monitored via Business Unit governance dashboards at the Safety & Quality Committee and via quarterly clinical audit reports.
<ul style="list-style-type: none"> 100% of NICE Quality Standards will be assessed for applicability on a monthly basis 	92% (December 2015)	Monthly	-	Work will be undertaken to increase the timeliness of the assessment approach and this will be monitored via Business Unit governance dashboards at the Safety & Quality Committee and via quarterly clinical audit reports.
<ul style="list-style-type: none"> 35% of NICE guidance will be audited 	24% accumulative (December 2015)	Quarterly	35% by March 2017	Works will be undertaken to increase the number of NICE guidance audited.
<ul style="list-style-type: none"> 25% of NICE Quality Standards will be audited 	16% accumulative (December 2015)	Quarterly	25% by March 2017	Works will be undertaken to increase the number of NICE quality standard guidance audited.
<ul style="list-style-type: none"> Participation in 100% of eligible HQIP audits 	89% (December 2015)	Quarterly	-	This will be an ongoing action but the trust must participate in all HQIP audits and use the feedback to learn and improve.
4.2 Improve the safety and effectiveness of medical and nursing handovers <i>Executive Directors: Derek Thomson (Medical Director)/Gail Naylor (Director of Nursing & Midwifery)</i> <i>Operational Lead: Dr Fiona Graham (Clinical Audit Lead)/Alex Herries (Change Team)/Lynn Anderson (Chief Matron)</i>				
<ul style="list-style-type: none"> All specialties will have an agreed standard for medical and nursing handovers which is written as a Standard Operating Procedure. 	-	October 2016	100% of wards	<p>2 As part of the 'Sign up to Safety' pledge, the implementing safety and effectiveness of medical and nursing handovers project has commenced.</p> <p>3</p> <p>4 The Standard Operating Procedure (SOP) has been developed and is going for approval to the</p>

Measurable Outcome/Action	Baseline 2015	Deadline	Trajectory 2016/17	Status
				Business Unit Boards to be approved by end February 2016. Following approval, the SOP will be sent to TPG for noting. 5 6 As part of the SOP, each ward and speciality will be required to develop their own hand over standard expected to be completed by April 2016.
<ul style="list-style-type: none"> 100% of available staff will be trained in line with the training needs analysis. 	-	October 2016	100% of available staff	
<ul style="list-style-type: none"> 100% of patients will receive a handover in line with the SOP. 	-	Q4, 2016/17	100%	Retrospective audit to be undertaken.
4.3 Implementation of the End of Life Strategy <i>Executive Director: Maurya Cushlow (Director of Nursing & Midwifery)</i> <i>Operational Lead: Anna Stabler (Deputy Director of Nursing and Quality)</i>				
<ul style="list-style-type: none"> Introduction of new care of the dying documentation 	-	April 2016	-	New documentation will be launched in April 2016. Training of identified champions has commenced.
<ul style="list-style-type: none"> A selection of patient records will be audited on a monthly basis to assess compliance with the core principles of care of the dying. 	-	February 2016	-	Complete - Lead Bereavement nurse has undertaken the audits.
<ul style="list-style-type: none"> A year on year improvement in the accurate completion of DNACPR forms. (EOL02/15 – CIC/WCH – MUST DO) 	-	March 2017	-	Ongoing prospective audit. Review of form undertaken and discussion regarding when the new national form will be launched and the planned approach.
<ul style="list-style-type: none"> 100% of relevant staff trained in end of life care and bereavement awareness. 	-	April 2016	-	A new TNA has been developed by Education & Development that identifies the appropriate staff to access training; this will be in place from April 2016.
<ul style="list-style-type: none"> Provide a bereavement office on site (EOL03/15 – CIC – SHOULD DO) 	-	February 2016	-	Complete – Bereavement suite in place at CIC.
<ul style="list-style-type: none"> The organisation will have a substantive consultant for specialist palliative care (EOL01/15 – CIC – MUST DO) 	-	December 2016	-	As part of the Success Regime, work to bring CPFT and NCUH together will include a joint post.
5.1 Enhancing Patient Experience <i>Executive Director: Maurya Cushlow (Executive Director of Nursing & Midwifery)</i> <i>Operational Lead: Anna Stabler (Deputy Director of Nursing and Quality)</i>				
<ul style="list-style-type: none"> Year on year improvement in patient satisfaction as evidence via national patient survey, FFT and the local 	-	March 2017	-	Patient experience dashboard developed.

Measurable Outcome/Action	Baseline 2015	Deadline	Trajectory 2016/17	Status
patient surveys				
5.2 Enhancing Staff Experience in line with the Organisational Development Strategy <i>Executive Director: Helen Ray (Executive Chief Operating Officer)</i> <i>Operational Lead: Christine Brereton (Director of Human Resources)</i>				
<ul style="list-style-type: none"> Staff surveys demonstrate a year on year improvement to meet the average in 3 years. 	-	March 2017	-	<p>A review of number of strategy documents and action plans for Workforce and OD has been undertaken and it is proposed to introduce a revised HR and OD Strategy for 2016/2017 which combines all of the previous actions plans and strategies. This will link in with the Trust's main objectives for 2016/2017.</p> <p>The strategy is currently being finalised and will be subject to consultation with internal stakeholders before being signed off by the Board by end of March. It is intended to be implemented by 1st April 2017.</p> <p>The draft strategy has four key aims:</p> <ul style="list-style-type: none"> Recruitment and Retention Staff Experience and Engagement Health and Well-being Organisational and Staff Development. <p>Each of these aims will have a specific action plan to address them and progress will be reported via the Workforce Group, EMT and FIP. All HR, workforce and OD activity will link back to this strategy. The strategy will contain key performance indicators/measures of success.</p> <p>The Staff Survey for 2015 has now closed. Results will be known publically on 23rd February 2016, but all Trusts will be given the full results by 8th February, therefore results need to be analysed to demonstrate whether there has been an improvement from 2015.</p> <p>A report will be submitted to our EMT on 17th February. It will be proposed to set up a task and</p>

Measurable Outcome/Action	Baseline 2015	Deadline	Trajectory 2016/17	Status
				<p>finish group, with a view of identifying four/five key objectives to address issues raised within the staff survey. Representatives from staff side will be invited to form part of this group. This will be supported by individual business unit action plans as in previous years, although we aim to focus on organisational issues and ensure that we engage with staff.</p> <p>As reported to Board on 26th January 2016, appraisal rates for medical staff is currently at 74.4% and is on target for full completion by 31st March 2016. For other staff, the completion rate is currently 45.57%, against a target of 95%. This is now calculated on a 12 month rolling period as per TDA guidelines.</p> <p>A proposal to improve appraisal completion will be submitted for consideration to the Executive Management Team on 17th February 2016 following discussions at the Workforce Committee in November 2015. This will propose to remove self- selection for appraisal completion within the year, and propose that all appraisals are completed within quarter 1 for 2016 and are linked to the annual business planning cycle.</p>
<ul style="list-style-type: none"> 95% of all staff receive an appraisal and have a PDP. 	<p>All Staff: 45.57%</p> <p>Doctors: 74.4%</p>	March 2017	95%	<p>As reported to Board on 26 January 2016, appraisal rates for medical staff are currently at 74.4% and is on target for full completion by 31 March 2016. For other staff, the completion rate is currently 45.57%, against a target of 95%. This is now calculated on a 12 month rolling period as per TDA guidelines.</p> <p>A proposal to improve appraisal completion will be submitted for consideration to the Executive Management Team on 17 February 2016 following discussions at the Workforce Committee in November 2015. This will propose to remove self- selection for appraisal completion within the year, and propose that</p>

Measurable Outcome/Action	Baseline 2015	Deadline	Trajectory 2016/17	Status
				all appraisals are completed within quarter 1 for 2016 and are linked to the annual business planning cycle.
<ul style="list-style-type: none"> 100% of all doctors have been subject to revalidation. 	88%	March 2017	>90%	Revalidation of Doctors is on target for those expected to have been revalidated to date, with the exception of those who have been deferred for valid reasons which have been given alternative dates.
<ul style="list-style-type: none"> 95% of available staff will be trained in line with the mandatory training policy. (U&E07/15 – WCH – SHOULD DO) 	81.2%	March 2017	80%	The overall completion rate for mandatory for quarter 3 as reported to Board on 26 th January 2016 was 81.2% against a target of 80%. Plans are in place to implement the use of 'competencies' within ESR which will enable employees and line managers to easily view compliance against statutory and mandatory training requirements through ESR self-service; expected date of completion of implementation April 2016. The Workforce Group will monitor and review training completion.
<ul style="list-style-type: none"> A nurse revalidation strategy is in place as of April 2016 and 100% of nursing staff have been revalidated by 2018. 	-	April 2016	April 2016 – Strategy Complete 2018 – 100% of all nurses revalidated.	Complete - The Trust's lead on revalidation is Richard Heaton, Chief Matron within Surgery. Communication has been sent out via the staff bulletin and letters will be sent out to staff whose revalidation dates are between April and June 2016. Workshops are planned for staff in February and March.
6.1 Sharing learning from errors and our experience <i>Executive Director: Derek Thomson (Medical Director)/ Maurya Cushlow (Executive Director of Nursing & Midwifery)</i> <i>Operational Lead: Michelle Woodward (Associate Director for Risk & Governance)</i>				
<ul style="list-style-type: none"> The incident reporting rate is, at minimum, in line with the national average incident reporting rate. (T05/15 – TRUST – MUST DO) 	NCUH has consistently been a below average reporter of incidents	April 2016	October 2016: maintenance of 'in line' or 'above average' incident reporting rate	<p>The criteria for reporting to the National Reporting & Learning System (NRLS) has been reviewed in line with the national approach; this has been formalised within the updated Incident Management Policy approved at TPG in February 2016.</p> <p>NCUH submitted 100% of eligible incidents to NRLS for the reporting period of April – September 2015; the NRLS national data will be published in April 2016 when we will receive confirmation of our incident reporting rate in comparison to other organisations.</p>

Measurable Outcome/Action	Baseline 2015	Deadline	Trajectory 2016/17	Status
				<p>However NHSE recently published the Learning from Mistakes League Table; NCUH was in position 224 and the reporting culture graded as 'poor'.</p> <p>Incident reporting rates are monitored on a monthly basis at the Safety & Quality Committee.</p>
<ul style="list-style-type: none"> There is a reduction in the number of incidents where patients suffer harm. (T05/15 – TRUST – MUST DO) 	NCUH has consistently reported incidents with a higher level of harm in comparison to other Trusts	March 2017	October 2016: 'in line' or 'below average' reporter of harm incidents	<p>A review of our grading will be undertaken during Q1 and Q2 of 2016/17.</p> <p>NCUH submitted 100% of eligible incidents to NRLS for the reporting period of April – September 2015; the NRLS national data will be published in April 2016 when we will receive confirmation of our level of harm in comparison to other organisations.</p>
<ul style="list-style-type: none"> The Trust make a year on year improvement in their position and grading in the national Learning from Mistakes league table. 	Poor	March 2017	Good	Link to NRLS focused work and Organisational Development strategy.
<ul style="list-style-type: none"> An e-learning Duty of Candour training package will be developed and incorporated into the wide trust TNA as mandatory. 	-	July 2016	-	Work will be undertaken to encompass the duty of candour training in an e-learning package that forms part of the trusts mandatory training TNA.
<ul style="list-style-type: none"> 100% compliance with duty of candour legislation 	2%	March 2017	100%	Further face-to-face training sessions to be planned and incorporated within already in place meetings. Workbook will be in place on Staff Intranet from 01/04/2016.
<ul style="list-style-type: none"> Maintain 100% of complaints acknowledged within 3 working days 	100%	March 2017	100%	
<ul style="list-style-type: none"> A year on year reduction in the percentage of complaints responded to over 30 working days 	67%	March 2017	20%	
<ul style="list-style-type: none"> Streamline and consolidate existing quality data into a smart monthly integrated governance dashboard for Business Units. 	-	September 2015	-	Complete - Integrated governance dashboards have been developed and presented at the Business Unit Boards. In addition there is exception reporting to each meeting of the Safety & Quality Committee.
<ul style="list-style-type: none"> Increased executive awareness of issues at a ward and department level within increased responsive support. 	-	December 2015	-	Complete - Patient Safety Walkabouts commenced November 2015 and data included relates to

Measurable Outcome/Action	Baseline 2015	Deadline	Trajectory 2016/17	Status
				complaints and the evidence of sharing the outcomes and learning
<ul style="list-style-type: none"> Ensure the requirements of the Mental Capacity Act 2005 are followed with regard to the application of Deprivation of Liberty Safeguards. All available staff to be trained by March 2016 with a focus on areas identified in the CQC report. (Target is 80% of eligible staff at each level). <p>(MED10/15 – WCH – MUST DO)</p>	Level 1 – 90% Level 2 – 79%	March 2016	80%	Training plans are in place within the Business Units that demonstrate the achievement of this 80% target.
6.2 Supporting a safety culture and learning organisation <i>Executive Director: Helen Ray (Executive Chief Operating Officer)</i> <i>Operational Lead: Christine Brereton (Director of Human Resources)</i>				
<ul style="list-style-type: none"> The Trust is recognised as an open and supportive employer using medical engagement surveys and the national staff survey feedback. 	-	March 2017	-	<p>A medical engagement strategy has been developed to engage with medical staff. This is discussed through the MSC and sets out a number of objectives around recruitment. Retention, policy development and communication aimed at improving openness and transparency around key organisational issues affecting our medical workforce. This has recently been updated (27 January 2016)</p> <p>Regular and ongoing discussions have taken place with medical staff representatives via the Joint Local Negotiating Committee (JLNC) which are held every two months. Members of the medical workforce/staff representatives will be invited to form part of the task and finish group for the staff survey as referred to in 5.2.</p> <p>Medical staff engagement links to the continuous improvement / change management plan.</p>
6.2 Never Events <i>Executive Director: Dr Derek Thomson (Medical Director)</i> <i>Operational Lead: Business Unit Directors</i>				
<ul style="list-style-type: none"> Undertake a thematic review of all never events which have occurred within the organisation 	-	March 2016	-	Complete - A thematic review of never events has been undertaken and a never events action plan has been developed in response.
<ul style="list-style-type: none"> Implementation of Never Events action plan <ul style="list-style-type: none"> Immediate debriefs for staff 	-	September 2016	-	Action plan focusses on systems/processes, human factors, training, leadership, NATSSIPs.

Measurable Outcome/Action	Baseline 2015	Deadline	Trajectory 2016/17	Status
<ul style="list-style-type: none"> ○ Implementation of NatSSIP Guidance ○ Review arrangements and standards of clinical practice, training, local induction and leadership ○ Ensure there are clear compliance frameworks in place that are effective and the monitoring arrangements are robust to provide clear unambiguous assurance ○ To accept the TDA offer of support in relation to review, training and assessment ○ Commission an independent review of theatres to include processes and human factors ○ Approach the Royal College of Surgeons to: <ul style="list-style-type: none"> ▪ assess compliance with national best practice and national recommendations ▪ undertake a diagnostics to assess culture in theatre 				

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