Success Regime
West, North & East Cumbria

NHS

Success Regime: Key challenges and baseline facts and figures

March 2016

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Key Messages

Key messages

Success Regime – Key Challenges and Baseline Facts and Figures

In presenting a summary of our starting position using data and facts we are seeking to ensure clarity on key issues and a degree of strategic focus on the things that are likely to be a factor in our future success. This document is aligned to the 3 key "gaps" identified in the national NHS five year forward view (health and wellbeing, care and quality, funding and efficiency) and summarises the nature of these "gaps" for West, North and East (WNE) Cumbria. Further summary information on the historical and governance context in WNE Cumbria is also provided.

From the baseline facts and figures in this document we have identified a number of key challenges:

Health and wellbeing

1. Our population is "super ageing" with a higher than average growth in the proportion of older people year on year.
2. 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. Primary prevention (e.g. addressing lifestyle risks) is an area where we need to do more.
3. Our geography makes service delivery harder than average – communities spread over large distances and with isolation a key factor.

Care and quality

4. Utilisation of more intense services (e.g. hospitals and care homes) is higher than necessary, although in line with national averages, with potential for earlier preventative and less intensive services to be offered and for people to move from intensive to less intensive settings more swiftly by enabling people to live more independently.
5. Key services (urgent & emergency care, secondary care diagnosis & treatment and rehabilitation) are not always provided sufficiently promptly and core access standards are not consistently met – this is especially the case for people who are frail or need multi-agency care.

Funding, efficiency and sustainability

6. The healthcare system is costing significantly more each year than the money available. Our workforce, buildings, IT and purchasing are all areas for increased efficiency and productivity. Funding for local authority services has reduced significantly and is forecast to continue doing so.
7. The health and care system is currently utilising an expensive and unpredictably large temporary workforce of doctors and other key professionals. This is a major factor affecting the cost and quality of services in primary, secondary and social care - feedback from staff is that they are often not working in a sustainable way.
8. The relationships between the public and services are varied with generally high levels of patient experience alongside some communities feeling extremely disenfranchised from their local health services. Trust is fragile between the public and healthcare organisations.

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Executive Summary

Executive Summary (1)

- The WNE Cumbria Success Regime is seeking to provide increased support and direction to the most challenged systems and deliver short, medium and longer term improvements across a number of areas and develop a sustainable leadership for the future. This document builds upon earlier work to develop a compelling case for change in WNE Cumbria with an agreed baseline position that identifies the challenges faced by the Regime

- **WNE Cumbria includes isolated and rural areas characterised by a complex socio-demographic structure that creates significant demand and cost pressures on the health and care system and difficulties in providing access to appropriate healthcare services**
    - There is an ageing, more deprived and complex population than the national picture. These differences can be expected to grow in future years based on current projections
    - The isolated and scarcely populated geography means higher travel times and additional difficulties in providing care with population density 80% lower than the national average and travel times to a GP twice the English average

- **The system is currently facing a series of quality challenges and performance related pressures but there is scope to improve the delivery of health and social care services**
    - Across WNE Cumbria, quality challenges in the Acute Trust and Mental Health and Community providers are well known and the delivery of integrated care can be improved. This leads to patients having unnecessary/avoidable episodes of care and access services in the wrong setting. However, there are real possibilities to reduce utilisation of health and care services

Executive Summary (2)

- Activity levels are higher than peer and national averages across key points of care. This is likely to lead to inefficiencies across the system, causing additional costs and negatively impacting performance targets and overall patient experience

- **Key challenges to change exist within the workforce and estates portfolio**
  - A key driver of the issues faced appear to be the lack of permanent workforce. Both providers have high rates of temporary staffing, increasing costs and limiting quality improvements
  - The estate portfolio is deployed across a wide geography; in poor condition impacting patients' experience and causing financial burden to the providers (PFI, backlog maintenance)

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Overall approach to this document

The Success Regime was put in place in WNE Cumbria to assist the health and care economy in achieving system-wide improvements

The Health and Care System known as '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. The aim of the national programme is to provide increased support and direction to the most challenged systems. The problems in these health and care economies are deep-rooted, long-standing and spread across the whole system as opposed to individual organisations. Local and national organisations may have worked hard for some time to improve services for patients and the public, but have not made the required progress. Transformation is now required and 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.

The programme aims to secure improvement in three main areas:

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

For successful delivery of the programme it is expected to see measurable improvement in relation to:

1. **Quality of care**, including patient experience
2. **Workforce** including, ongoing leadership capacity and capability, and long term workforce recruitment sustainability and development
3. **Financial performance**
4. **Public confidence,** involvement and empowerment
5. **System-wide organisational stability**

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The WNE Cumbria system is defined as a combination of districts and health and social care organisations

Geographically, the WNE Cumbria system is defined as the districts of:

- **Allerdale:** 96,471 residents
- **Copeland:** 69,832 residents
- **Carlisle:** 108,022 residents
- **Eden:** 52,630 residents

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

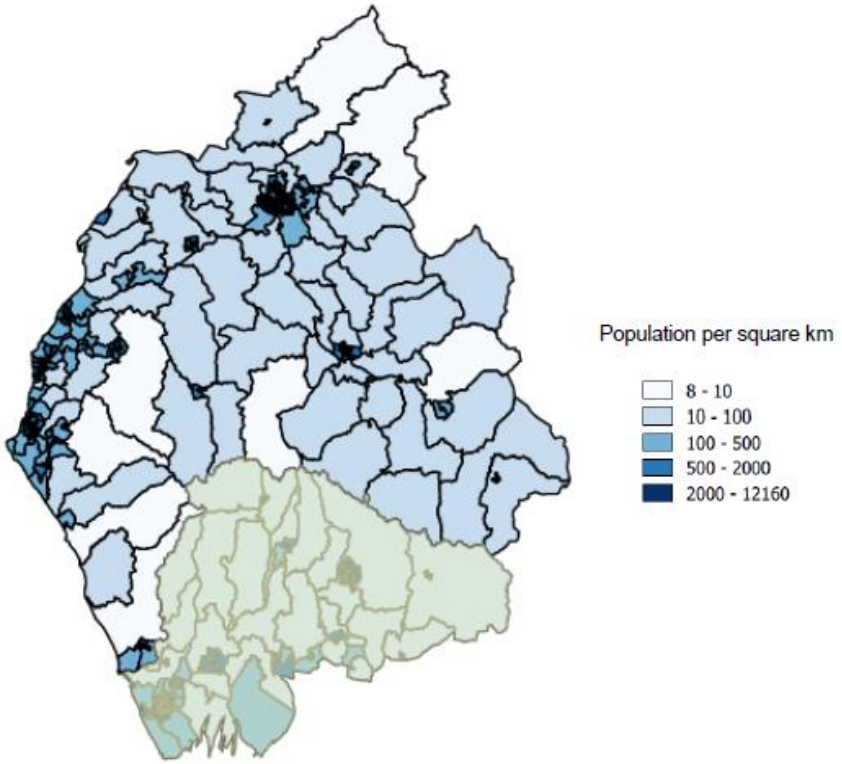
Health and social care services are delivered to the WNE Cumbria population by a wide variety of organisations. Therefore, this document mainly focuses on providers residing directly in the area with the following entities being directly considered in the analysis - also defined as the Local Health and Care Economy (LHCE):

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

Other peripheral organisations also deliver services to the WNE Cumbria residents. As such, they may be considered indirectly in this document or at other stages of the programme. These are:

- **Northumbria Healthcare NHS Foundation Trust**
- **Newcastle Upon Tyne Hospitals NHS Foundation Trust**
- **University Hospitals of Morecambe Bay NHS Foundation Trust**

Fig 1: WNE Cumbria – Population density map



Source: ONS.

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Health and Wellbeing

WNE Cumbria has an ageing and rural population which is putting significant demand on health and social care services

Ageing population

WNE Cumbria has a 'super – ageing' population. This means it has an increasing number of people in older age groups and a decreasing number of people in younger age groups.

Between 2015 and 2020, people aged under 60 years are expected to decrease by 3.4% and those 60 years or older are expected to increase by 8%. By contrast, across England these numbers are +1.8% and +9% respectively.

An older population could imply more complex needs and higher disease prevalence.

High prevalence

Prevalence rates for most major disease groups are significantly higher for Cumbria than England or its peer group. The difference is particularly significant for asthma, depression and obesity.

Furthermore, the expected growth in prevalence rates of major diseases in WNE Cumbria is greater than the national average. For example, over the next five years, growth in dementia is projected to be 6.2% for WNE Cumbria and 4.5% nationally.

High demand

The ageing population and high disease prevalence could be a key factor for the high levels of demand across care in WNE Cumbria.

Utilisation of health and care across the WNE Cumbria will be discussed in the Care and Quality section of this document.

Inequality in outcomes

Average health outcomes mask high variation at a more disaggregated geographical level. There is significant variation in deprivation across districts in WNE Cumbria.

On most measures of individual lifestyle choice and socio-economic conditions, Eden is much better than other districts. However, a number of other districts perform significantly worse. Teenage pregnancies in Carlisle and smoking in Copeland are particularly high.

This pattern is also borne out in terms of life expectancy; with Eden performing better than a number of other areas.

Rural populations

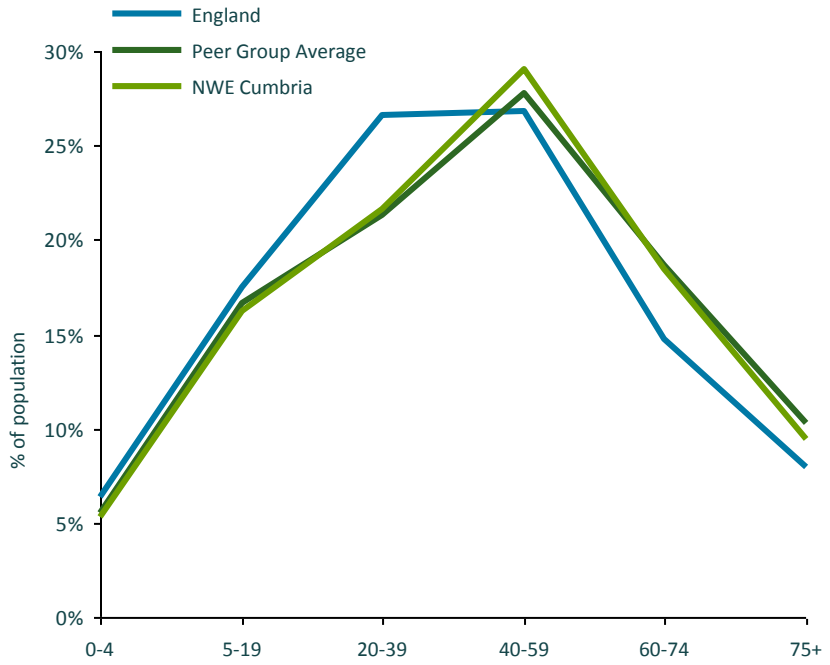
WNE Cumbria is one of the most rural counties in all of England, with a population density of 74 people per sq. km, versus 413 as a national average. This varies across districts, with Eden having 25 people per sq. km and Carlisle having 104 people per sq. km.

Distinct from rurality is the issue of geographically isolated areas across the county. These are removed from essential services and transport links, making access to hospitals and services more difficult. As an example, the average road distance to a GP surgery in Eden is more than twice the average distance nationally.

An ageing population is placing increasing pressure on health and social care services

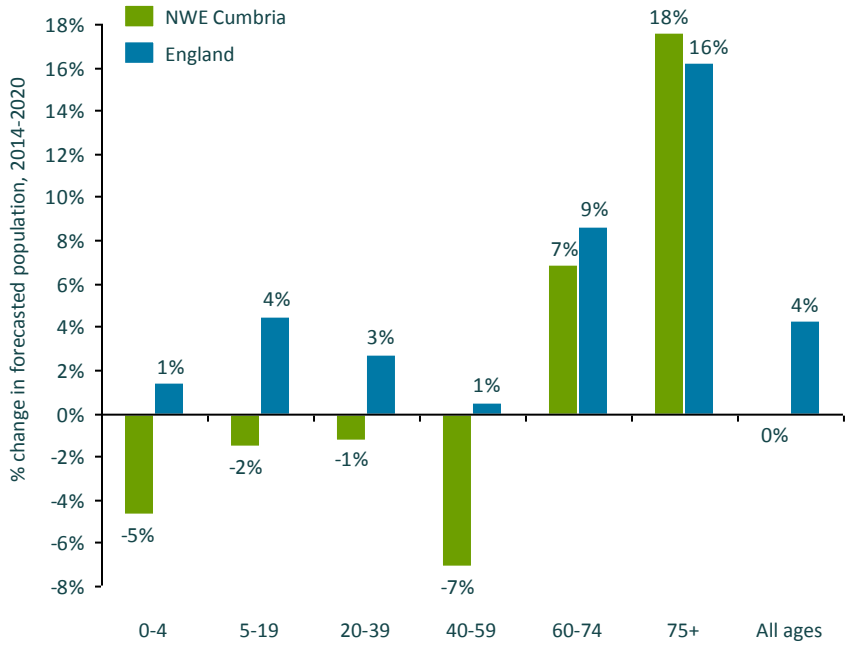
WNE Cumbria has a more elderly population, when compared to the rest of the country. The elderly population is growing, while the younger population is falling. Between 2015 and 2020, the number of people aged under 60 years is expected to decrease by 3.4% and those 60 years and older is expected to increase by 8%. This contrasts to a national picture of +1.8% and +9% growth respectively.

Fig [2]: Population structure (2014)



Source: ONS. Population figures are for 2014.
Peer group includes the 10 most similar CCGs to NHS Cumbria CCG, as identified by the Commissioning for Value framework

Fig [3]: Forecast growth in population by age

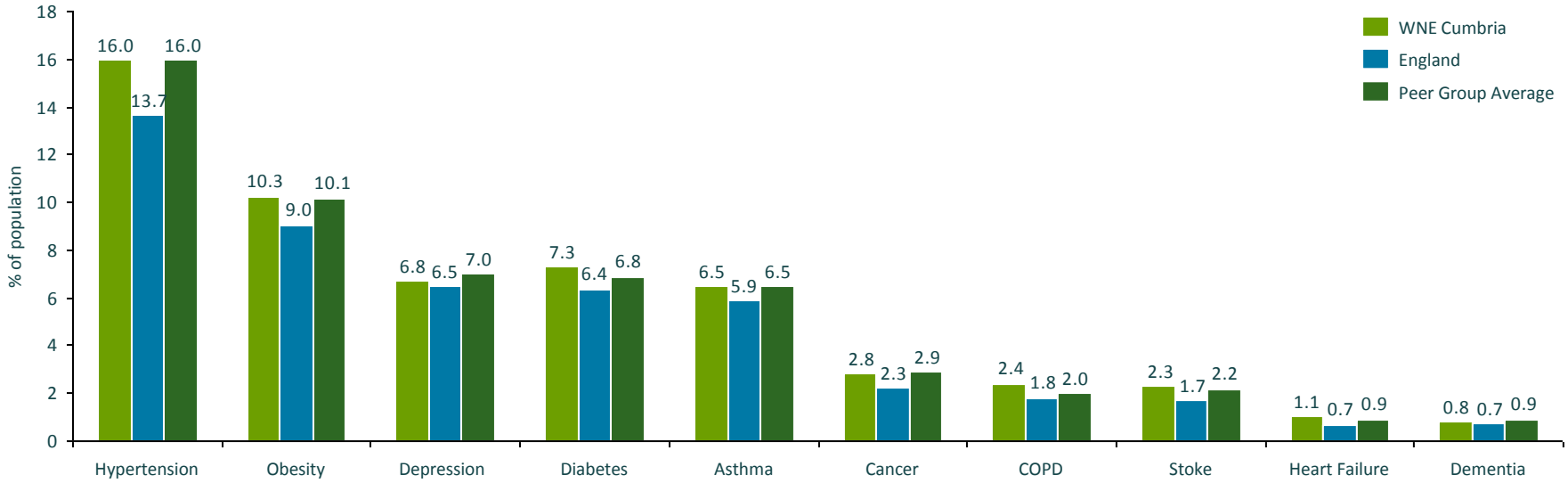


Source: ONS, as forecast in 2012/13

The ageing population has high levels of prevalence across a number of key disease areas

Prevalence rates for almost all disease groups are higher in WNE Cumbria, compared to the national and peer group average. The difference is more pronounced for some diseases (hypertension rates are c.17% higher than the national average) and less pronounced for others (depression rates are c.4% higher than the national). Given the levels of prevalence, WNE Cumbria may also have high comorbidity. There is strong evidence that having mental health problems increases the risk for a range of physical illnesses; for example, depression was found to increase risk of Coronary Artery Disease by between 50 and 100 percent*. Similarly, there is evidence that a range of long term conditions significantly increase the risk of mental illness**. These high levels of prevalence could be caused by good level of identification of diseases. However, the pathway analysis presented in Appendix A, suggests that the system is performing in line with national benchmarks in terms of diagnosing and identifying diseases. The higher rates of prevalence could therefore be the result of underlying factors, such as lifestyle.

Fig [4]: Prevalence rates for major disease groups



Note: Peer group includes the 10 most similar CCGs to NHS Cumbria CCG, as identified by the Commissioning for Value framework
**Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care (2011).*
***Long term conditions and mental health, The cost of comorbidities, King's Fund (2012)*
JNSA reports have similarly found that WNE Cumbria is higher than national average prevalence across most disease areas.
Source: Quality and Outcomes Framework 2014-2015

The high prevalence of mental health conditions implies a high population need for mental health services

Cumbria has high numbers of people with mental health needs, with prevalence being c.9% higher than national benchmarks. Similarly, WNE Cumbria's demographic structure and older population leads to a high prevalence of people suffering from dementia, c.12% above national average.

The higher prevalence identified could result in greater demand which is not currently seen by mental health services. The result of this is not fully analysed. One potential hypothesis could be that some of the demand is actually being supported effectively within general practice.

Fig [5]: Mental Health problem, prevalence

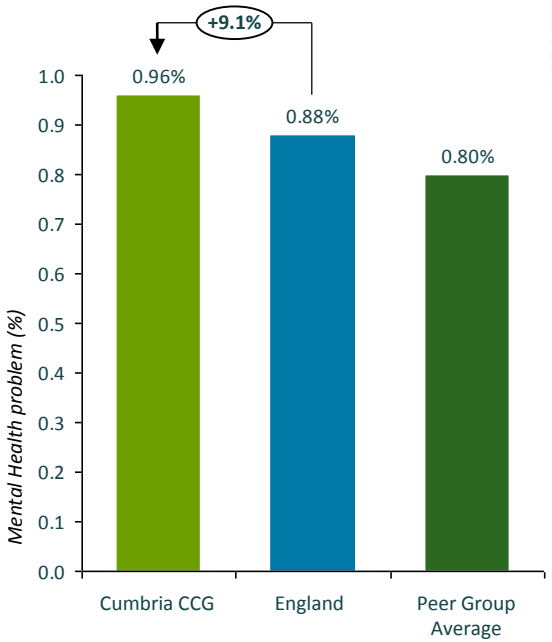


Fig [6]: Prevalence of dementia

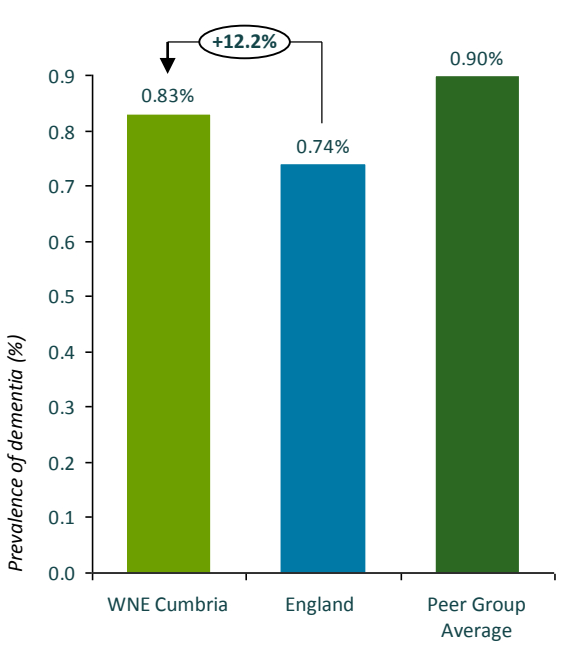
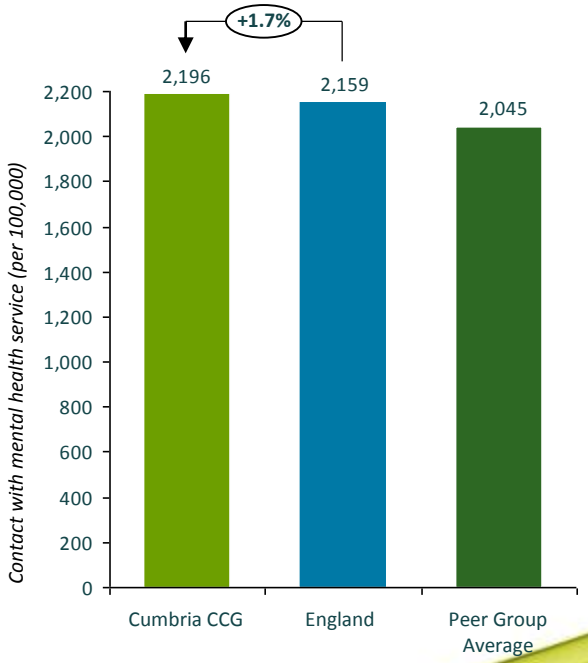


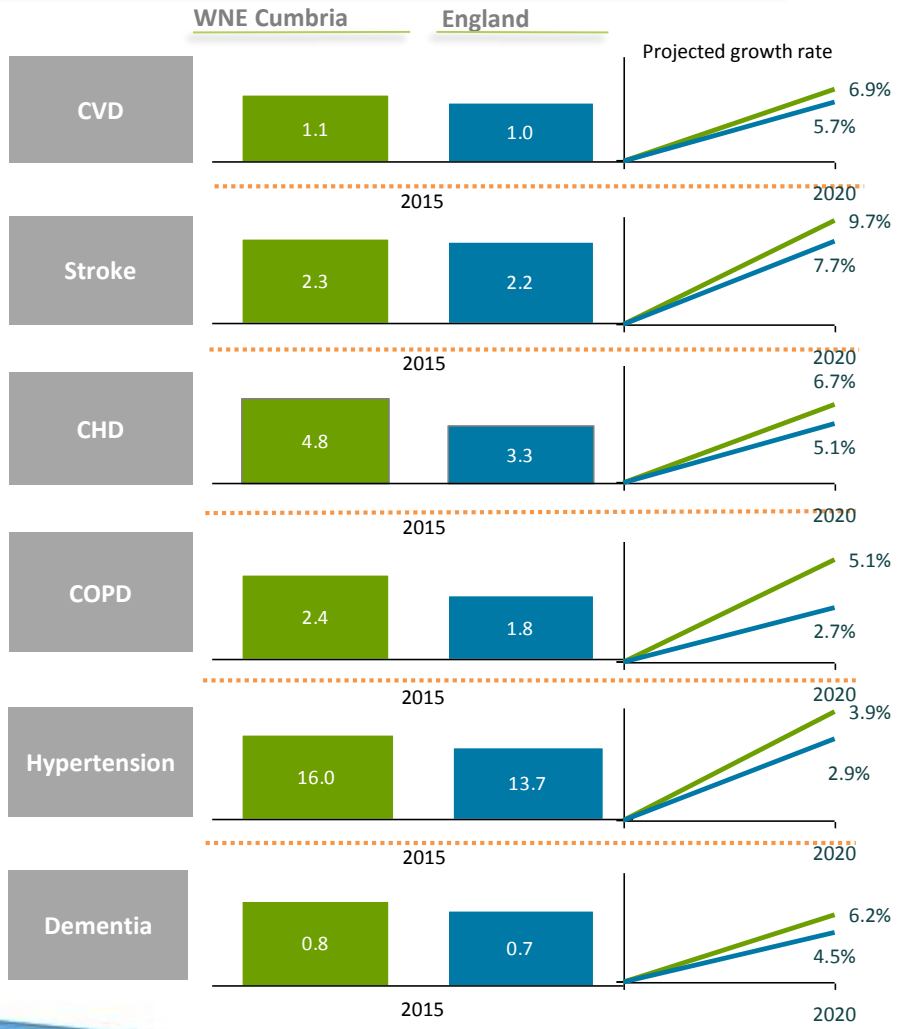
Fig [7]: People in contact with mental health service



Source: QOF,2015. Public Health England, 2014.

Prevalence rates are expected to increase significantly over the next few years

Fig [8]: Current and projected prevalence rates for major disease groups



Source: Network of Public Health Observatories 2010/11

**JSNA, 2012 - 2015*

Prevalence rates for major cardiovascular and respiratory diseases are expected to increase across WNE Cumbria over the next five years.

Across a selection of disease areas, rates of increase are greater for WNE Cumbria then for England. In particular, the rate of growth for COPD is double the rate for England and the rate of growth of dementia is more than 35% greater in WNE Cumbria than England.

Diseases such as cancer (particularly lung cancer) and circulatory disease are the main causes of premature mortality in Cumbria*; hence tackling these trends in prevalence could be important in improving key health outcomes.

WNE Cumbria's ageing population places particular pressure on social care services

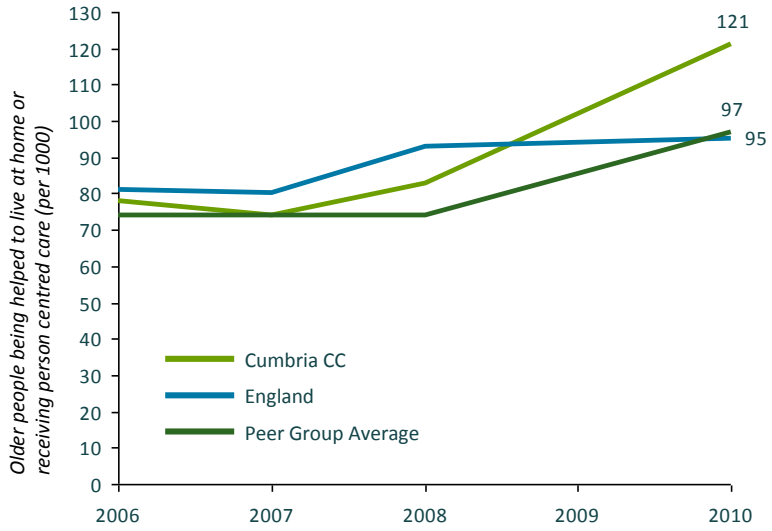
WNE Cumbria's ageing population is likely to add additional pressures on social care services.

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 (see appendix B). This is despite the overall population remaining relatively constant.

Over the past few years, the number of older people receiving person centred care is increasing more sharply than the peer group or national average (55% increase for Cumbria County Council between 2006-2010).

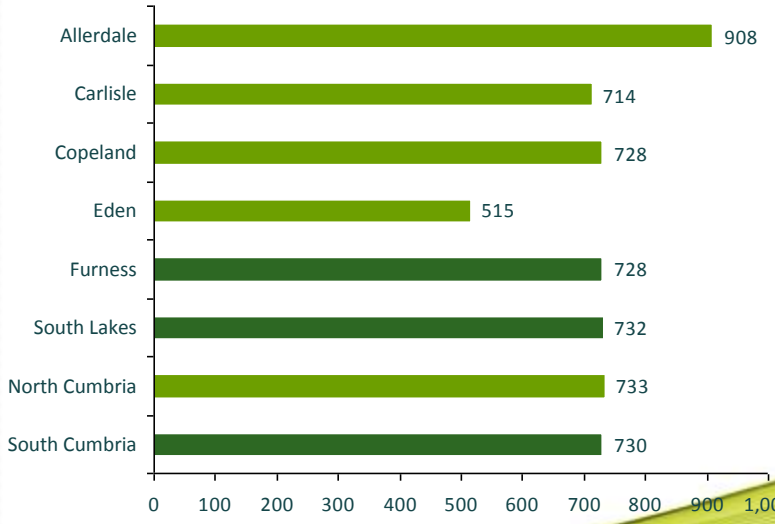
Within Cumbria, there is no significant difference between WNE and South Cumbria in the people receiving residential or nursing care. At the same time there is a large disparity within WNE Cumbria, with a 76% difference between Allerdale and Eden. According to Adult Social Care Outcomes Framework (ASCOF) data, Cumbria CC has c.25% more people receiving residential/nursing care per capita (see Fig [22])

Fig [9]: Older people being helped to live at home or receiving person centred care



Source: HSCIC

Fig [10]: Number of people receiving Res/Nursing Care (per 100,000 population)



Source: Cumbria CC - District Activity Profile (DAP) - 1st October 2014 - 30th September 2015

There is high variation in the levels of deprivation across WNE Cumbria…

WNE Cumbria has high levels of deprivation, with 8.4% of the population living in the most deprived decile of England. There is also high variation in deprivation across districts in WNE Cumbria, with Copeland at the 22nd percentile of the Index of Multiple Deprivation (IMD) distribution and Eden at the 61th percentile nationally. Only Eden is better than the national average for the Index of Multiple Deprivation.

At a more disaggregated geographic level, the most deprived Lower Super Output Areas (LSOA) in WNE Cumbria is at the 2nd percentile on the IMD and the least deprived LSOA is at the 97th percentile.

Given the link between deprivation and poor health outcomes established in the literature*, this implies that there is likely to be high inequality in health outcomes across Cumbria.

Fig [11]: Index of Multiple Deprivation Score (IMD) for districts across England

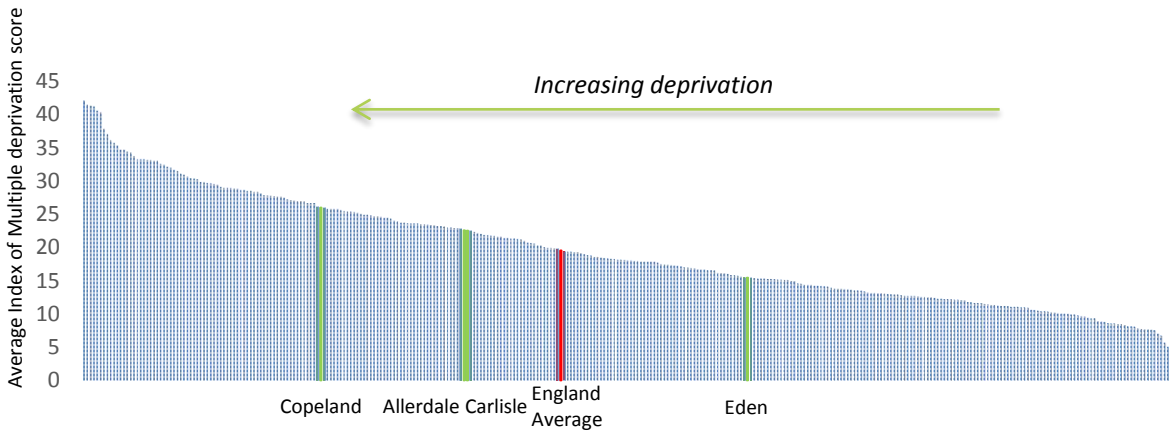


Fig [12]: IMD for WNE Cumbria LSOA's

National deciles of deprivation	% of WNE Cumbria LSOAs
1 – Most deprived	8.4%
2	8.4%
3	12.6%
4	12.6%
5	13.1%
6	15.4%
7	9.8%
8	7.9%
9	7.9%
10 – Least deprived	3.2%

Source: Department for Communities and Local Government, 2015.
Notes: A higher IMD score implies more deprivation in an area.
** Inequalities in life expectancy, The King's Fund; Fair society, healthy lives (The Marmot Review) 2010*

…deprivation is also creating variation around life expectancy and health outcomes

Average life expectancy and healthy life expectancy across districts in Cumbria reflect the pattern in deprivation. Eden is the only district that performs above national average on both measures.

Cumbria's overall performance on a range of health and wellbeing indicators disguises significant inequalities at district, 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.

Fig [13]: Life expectancy

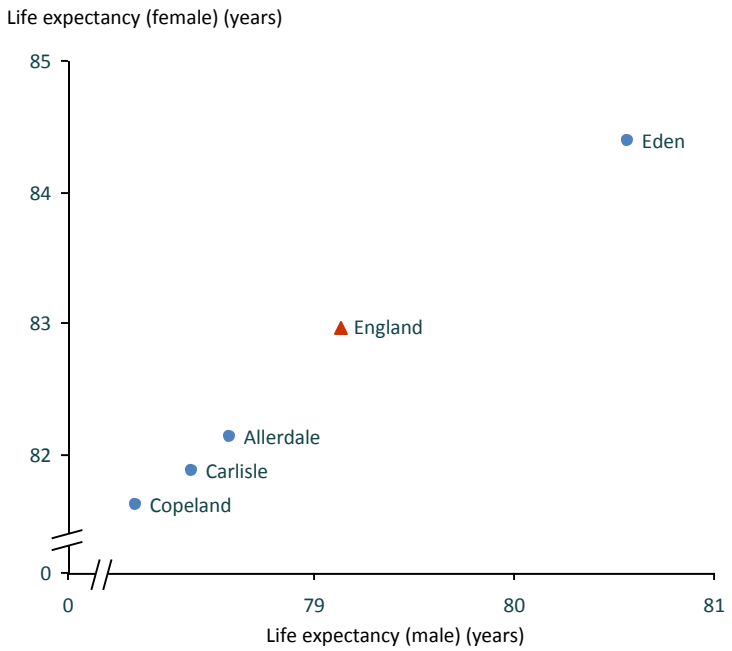
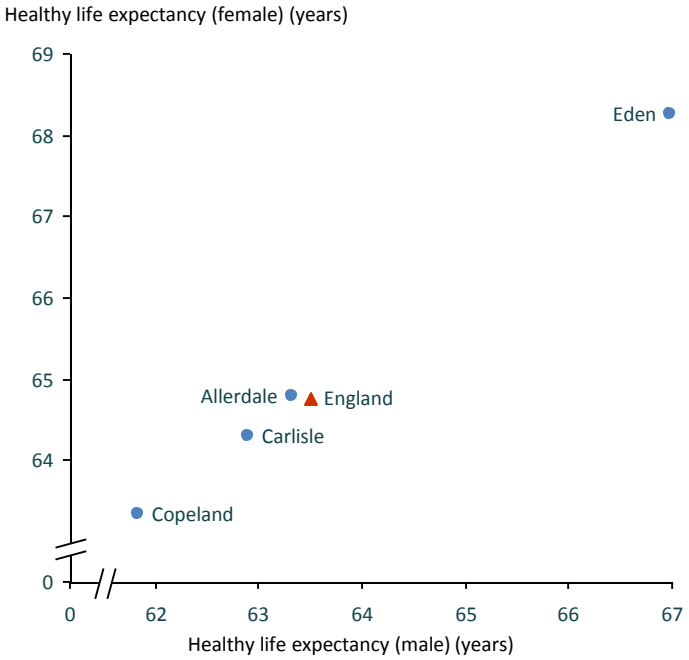


Fig [14]: Healthy life expectancy



Source: ONS, JSNA 2012 - 2015

There is also a wide variation across other indicators of individual lifestyle choice and socio-economic conditions

Table [15]: Inequality in healthcare outcomes and access across WNE Cumbria

Indicator	Allerdale	Carlisle	Eden	Copeland
Percentage of children with active dental decay	32.4%	28.80%	27.8%	29.6%
Percent participating in recommended physical activity	14.2%	14%	17.1%	16.7%
Violent crime per 1,000	13.4	19.7	8.7	13.2
Claimants of incapacity benefit with mental or behavioural problems per 1,000	29.4	33	15.7	36
Prevalence of child obesity	10.2%	9.50%	8.5%	10.8%
Percent of live births with infant <2,500 grams	6.7%	8.7%	5.6%	5.4%
Teenage conception rate per 1,000	128	161	41	30
Mortality from accidents per 100,000	36	32.1	23.1	31.9
Smoking prevalence	18.4%	22.20%	11.3%	28.4
New cases of tuberculosis per 100,000	1	3.7	0	1.4
Road injuries and deaths per 100,000	42.6	26.9	96.9	35.7

Better than WNE Cumbria average

Worse than WNE Cumbria average

Equal to WNE Cumbria average

Source: HSCIC 2010-2013, Cumbria NHS

Various lifestyle choices and general socio-economic and environmental conditions influence the health and well-being of a population.

Table 15 provides a summary of WNE Cumbria's performance against a variety of indicators capturing these dimensions. As with life expectancy, there is considerable disparity across the various districts in WNE Cumbria.

Measures showing some of the greatest disparity include smoking prevalence and teenage conception rates. Copeland has more than twice the prevalence rate for smoking as compared to Eden, implying an additional 9,500 smokers. High teenage conception rates in Allerdale and Carlisle are indicative of significant health issues relating to the health of children and young people in some parts of the county.

WNE Cumbria is rural and has pockets of geographic isolation, with consequences for access to health care

WNE Cumbria is one of the most rural counties in all of England, with a population density of 74 people per sq. km. This varies across districts from Eden having 25 people per sq. km to Carlisle having 104 people per sq. km. The low population density means there is a trade-off between providing easy access to essential health care and running sub scale services that are costly.

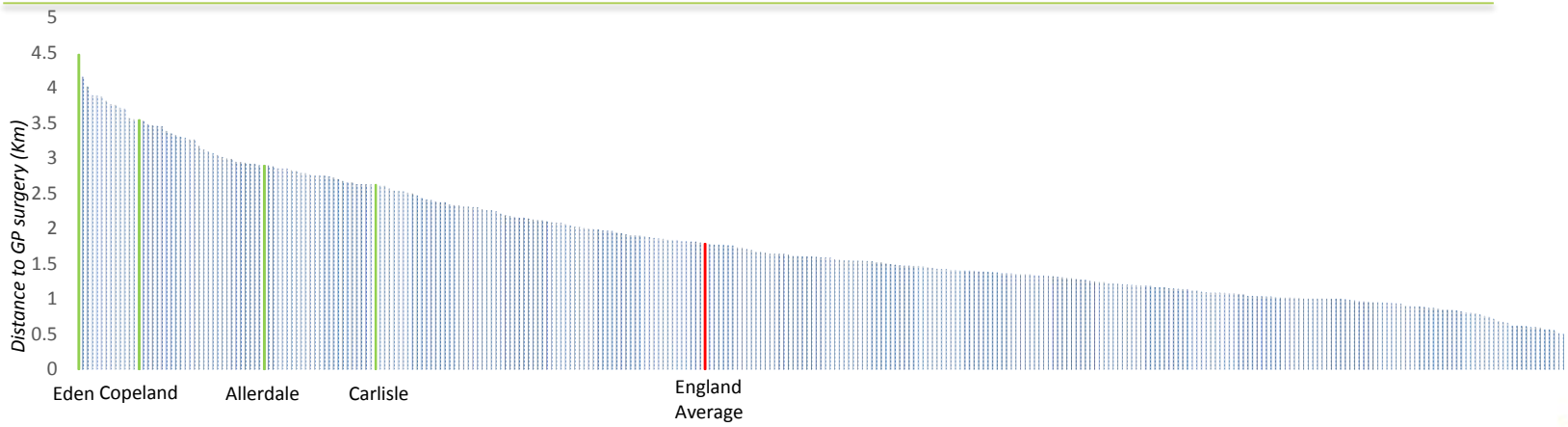
Distance to GP services highlights the geographical isolation of many pockets in WNE Cumbria. The average distance for Eden is the highest among all districts nationally, with all four districts falling in the top quartile. At a more granular level, certain areas are even further removed.

Overall the west coast of Cumbria (c.120,000 population) is especially isolated from the rest of Cumbria as well as the rest of England. For example, the towns of Whitehaven and Workington, with populations of roughly 25,000 each, are about 39 and 30 miles respectively from Cumbria's largest urban centre of Carlisle, and 140 miles from Manchester (the largest metropolitan city in the North West).

The most rural district, Eden, also faces the highest barriers to housing and other services. Copeland is the only district with access above the national average.

Under the NHS's definition of GP, North Cumbria has 23% of its GPs in the two most rural settings (out of 8), whilst only having 4.3% in the two least rural settings.

Fig [16]: Road distance to GP surgery (km)



Source: Department for Communities and Local Government, 2010. NHS rural/urban definition of GP practice 2011

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Care and Quality

The health and care economy of WNE Cumbria has significant quality and financial challenges

Quality and Outcomes

Historically, there have been significant quality challenges across the LHCE.

The overall Care Quality Commission (CQC) rating for acute services is 'requires improvement'. The rating for mental health and community services also highlights risks around governance and patient safety. On the other hand, both primary care and social care services in WNE Cumbria seem to be performing well according to CQC ratings, with c.94% and 92% of practices achieving a rating of 'Good' or above respectively. GP practices also scored well with regards to QOF ratings, with an average of c.97%, compared to a national average of c.94%, c.3.2% above the national average.

The acute provider has been in special measures since 2013, initially due to high mortality rates. According to the CQC, difficulties in recruiting and retaining the right workforce, especially at a senior consultant level, have been the main driver behind the acute sector's quality issues.

Patient satisfaction across care settings is in line with national averages. The adult social care survey and mental health patient survey show that patients are generally satisfied with these services.

Utilisation and demand

Utilisation of services across settings of care is high.

A number of sources suggest that non-elective admissions are broadly in line with national and peer averages, but there is scope to move to best in class performance. Mental health contacts and attendances are c. 30-40% higher than other organisations nationally.

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 the peer group.

Some of the demand pressures faced by WNE Cumbria as a health and care system are driven by an ageing population. However, health systems facing similar pressures have rates of emergency admissions that are between 5% and 20% lower than WNE Cumbria.

Reviews conducted by the Oak group report have also highlighted that the levels of non-qualified admissions are largely in-line with the national average and the percentage of non-qualified continuing days of stay is much higher, both within District General Hospitals.

Integrated and joined up care

There is currently limited integration and coordination of care across the system.

A detailed pathway analysis for key disease groups (e.g. diabetes, COPD, CVD, asthma etc.) shows that indicators in the earlier and later stages of the pathway (prevention and ongoing management) are on average, performing worse than the national average.

There is also evidence that some acute activity could be dealt with at lower levels of care. Emergency admissions that do not usually require hospital admission are 12% greater than the national average; whilst admissions that are generally dealt with in primary care are 8% higher.

Higher utilisation is partly driven by lower levels of prevention being delivered. For example, smoking and obesity prevalence is much higher than national and peer benchmarks.

There are a number of quality challenges the health economy is seeking to address

There are a number of quality challenges facing the health and social care system in WNE Cumbria. WNE Cumbria's acute services have been placed in special measures since 2013, driven by higher than average mortality rates. While there has been continuous progress in improving services and mortality rates since then (NCUHT mortality indicators are now in the 'as expected' range), the latest CQC report for NCUHT still gave a 'requires improvement' ranking to the trust. In particular, issues around recruiting and retaining skilled workforce limit the organisation's ability to provide effective care. Other challenges for acute services are around governance and risk management systems, support around clinical audits and patient safety management.

Acute CQC ratings

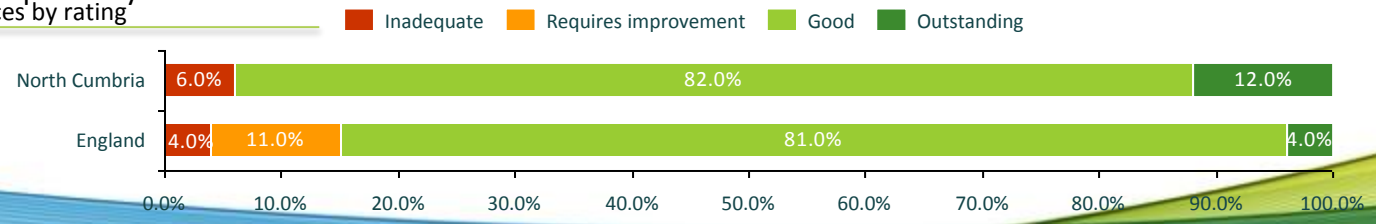
Safe	Effective	Caring	Responsive	Well-led
Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement

CQC inspections of mental health services in WNE Cumbria has also highlighted some areas of potential risk. These include concerns around patient safety (e.g. dealing with patient safety alerts in a timely way), effectiveness of care (e.g. patients with access to Independent Mental health Advocate service) and governance processes (e.g. elevated risk rating for governance by Monitor). Social care services in WNE Cumbria are also facing pressure due to a high number of older adults in residential and nursing care homes. In recent months, delayed discharges due to social care have been increasing across the health economy. The overall CQC ratings for Cumbria Partnership NHS Foundation Trust (CPFT) are awaited following an inspection in November 2015.

CQC and Quality Outcomes Framework (QOF) ratings for primary care indicate that services are currently performing well. 82% of primary care practices in WNE Cumbria achieved 'Good' CQC ratings*; this aligns with wider CQC ratings which also rank as 'Good' rating c.82% of practices nationally. In addition, c.12% of practices have an 'Outstanding' rating, twice as much as the national average.

Latest social care CQC ratings (2015) show WNE Cumbria to be performing well compared to national and peer group average. Social care organisations in WNE Cumbria had an average rating of c.76% of 'Good'*, compared to 63% and 65% for England and Peer group average respectively.

% of practices by rating



Source: CQC rating, Sep 2015; CQC Intelligent Monitoring report 2014, 2015
**17 GP practices and 38 social care organisation rated by CQC*

Despite the challenges faced by the system, patient satisfaction across various settings of care is in line with benchmarks

Overall patient satisfaction levels, as measured by patient surveys, are in line with the national average for social care and mental health services.

In addition to this, the Friends and Family Test (FFT) shows that in 2015 91.2% of staff at WNE Cumbria's acute trust would recommend their place of work compared to national averages of 91.3%, with the top quartile being 96.5%. However, the results should be treated with some caution, given the national response rate was c.23%.

Similarly to the staff FFT, the FFT for patients shows that overall WNE Cumbria's acute trust is in line with national benchmarks, both recommendation rates for inpatients and outpatients are in line with national average, whilst A&E is c.7% below the national average.

Fig [17]: Overall GP experience

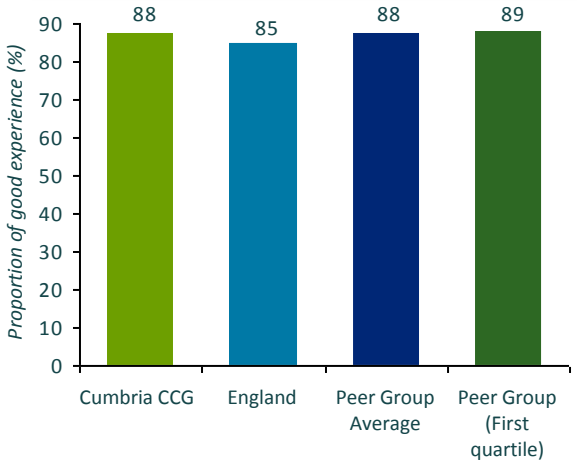


Fig [18]: Adult social care survey outcomes

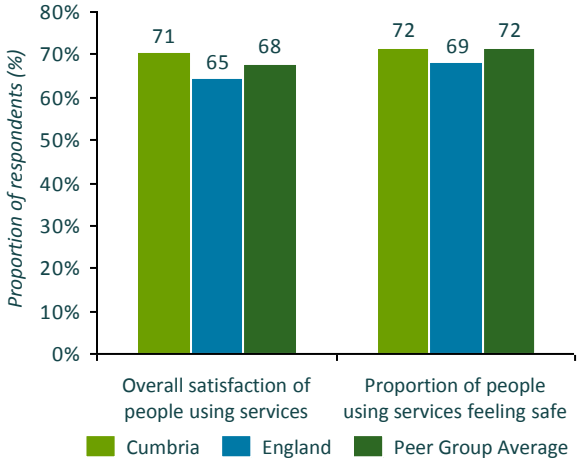
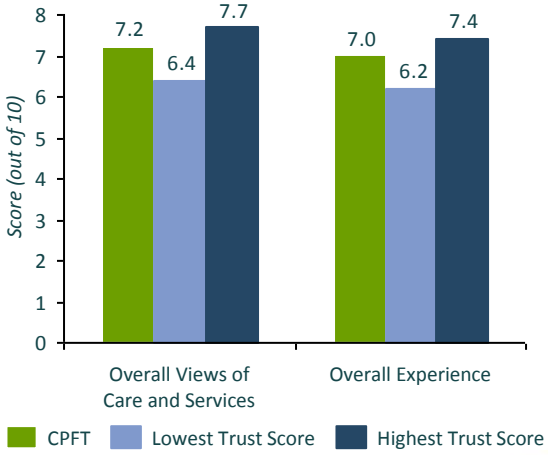


Fig [19]: Mental health patient survey outcomes



Source: QOF 2014 - 15, HSCIC 2014-15, Adult Social Care Outcomes Framework 2014-15; Patient Survey Report 2015
For the 2015 Mental Health Patient Survey, 13,000 responses were received, with a response rate of 29%.

A&E attendances and emergency admissions at the main acute hospital have increased by c.10% and 20% respectively over last four years

Overall A&E attendances per capita are and have been historically lower than national average (as seen in Appendix B), potentially due to the rurality of the area and longer travel times patients have to face.

However, attendances at the North Cumbria University Hospitals Trust (NCUHT) A&E department have increased by c.10% over the last four years, compared to a growth rate of 4% across peers. Growth at NCUHT remains below the level observed nationally at c.19%.

Emergency admissions have also increased by 20% between 2011 and 2015, compared to increases of 6% and 4% nationally and across peers respectively. The growth in A&E and admissions suggests increasing pressure on the system.

A similar picture arises when looking at A&E Type I attendances in WNE Cumbria. Comparing weekly information* across 14/15 and 15/16, these types of episodes of care seem to have increased by c.8% across the patch.

Fig [20]: Growth rate in A&E attendances**

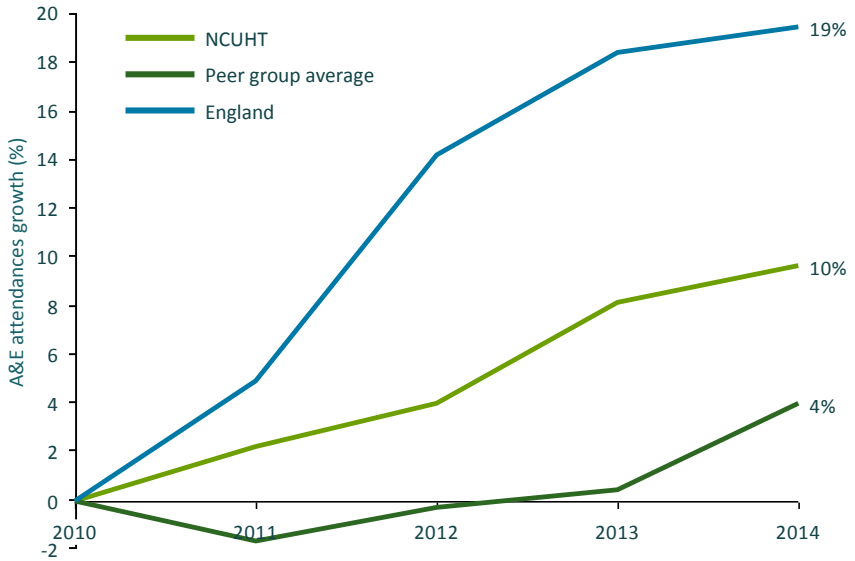
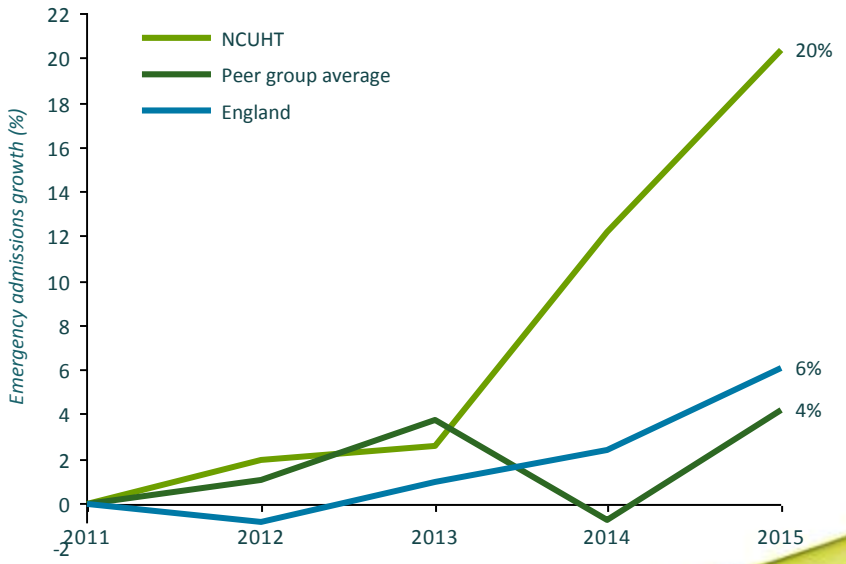


Fig [21]: Growth rate in Emergency admissions



Source: HSCIC, HES

**Weeks 19 to 23, data obtained from NECS*

***Peer group trusts as defined by NHS productivity have been used and include QE Gateshead, CHSFT, Northumbria Healthcare, UHMB. STFT and Newcastle Upon Tyne Hospitals Foundation Trust have been removed from the peer group due to irregularity between 2011-2012 where attendances more than doubled.*

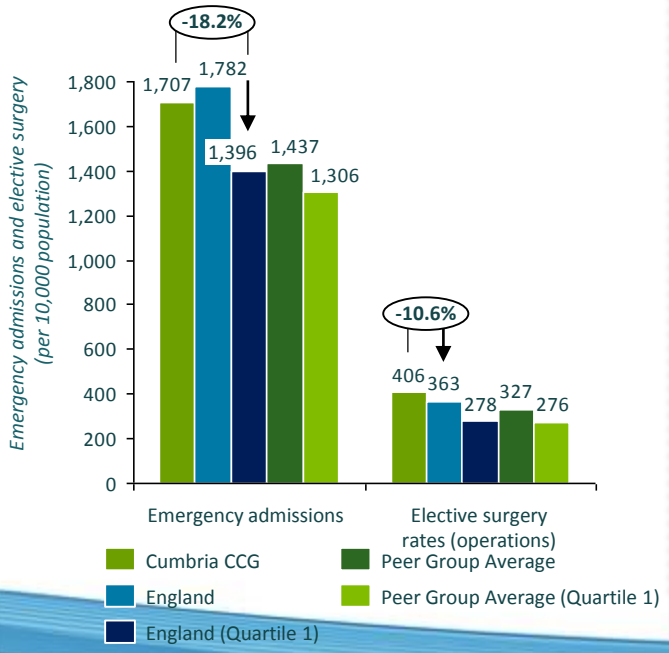
Utilisation of services across settings of care is high

A number of sources suggest that non-elective admissions are broadly in line with national and peer averages, but there could be scope to improve.
Mental health contacts and attendances are c. 30-40% higher than other organisations nationally.

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 the peer group.

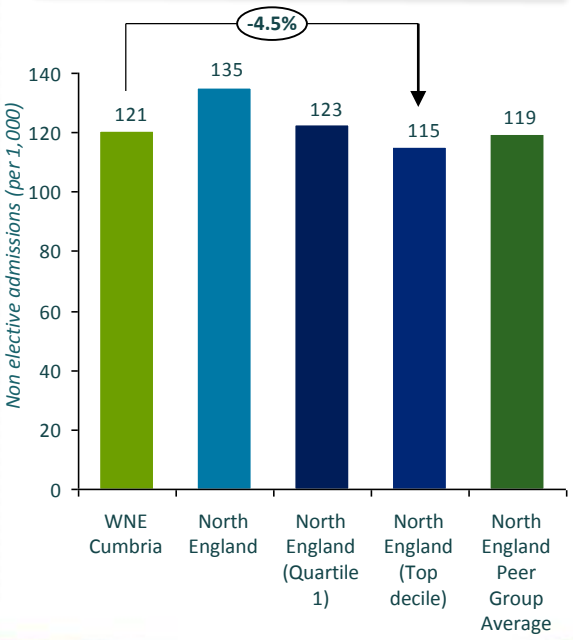
Reviews conducted by the Oak group report have also highlighted that within District General Hospitals, the levels of non-qualified admissions are largely in-line with the national average. However, the Oak Group also reports non-qualified continuing days of stay to be much higher than the national average in both acute and community care. This contrasts with positive performance in the more high level Length Of Stay (LOS) indicator where both acute and community services are below the national averages.

Fig [22]: Inpatient care indicators



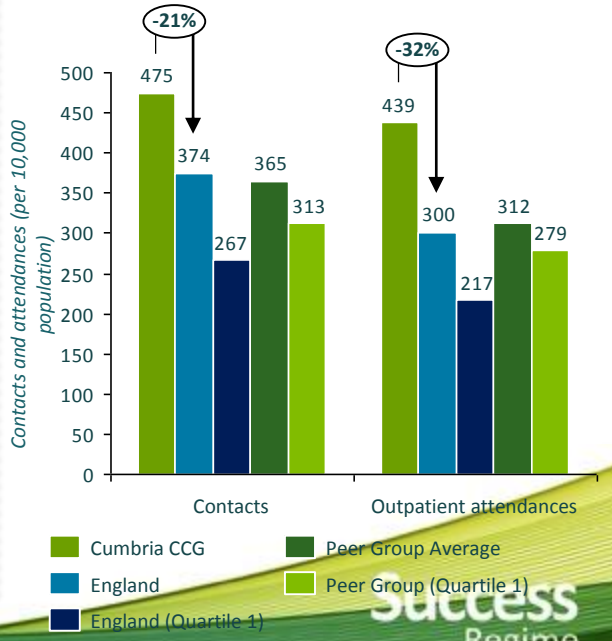
Source: Better Care Indicators 2013/14

Fig [23]: Non elective admissions



Source: Dr Foster – Latest year available (14/15 to 15/16)

Fig [24]: Mental health attendances and contacts



Source: HSCIC (2014/15)

Demand pressures are particularly significant across the UEC pathway

The A&E department has currently not been achieving the 95% four hours target performance. WNE Cumbria's performance has fallen over the last four years. In 2014, the proportion of A&E incidents dealt with under 4 hours was c.94% for both NCUHT and England. More recent (monthly) figures for October 2015 show performance of 85% for NCUHT (compared with 92% nationally*). In addition, admission waiting times are c.18% higher than the national average and 55% higher than peer group average.

The Oak report suggests that 78% of admissions to acute hospitals come through the A&E pathway. Consistent with high levels of NEL admissions, the attendance-to-admissions conversion rate is c.44%, compared to c.25% nationally and c.28% for peers. However, the higher conversion rate could also be impacted by a number of factors. These could include MIU activity not being part of the total A&E activity, potentially differences in patient acuity and referral decisions by GPs.

Fig [25]: A&E attendances resulting in admission

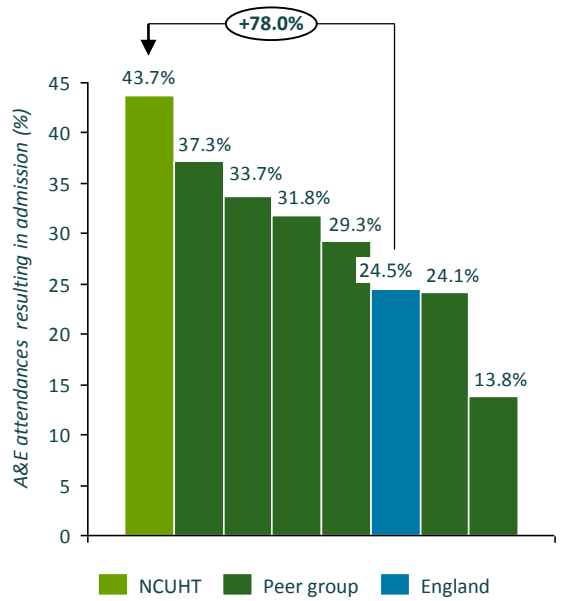


Fig [26]: Waiting time before admission

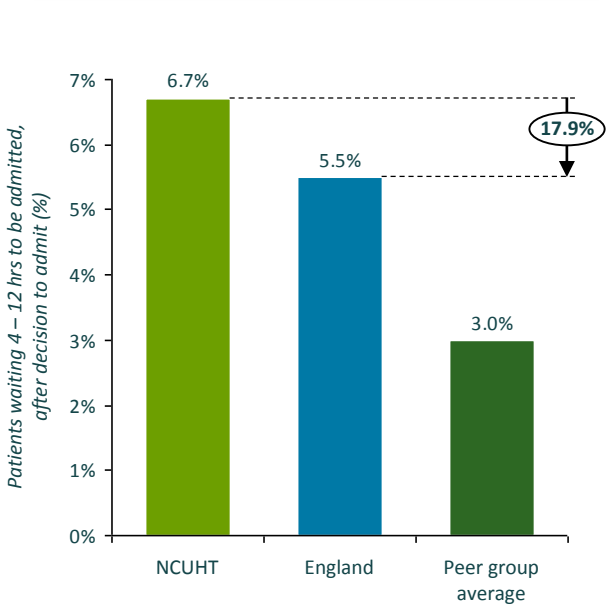
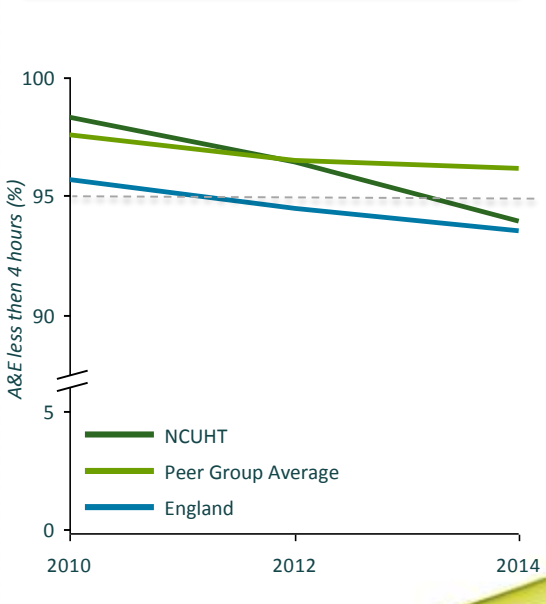


Fig [27]: A&E incidents dealt with < 4 hrs



Source: HSCIC 2014/2015

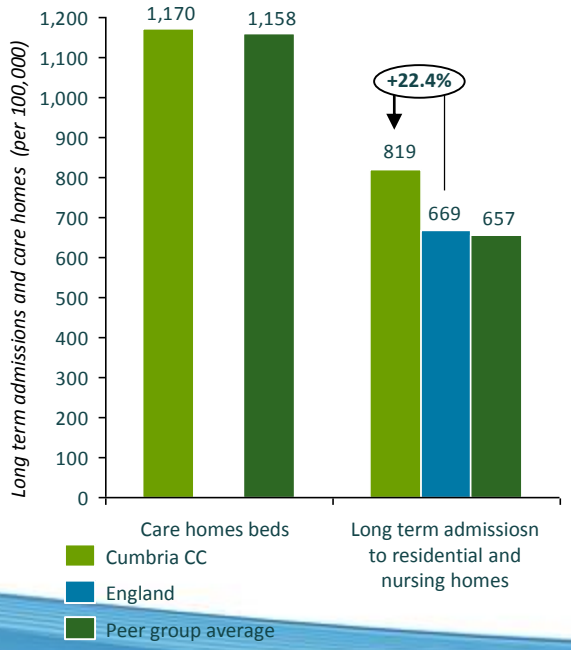
*Peer group data is unavailable for these indicators.

The WNE Cumbria health economy is facing significant demand pressure across health and social care

Cumbria County Council is also facing a number of demand pressures particularly around residential and social care admission. Cumbria is in line with peers for the quantity of care home beds per 100,000, however Cumbria has a much higher proportion of long term admissions to residential and nursing homes, underpinning that utilisation is higher than peers. Pressure can also be seen in the bed occupancy for community hospitals, where WNE Cumbria is consistently above the 85% occupancy threshold target. This is a long standing issue as can be seen in Appendix B.

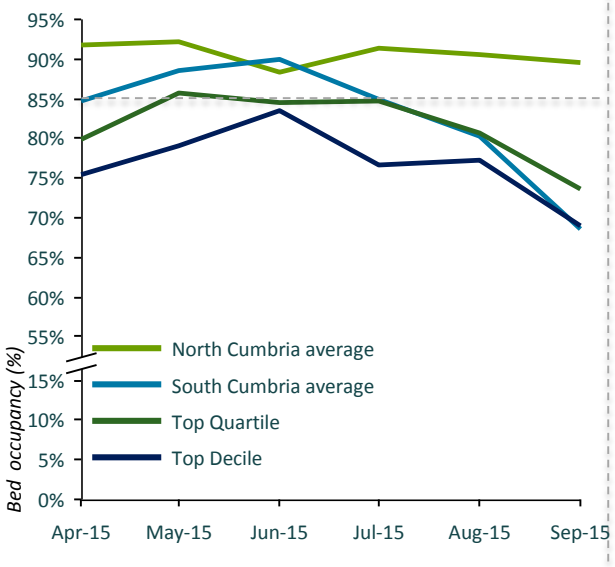
On the other hand, capacity in primary care services seems to be relatively in line with needs. This is reflected in a relatively high GP per population ratio, which is c.18% higher than national average. However, other indicators presented in the following slides suggest that primary care could be better integrated with the rest of the system.

Fig [28]: Care homes and Long term admissions to residential and nursing care homes



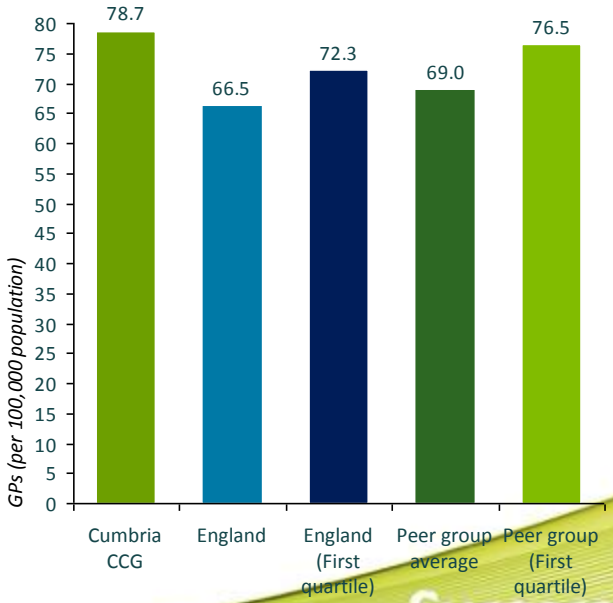
Source: ASCOF 2014/2015; correction proposed by Cumbria CC

Fig [29]: Bed occupancy at Cumbria community hospitals



Source: CQC, Nov 2015

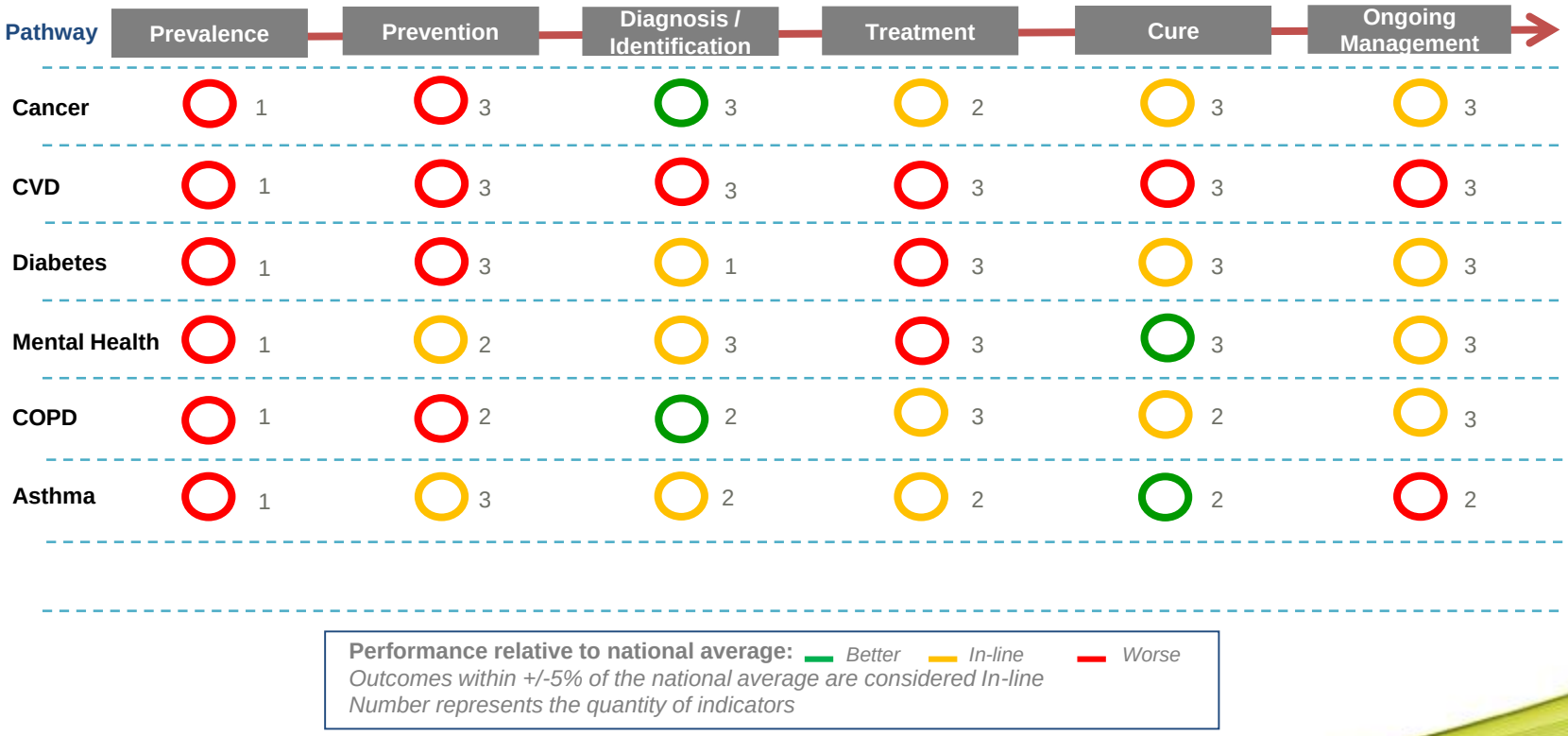
Fig [30]: Number of GPs



Source: Data provided by the Cumbria CC

There is potential for more preventative care along the pathway for key disease groups

The summary analysis along key pathways below shows that indicators in the earlier stages of the pathway, around prevalence and prevention, could be improved compared to national averages. Ongoing management of patients also highlights some areas of potential development; for instance, rates of follow up depression assessments in Cumbria are much lower than the peer and benchmark averages. The detailed indicator analysis is presented in Appendix A.



Note: *Average scores reflect performance and degree of variation between Cumbria relative to national average. Number next to the performance indicator represents the number of outcomes assessed. Source: HSCIC; ONS*

A more effective prevention strategy could reduce future pressures further along the pathway

The pathway analysis presented in Appendix A suggests that WNE Cumbria could improve its approach to preventing major illnesses. Cumbria is below national benchmarks across a range of prevention indicators (e.g. smoking/obesity prevention and cardiovascular risk assessments for hypertension patients), signalling a higher likelihood across the region to contract major diseases. For example, after a four weeks programme, there were only half as many people who quit smoking in Cumbria when compared to national average.

Fig [31]: Successful smoking 'quitters' after four weeks per 100,000

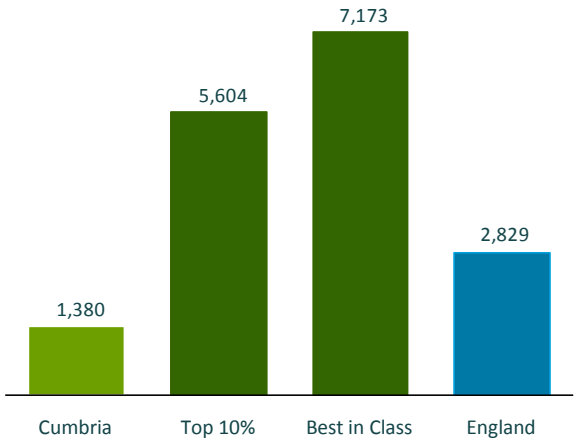


Fig [32]: Obesity prevalence

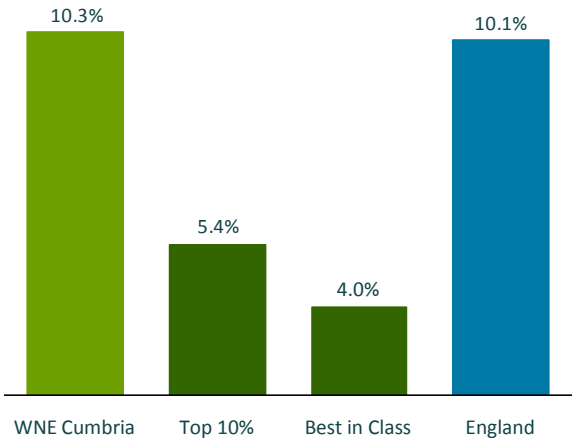
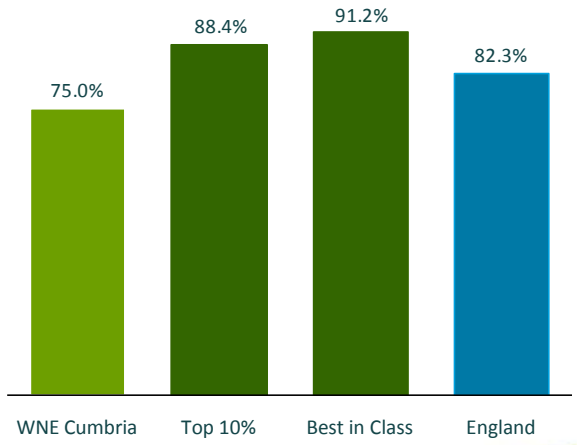


Fig [33]: Cardiovascular risk assessments in patients with hypertension



Source: QOF 2014/2015

Source: HSCIC 2012/2013

Treatment outcomes in WNE Cumbria could potentially be improved by reducing waiting times

The WNE Cumbria health economy is consistently above national averages in terms of Referral To Treatment Times (RTT) and wider waiting times. Within the acute sector, admitted and non-admitted RTT are c.9% higher and waiting times are c.6% above. In mental health and community, RTT times are c.24% above national benchmarks. Reducing treatment waiting times could potentially improve outcomes and patient satisfaction with health and care services.

Fig [34]: Referral to Treatment Times

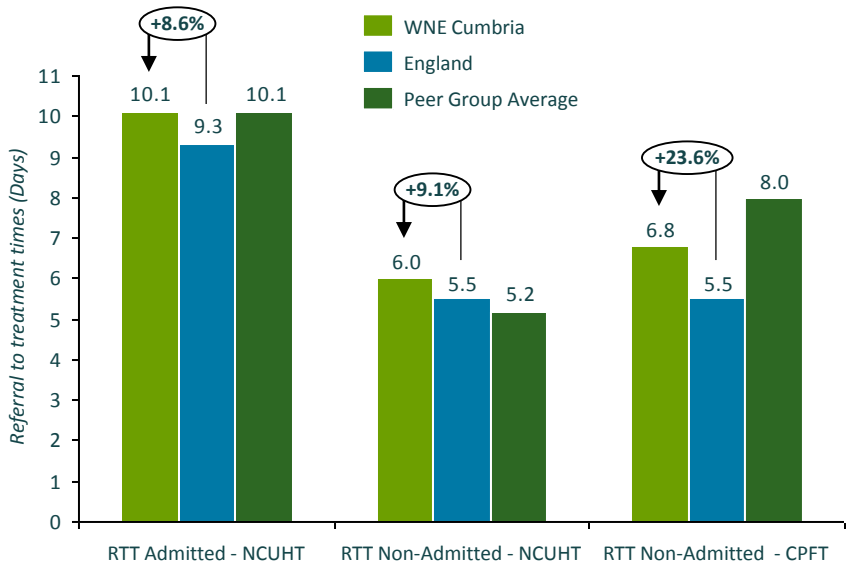
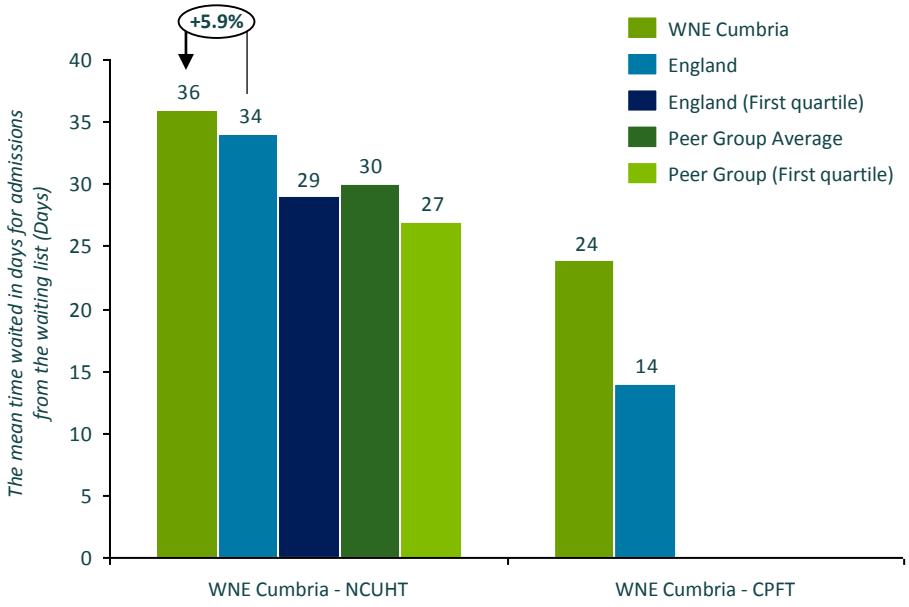


Fig [35]: Median Waiting Times **



Source: NHS England, 2014-15, HSCIC, 2013-14

A degree of variation exists in service utilisation across WNE Cumbria GP practices

Fig [36] Non elective activity per GP in WNE Cumbria

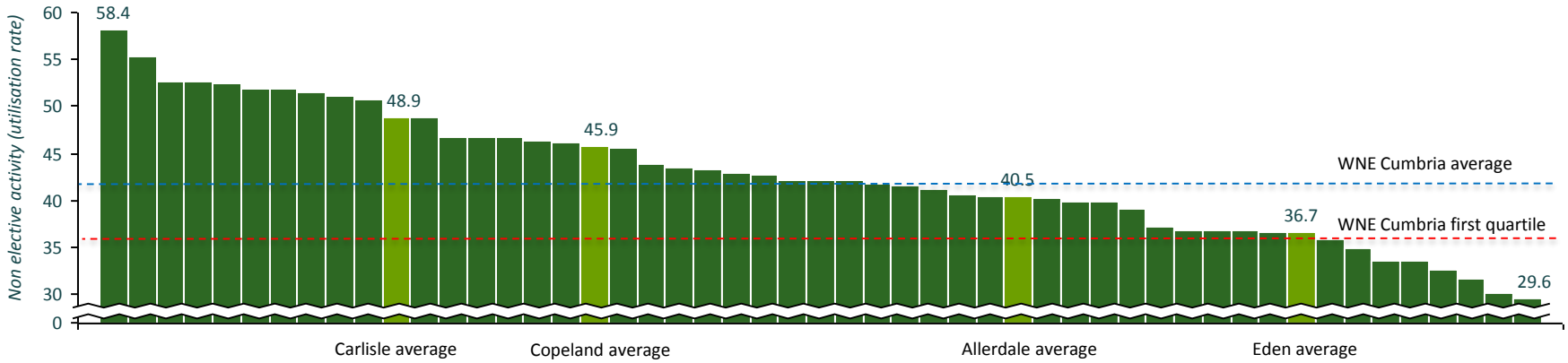
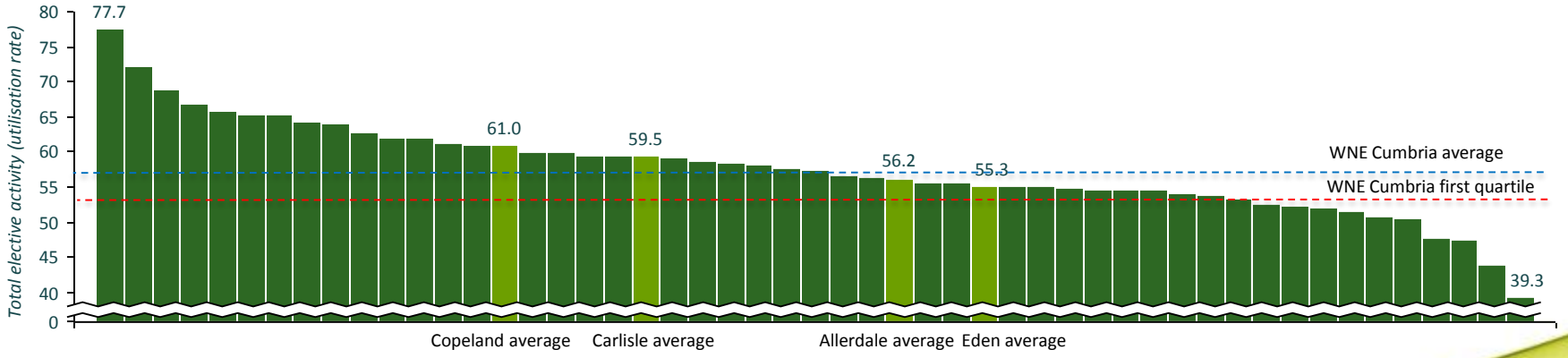


Fig [37] Total elective activity per GP in WNE Cumbria

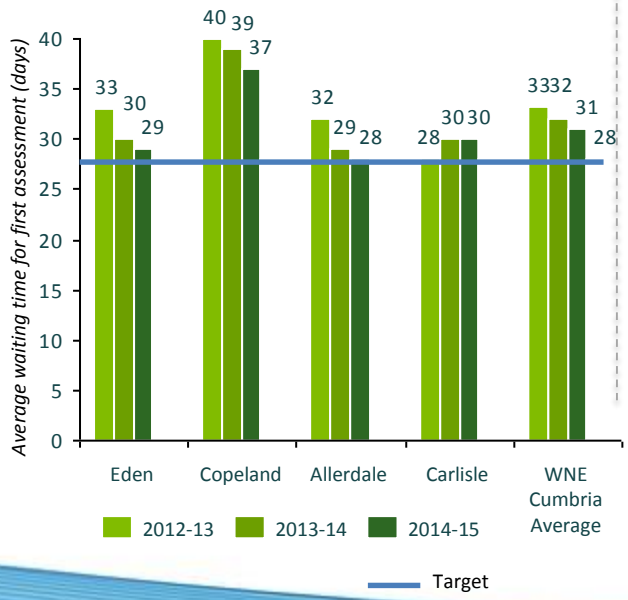


Source: health evaluation data 2013.
**Data is not standardised, which will account for some of the variation between GPs*

Pro-active on-going management of high-risk cohorts in the later stages of the pathway could also help reduce the need for acute episodes of care

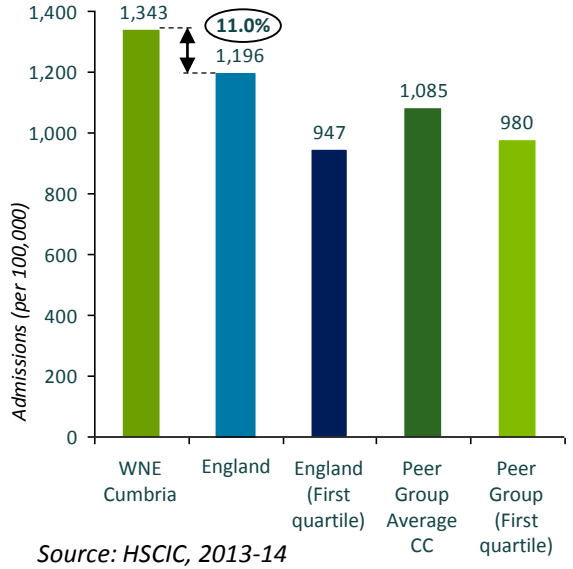
A number of indicators suggests that acute admissions could be treated more within community and primary care. For example, emergency hospital admissions usually managed in primary care are c.3% greater for the Cumbria County Council area compared to the rest of England and c.27% higher than the national top quartile. Emergency admissions that do not usually require hospitalisation are also c.11% higher than the national average. Moreover, the LHCE has experienced a relatively consistent level of avoidable admissions between 2012 and 2014, indicating that the system has yet to find effective strategies to deliver improvement.
The Oak report also highlights WNE Cumbria's problems, with 23% of acute admissions that could potentially be provided at lower intensity settings. Similarly 18% of community admissions were found to be non-qualified.
In social care, waiting times are on average c.11% higher than target for 14/15. However, performance has been improving through the last three years, achieving a reduction of c.6% between 12/13 and 14/15.

Fig [38]: Average waiting time for first assessment in days in Social care



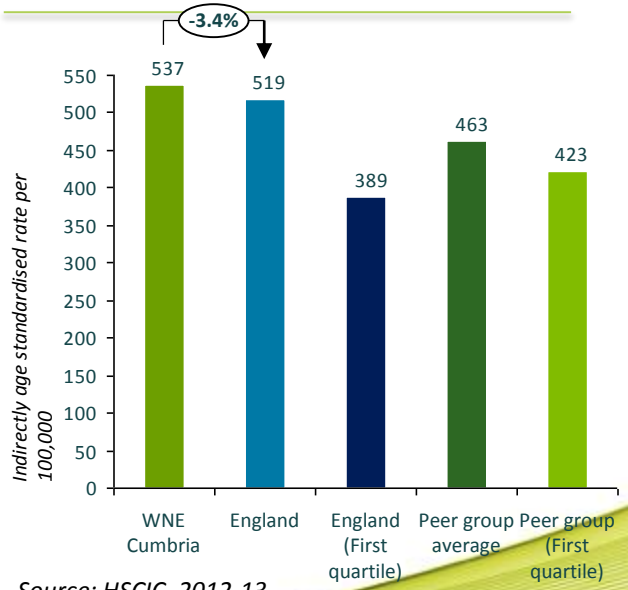
Source: Data provided by Cumbria CC

Fig [39]: Emergency admissions for acute conditions that should not usually require hospital admission



Source: HSCIC, 2013-14
Peer Group: 8 similar Upper/Lower Local Authorities to Cumbria Local Authority

Fig [40]: Emergency hospital admissions for acute conditions usually managed in primary care



Source: HSCIC, 2012-13
Data for 2012/13 standardised to persons 2008/09 in data source

Transfers of care have been handled relatively timely in WNE Cumbria despite the limited availability of social care beds. However, there has been a recent spike in delays

Across WNE Cumbria, patients are moved to their homes or lower intensity settings of care within a short period of time. This is evidenced by delayed transfers of care for acute and non-acute being c.5% lower than national benchmarks. However, this performance has declined over recent months, with the last two months having a c.89% increase in overall delayed transfers across the system and achieved rate being c.17% higher than targeted. The system is however prone to high levels of volatility as highlighted in Appendix B.

The high utilisation of residential and nursing care beds in social care is placing some constraints on the health sector. The rate of delayed discharges due to social care support is c.13% lower than the national and peer group average. Analysis conducted in previous years also shows that the majority of delayed acute discharges are due to external sources, such as the availability of lower intensity beds.

Fig [41]: Delayed transfer of care per 100,000 population – Acute and Non-Acute

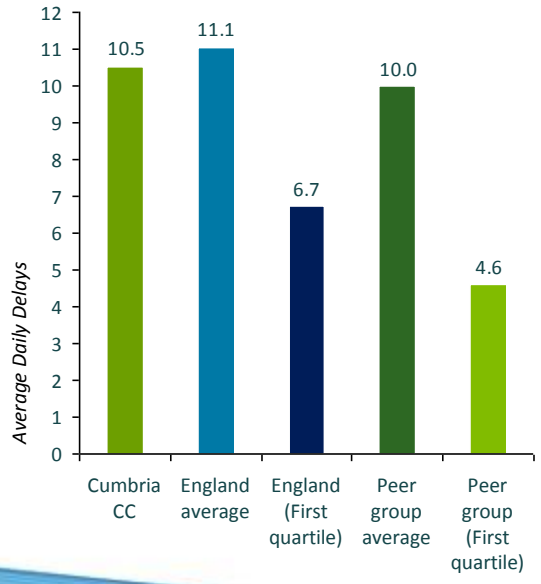
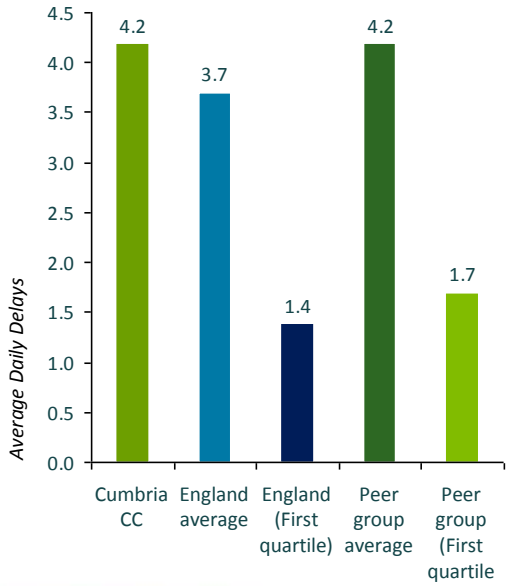
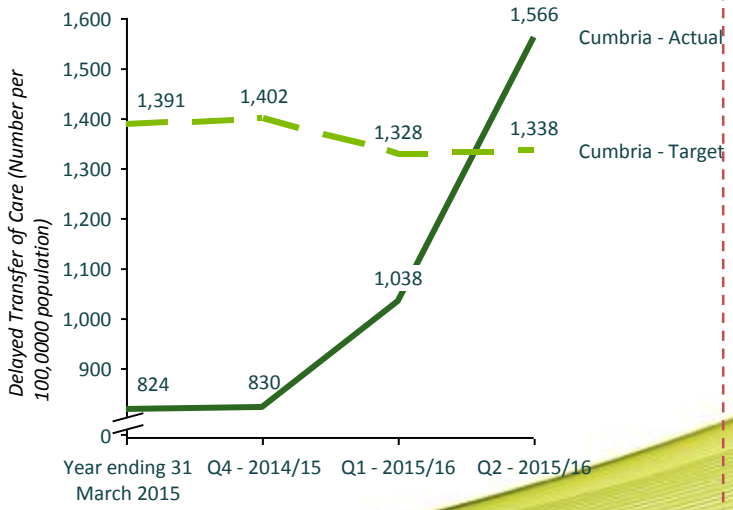


Fig [42]: Delayed transfer of care per 100,000 population attributable to Social Care



Note: County Council currently confirming validity of latest data

Fig [43]: Delayed transfers of care - Overall



Source: NHS England, HSCIC, 2014-15

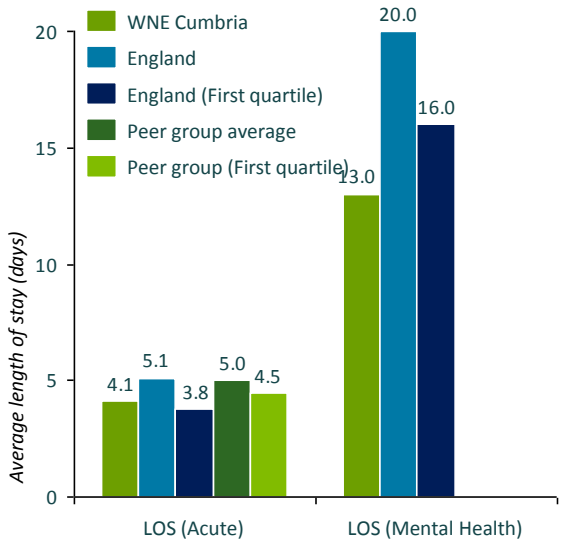
Source: Quarterly performance scorecard, November 2015

Patients' length of stay across different points of care is also in line with national benchmarks

Despite the high utilisation, the WNE Cumbria system seems to be performing broadly in-line with national benchmarks in terms of Length Of Stay (LOS). From an acute perspective, average LOS is c.24% below national average. Similarly, LOS for mental health is c.54% below other trusts nationally*. Over the last two years, the social care sector has also managed to improve its performance in terms of LOS, achieving an average 8% reduction across the WNE Cumbria localities. However, more recently, LOS has increased significantly, this could be linked to the increase in delayed transfer of care established on the previous slide.

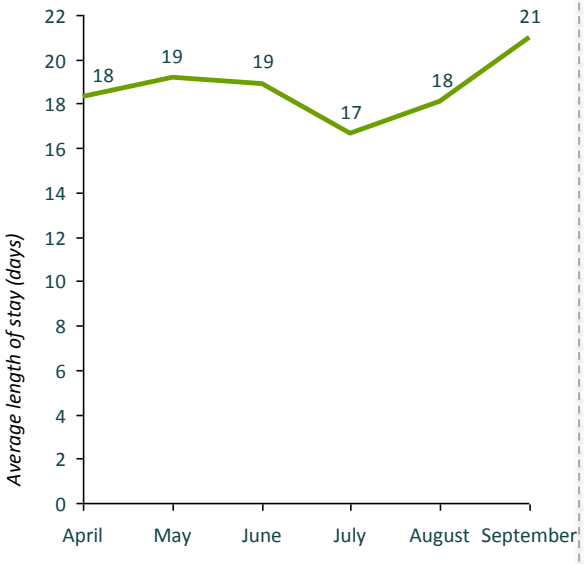
However, length of stay is only a high-level indicator and more in-depth analysis is required to understand effective performance across comparable services and patient mixes. Furthermore, the Oak group report has highlighted that 62% of continuing stay days in acute, and 47% in community, could have been provided at a lower level of care. This, alongside the figures around avoidable emergency admissions, suggests better integration across the system could help ensure that, where possible, patients are treated within a lower intensity settings of care.

Fig [44]: Average Length of Stay in Days



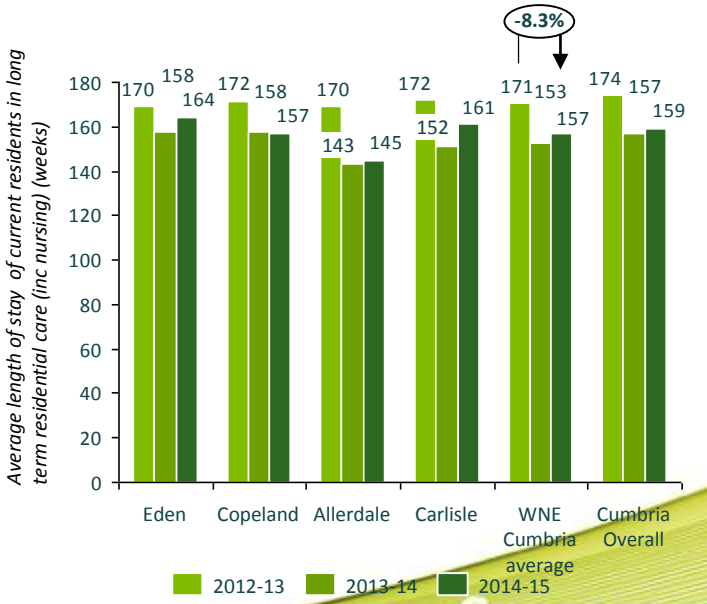
Source: HSCIC 2013/14.
Note: Median LOS for mental health services has been used to minimise the impact of some outlier data points

Fig [45]: Average length of stay



Source: Community Hospital Activity performance pack Sept 2015.

Fig [46]: Average length of stay of current residents in long term residential care (inc nursing)



Source: Residential and nursing care activity 2013-2015 – Cumbria County Council
Data only available for Cumbria CC

* These findings could in part be explained by the higher proportion of beds in community hospitals across WNE Cumbria, but further analysis is needed

Patient views around discharge processes in the LHCE also highlight problems around safe discharge and ongoing management

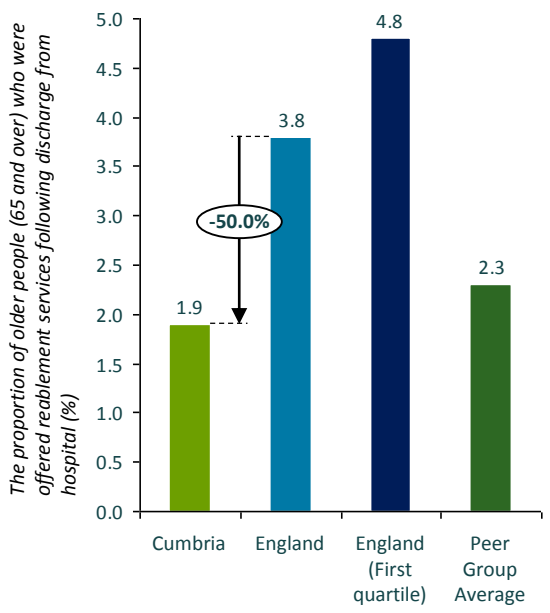
Historically, WNE Cumbria has had a lower rate of emergency readmission following discharge than the national average. However, the system could do more when it comes to supporting and managing patients through and after the discharge process. For example, c.50% less older people are offered reablement services compared to national benchmarks. These issues have also been highlighted in a HealthWatch and Oak Group report. The latter shows that, while non-qualified admissions are largely in-line with the national average of 25% at DGH (District General Hospital) sites, the percentage of non-qualified continuing days of stay (also known as Length of stay) is much higher. The report also highlights that non-qualified acute care days were due to internal reasons 67% of the time, with 53% of those caused by consultant related issues (i.e. 35% of total). External reasons are dominated by a lack of available beds which is responsible for 51% of delays. Within community, half of non-qualified days were due to internal reasons, with discharge process being incomplete creating 58% of delays. Similarly to acute, of the external reasons, more than half (53%) of non-qualified days were caused by no alternative bed being available (see Appendix B).

Fig [47]: Patient Experience of care and discharge – Survey and report results

Care	• 52.8% respondents **'dissatisfied' or 'very dissatisfied'** with treatment • 59.4% respondents felt that **not all health issues were considered** when discharge was planned
Operational Process	• 67% of the reasons of non-qualified days were **within the gift** of the hospital • Of the internal reasons, 28% related to **incomplete discharge process**, and 53% to **consultant issues** • Of the external reasons, 51% emanated from **lack of availability of alternate bed**
Discharge	• 50% respondents **did not feel ready** for discharge from the hospital • 60% respondents **did not feel involved** in the discharge decision making process
Follow-up	• 40% respondents **readmitted** to hospital within 28 days • 70 % of respondents reported that there was **no contact from the relevant healthcare service following discharge**

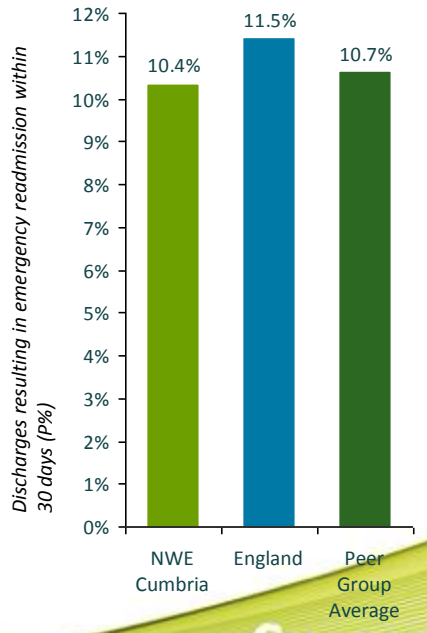
Source: Special Inquiry into Unsafe Discharge – Frail & Elderly Cumbria

Fig [48]: Proportion of 65+ offered reablement services following discharge



Source: ASCOF report, 2014-15

Fig [49]: Discharges resulting in emergency readmission



Contents

Funding, Efficiency and Sustainability

WNE Cumbria is facing a series of sustainability challenges across finance, workforce, estates and IM&T

Workforce

WNE Cumbria has consistently struggled across a number of workforce related areas.

Providers of care are having to cope with ongoing recruitment and retention pressures, particularly around medical posts. Due to these difficulties, the system has been heavily reliant on a temporary workforce, with over 150 locums being used across mental health, community and acute care. Primary care is also facing difficulties, with a 25% shortage in some GP areas.

These issues will need a number of system solutions including training or career development opportunities, improving, new role and more technology enabled care.

Further analysis on the key workforce fragility is being undertaken by the workforce work stream within the Success Regime.

Financial information is being updated and will be available by the end of March.

Estates and IM&T

The LHCE is characterised by a highly fragmented estate deployed across a wide geography. Quality issues have also been identified, with Patient-Led Assessments of the Care Environment (PLACE) scores being below national averages across various sites. Diverging organisational directions have also not enabled the delivery of an integrated system-wide estate strategy, which has been one of the partial drivers of the current footprint.

Key areas of the system's estate require significant redesign and quality improvement in order to support future care models. Providers of care will have to develop an estate stratification and an integrated estate strategy to deliver the required improvements.

Some key informatics enablers are in place. However, shared strategy decision making and delivery have contributed to factors such as the complexity of the LHCE, and the lack of clarity over future organisational structure, mandate and the accountable strategy for delivery groups.

WNE Cumbria is currently facing significant difficulties in recruiting and retaining staff across all points of care, with key specific areas lying in primary and acute care pathways

Primary care

Primary care workforce issues are a national problem, and due to this national shortage of staff, areas like Cumbria are struggling to compete and attract staff. WNE Cumbria currently has c.19 WTE GP vacancies (c.11.25% of expected GP establishment), with some of these positions vacant for up to two years. WNE Cumbria also suffers from the additional pressure of having a high proportion of older GPs. This means that, by 2020, 25% of its current GPs workforce will be looking to retire adding pressures to the workforce issues across primary care.

Acute care

Despite efforts by the acute trust to improve the numbers of medical consultants employed, there are numerous vacant consultant posts. In March 2015 there was a deficit of 55.8 WTE. Some vacancies are covered by locum doctors in areas, with 51 rotas dependant on locum medical staff. This represents an incredibly large amount of the Trust's medical workforce and signals difficulties in recruiting and retaining permanent staff. Within Nursing, the minimum staffing levels set for wards and departments are often covered by bank staff, overtime and agency nurses. Even with a high level of temporary staffing, vacancy rates are still high which has an adverse effect on the timeliness of treatment for patients and support to junior staff members.

Mental health, community care and social care

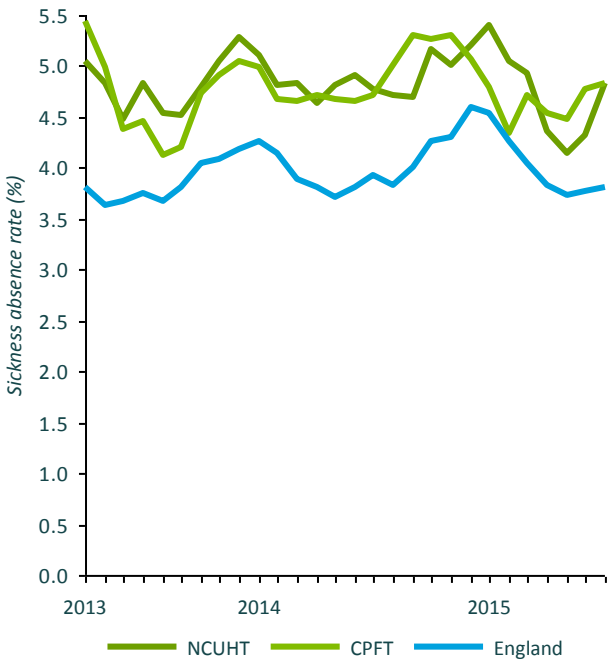
Key areas of workforce fragility exist in psychiatry, nursing and social workers. These are presently being tackled by a number of measures, including temporary staffing, however the level of fragility is less than the current risks faced by primary and acute care. However, without significant remodelling of services, these fragilities will increase by limitations presented by the structure of the workforce; for example, temporary reductions in the number of sub-acute or community hospital beds due to pressures in staffing numbers.

Source: Cumbria General Practice Development Plan November 2015, North Cumbria University Hospitals NHS Trust Quality Report. March 2015. North Cumbria University Hospitals NHS Trust, Trust Board Date of Meeting: 24/11/2015

Workforce issues are also reflected in low system-wide ratings across staff satisfaction metrics

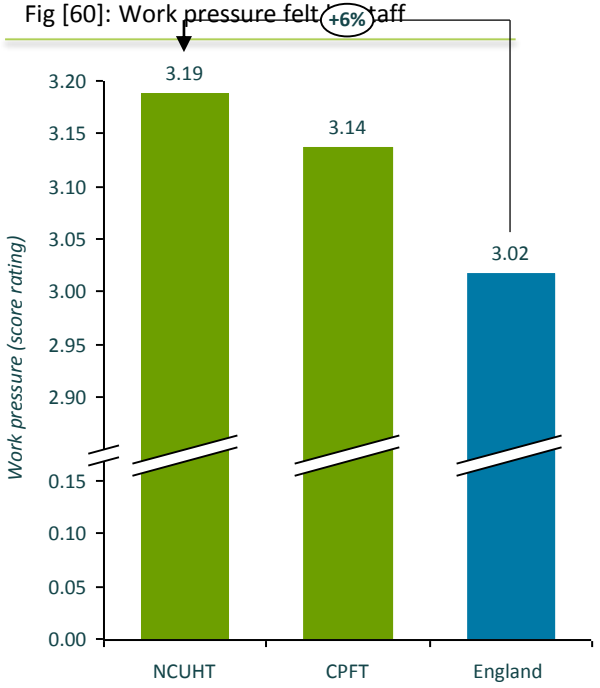
Both NCUHT and CPFT have had sickness absence rates significantly above national averages for several years, with the most recent figures being c.26% greater than other providers nationally. In addition to this, both trusts have high levels of work related pressure felt by their staff, with both the acute and the mental health/community provider being c.6% and 4% above other providers nationally. These factors are likely to impact on the systems ability to recruit and retain staff, limiting providers ability to deliver high-quality care.

Fig [59]: Sickness absence rate



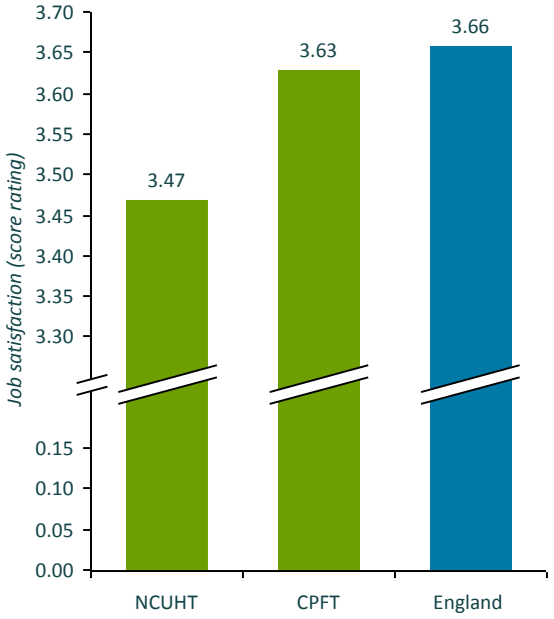
Source: HSCIC 2013/15

Fig [60]: Work pressure felt by staff



Source: National NHS staff survey 2014

Fig [61]: Staff job satisfaction (high is better)



Source: National NHS staff survey 2014

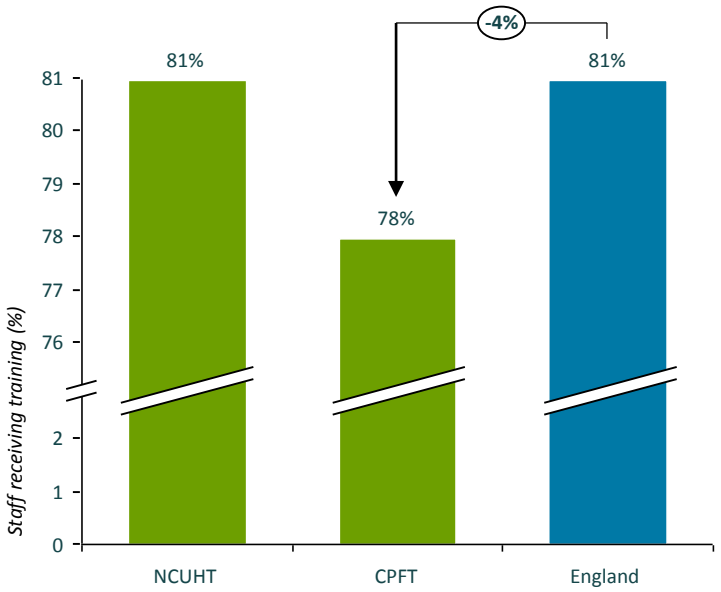
Workforce training and development could be improved in WNE Cumbria

The providers in the LHCE have also been facing challenges in training and developing their staff. The acute provider achieved its target with c.80% of staff completing all mandatory training, though performance varied across services and professional groups. The proportion of staff to have an appraisal (an important driver of career development) was the same as the national average (84%), however only 30% of staff considered this appraisal to be 'well structured'*. Some parts of the health economy have already initiated work to address this.

Similarly, only 78% of CPFT's workforce has received training in the last year. Of all staff, 76% had an appraisal, and 32% of all staff found this appraisal to be well structured.

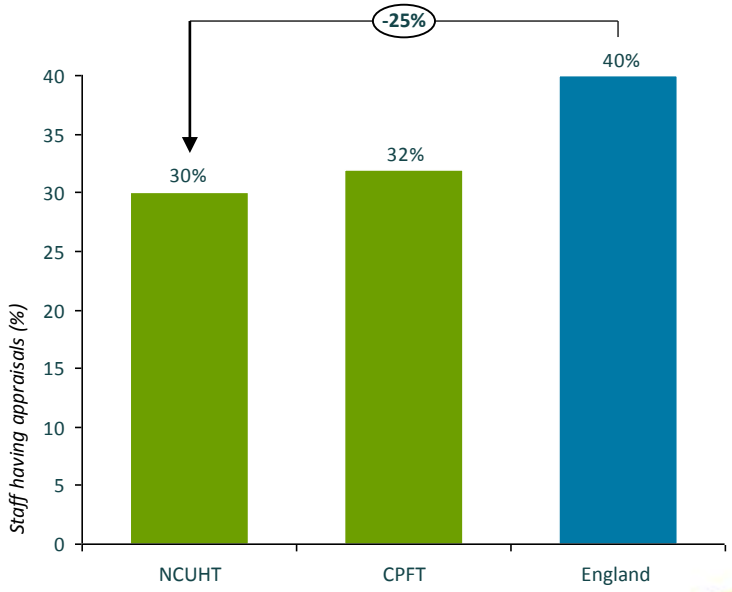
Addressing some of these training and development issues could potentially lead to an improvement of the recruitment and retention problems faced by the system.

Fig [62]: Staff receiving job related training/learning/development in the last 12 months



Source: NHS staff survey 2014

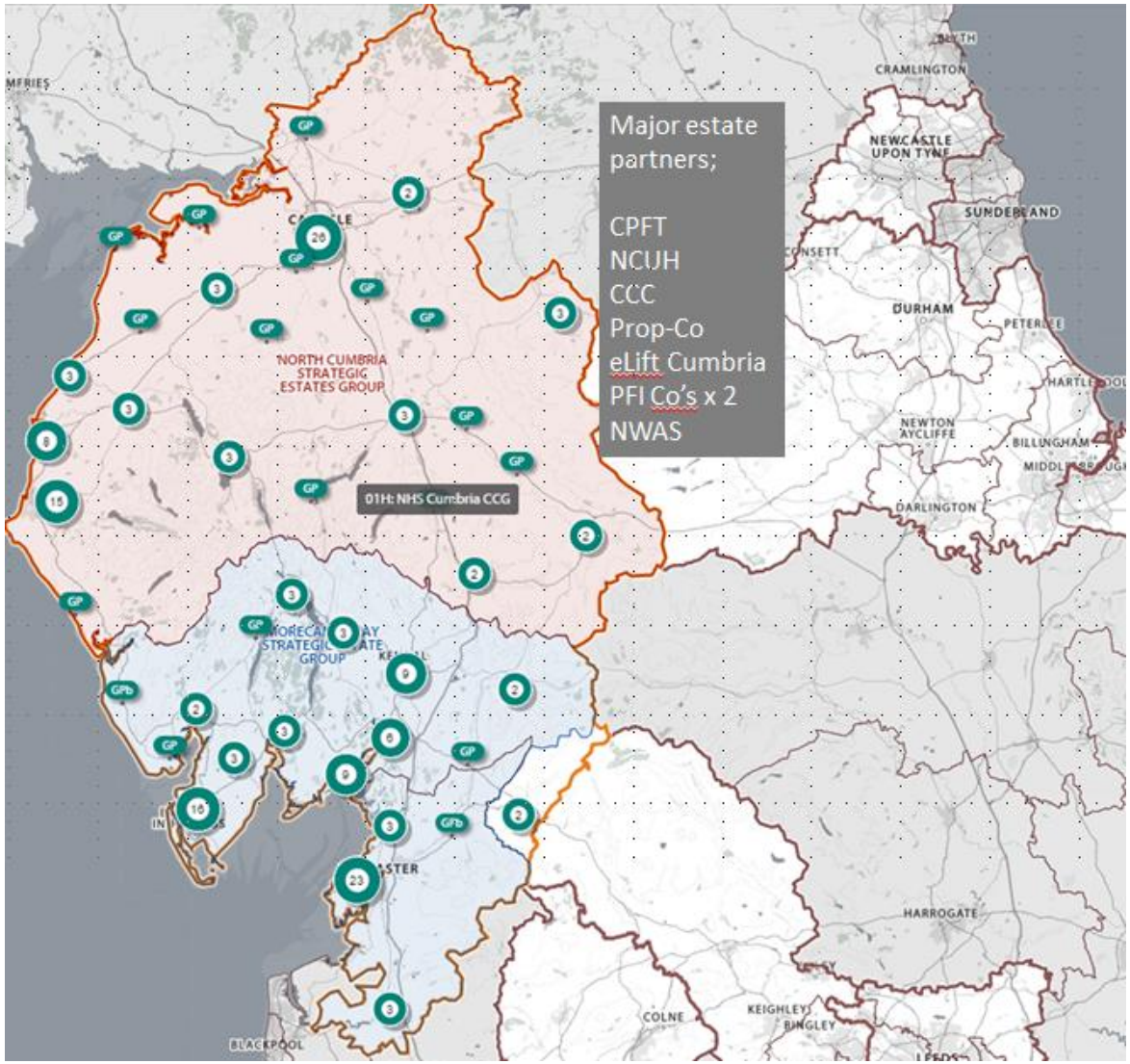
Fig [63]: Staff having well structured appraisals



Source: NHS staff survey 2014

**A staff member is considered to have had a 'well structured' appraisal if they answered 'yes' to the following questions: 'Did it help you to improve how you do your job?', 'Did it help you agree clear objectives for your work?', and 'Did it leave you feeling that your work is valued by your organisation?'.*

The estates available to the system are spread across a wide geography



Success Regime
West, North & East Cumbria

WNE Cumbria could improve its estates management strategy to address financial pressures and facilitate changes to the model of care

- The LHCE is characterised by a very fragmented estate deployed across a wide geography. There is also a lack of estate stratification and integration across partners. As such, the system's estate requires significant redesign in order to support future care models.
- This has resulted in historic under-development of key sites and opportunistic piecemeal development across the patch. Backlog/upkeep is a major future financial pressure.
- Estate planning has been tactical and an integrated strategic approach is not fully in place for the patch due to previously diverging organisational directions.

Lift Company in Place – not all partners signed up

Two PFI's on patch- both have performance issues

Estate issues exist at all levels (acute, ambulatory, primary and support services)

Most sites are multi-occupancy and where inter-organisational estate issues have arisen they have not been solved.

Fig : Summary estates statistics

Sector	Number	Floor Area (GIA m2)	Floor Area (%)	Annual cost (£m)	Annual cost (%)
Acute	2 sites (15 buildings)	115,077	74%	£20m	62%
Community/Mental health	15	41,290	27%	£8.45m	26%
Primary care	60	N/A	N/A	£3.79m	12%
Total	**77**	**156,367**	**100%**	**£32.24m**	**100%**

Estate sites in WNE Cumbria could be improved across a number of areas

The estates pressure faced by the LHCE are partially illustrated through the summary PLACE (Patient-Led Assessments of the Care Environment) scores. These scores cover important measures that have been identified by patients as important. The sites of the acute provider seem to require the most significant improvement, with Cumberland Infirmary being the least satisfactory between of the two establishments by a margin. Community and mental health facilities are only doing marginally better, with mental health sites being the best and scoring well on the Privacy and Dignity domain.

PLACE outcomes reinforce the message that WNE Cumbria estates need to be brought up to standards in light of the system redesign and the new clinical strategy.

Fig [64]: Summary PLACE scores (2015)

Estate Type	Privacy and Dignity % Score	Condition % Score	Cleanliness % Score
CIC	76%	77%	91%
WCH (prior to new hospital opening)	83%	76%	91%
CPFT – Mental Health (Range over 2 sites)	91% - 97%	94% - 95%	99% - 100%
CPFT – Community (Range over 9 sites)	69% - 87%	80% – 99%	91% – 100%
National average (at site level)	87%	91%	98%

Key: = performing above 5% of national average; = performing +/-5% of national average; and = performing below 5% of national average.

Metric definitions:

- **Privacy and dignity:** shows how fit for purpose the design is (e.g. provision of recreation areas, changing and waiting facilities, access to media etc.)
- **Condition:** indicates how much backlog maintenance required (e.g. lighting, condition of fixtures and fittings, car parking, waste management)
- **Cleanliness:** indicates how well the facility is being managed now (including patient equipment, bathrooms, furniture, floors, fixtures)

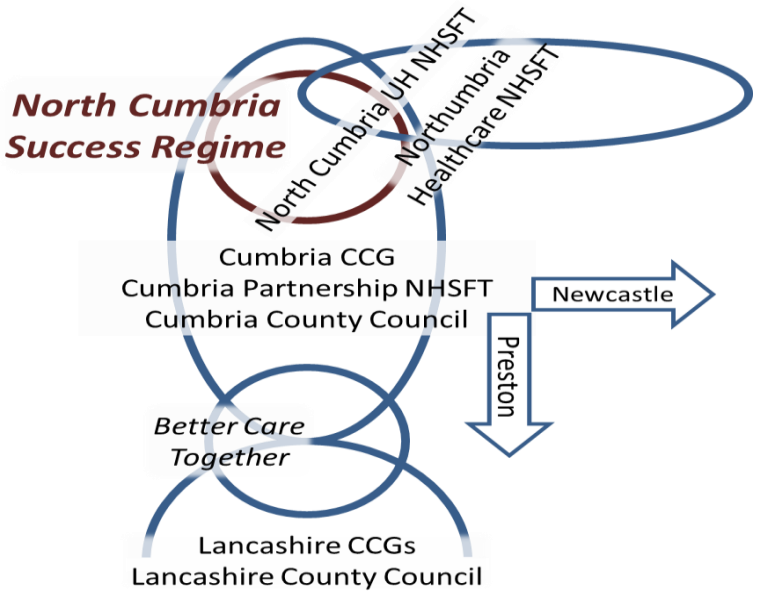
The IM&T infrastructure and resources are deployed across a broader area than WNE Cumbria alone

Some key informatics enablers are already in place across the LHCE. These include things such as infrastructure, primary care systems and governance.

However, shared strategy, decision making and delivery has been delayed or prevented by factors including:

- Complexity of the health and care economy
- Intra-organisational funding
- Inter-organisational (inter-personal) relationships
- Lack of clarity over future organisational structure, mandate and authorised / accountable strategy and delivery groups
- Lack of effective clinical engagement in strategy development and requirements specification

Fig [65]: IM&T deployment map



To provide a baseline on key issues over 30 senior clinical and informatics professionals in primary and secondary care were interviewed in an independent process facilitated by NHS England. The process was conducted for the Success Regime to provide input into the Cumbria Digital Roadmap as part of the current national informatics roadmap exercise.

The following slides will present the IM&T baseline, strengths and risks/barriers in WNE Cumbria alongside the identified areas of action

Strengths, Risks and Baseline

Strengths

- Hardworking staff committed to clinical service delivery enabled by informatics
- System convergence and interoperability (e.g. EMISweb, Strata, ICE)
- Pan-Cumbria infrastructure (e.g. COIN, Wi-Fi)
- Transformative digital technology potential (e.g. Cumbria Rural Health Forum)
- Excellent information governance service

Barriers and Risks

- Lack of agreed strategic informatics direction driven by clinical service strategy
- No agreed strategy for data management, quality improvement, development and business analysis
- Lack of interoperability decreases safety of transfers of care
- Inefficient processes; variable levels of digitisation
- Individual relationships are sound but cultural legacy stifles integrated decision making and delivery
- Staff recruitment and retention

Baseline

- Primary Care has generally well developed systems and digital records, system standardisation
- Community service implementing EPR concerns noted about service requirements and interoperability
- Secondary care mainly reliant on paper and inefficient processes. Delayed strategic decision making and delivery of clinical e-documentation
- Social care not generally integrated into data flows
- Need for increased sufficient & effective clinical engagement
- Infrastructure foundations and skilled staff in place

Identified areas for action

Short Term Improvements

- Acute hospital systems implementation moving to paper-light
- Health and care economy informatics governance structure agreed and implemented
- Production of a prioritised plan for data and digital transformational change
- Prioritise development of electronic transfers of care within and between organisations

Medium Term Transformation

- Create sustainable shared informatics transformation programme
- Clear MoU, governance and accountability to all boards
- Pooled funding and resources where necessary
- Health and care economy benefits-based decision making
- Clinical engagement and informed client programme to increase effectiveness of strategic and tactical decision making
- Change the dialogue to the art of the possible
- Organisational development to support economy working

Leadership

- Share existing good practice, knowledge and skills – create a hub of excellence
- Recognise the balance between delivering the new business as usual data and digital landscape with innovation
- Jointly agree and roll out innovations that return efficiency savings, safer care and higher quality
- Commit to improving data quality, data flows and business intelligence across the economy

Contents

Historical and Governance context

The local health and care economy has been facing some historical challenges governance

Organisational change

A considerable amount of organisational changes have happened within the health and care economy over the last 15 years.

This has resulted in:

1. Fragmented and underdeveloped inter-organisational relationships; and
2. Limited stability to identify, address & embed common system-wide goals.

Regulatory scrutiny

Monitor, TDA, CQC and Ofsted all have identified concerns about quality and sustainability in various aspects of WNE Cumbria.

Public confidence

There is limited public confidence across the system.

This is due to the :

1. Many and longstanding issues which are evident locally; and
2. Inconsistent and intermittent system efforts to counter the public perceptions and wider experiences.

WNE Cumbria has faced significant organisational changes over the last 25 years

- One acute hospital Trust in Carlisle
- One combined integrated Trust in West Cumbria (Mental Health, Community & Acute)
- One Community and Mental Health Trust in East Cumbria
- One Health Authority (HA) - combined from HA & Family Health Services Authority (FHSA)
- Few GP fund holders – limited to a handful of larger practices in Carlisle, Maryport & Workington
- One Cumbria Ambulance Service Trust
- One Cumbria Social Care (Adults and Children) department in Cumbria County Council

- One acute hospital Trust across WNE Cumbria
- One combined Mental Health Trust across WNE Cumbria - in 2007 this expanded to cover all of Cumbria
- Community services provided by three Primary Care Trusts (PCT) - in 2006 these merged into 1 Cumbria PCT
- GPs moved to new national contracts in 2004
- North West Ambulance Trust created in 2006
- Separation of adults' and children's social care into two separate directorates in 2006

- One acute hospital Trust across WNE Cumbria – acquisition path with Northumbria
- Mental Health & Community Services combined in one countywide Trust
- PCTs cease to exist and CCGs are created
- Two GP Federations formed
- Cumbria Alliance (CEO)'s launch two key programmes and then Success Regime in WNE Cumbria
- Public Health transfers to Cumbria County Council

Over recent years, the WNE Cumbria health and care economy has been subject to increasing scrutiny by the regulators

Monitor Making the health sector work for patients	Longstanding interest in Quality Governance improvements required at CPFT (now improving and close to being resolved). Recent interest in Financial Performance deterioration at CPFT over last 12 months (now improving) but long term issues remain un-resolved. Interest in securing the best outcome for Northumbria acquisition.
tda Trust Development Authority Quality. Delivery. Sustainability.	Longstanding interest in securing a viable future for NCUHT via an acquisition process with Northumbria. Ongoing support provided on financial and performance issues – financial sustainability a major issue for many years.
Care Quality Commission	Two inspections at NCUHT highlighting areas for improvement (and areas of good practice). The initial inspection prompted "special measures" and the second inspection noted progress on key issues but a much broader "system" effort required to secure overall high quality for acute care sustainably. CPFT inspection took place in Nov 2015 and outcome not yet known.
Ofsted	Cumbria County Council children's services placed in highest category of risk/poor performance following longstanding regulatory concerns.

The public has been voicing its concerns over the sustainability of the health and care system, as well as reporting high levels of patient experience

Despite a vocal and concerned public, there have been several examples of health and care workers and the wider population working together to make system wide improvements. The ambition of bringing these isolated movements together into a wider programme is very much at the heart of the Success Regime

A strong public opinion has been voicing its concerns over the issues faced by the health and social care services

- *The vibrant and strong natural communities across WNE Cumbria have a strong sense of local pride and ownership of visible local services (e.g. hospitals built by subscription)*
- Longstanding **fear** of :
  - **Service retractions** from West Cumbria – Acute & Mental Health (based on real actual bed reductions and perceived reductions in services over a long time); and
  - **Reductions in beds** in community hospitals following stark proposals to consolidate sites in 2005 and resultant widespread public protest.
- Widespread **perceptions** of:
  - **Poor quality** of some local acute services evidenced by increased out of county flows (patient choice); and
  - Carlisle **PFI** being a major contributing factor to the issues faced by the LHCE.
- Split views on the **benefits of acquisition** (summarised as East Cumbria supporting and West Cumbria opposing) reinforced by position of respective MPs.

Public confidence has also been eroded

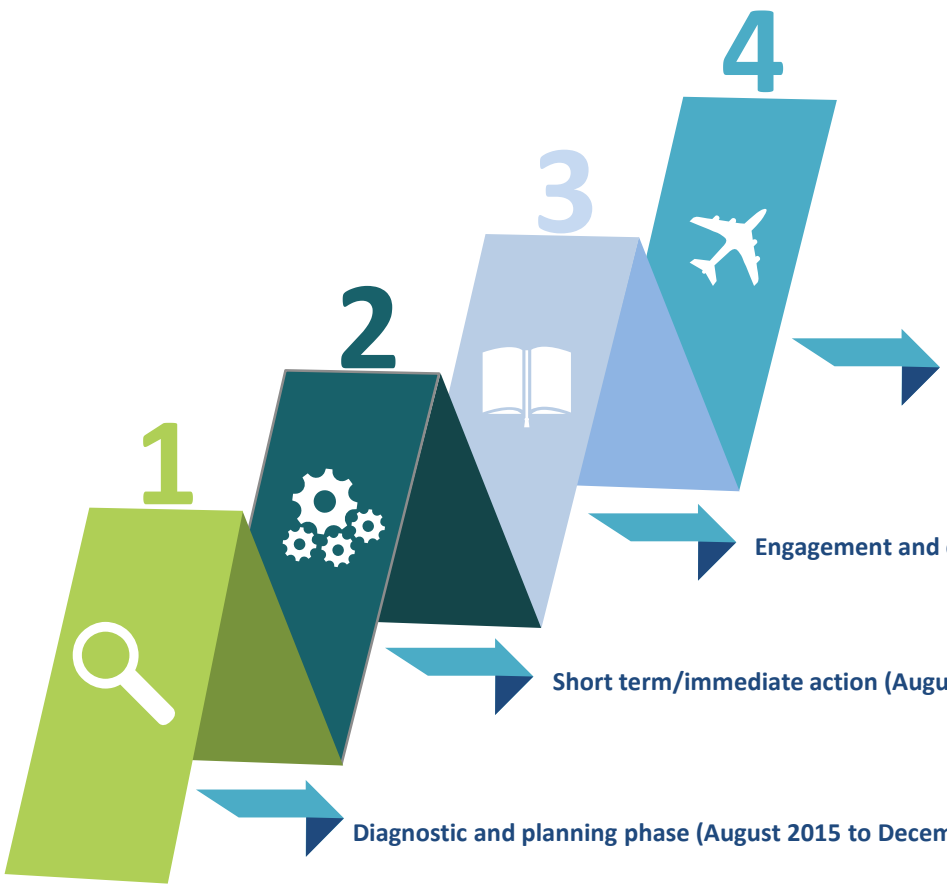
- Relentless **negative local media coverage** that has not been sufficiently countered.
- **Staff report** (staff survey) **low levels of organisational confidence** which implicitly reinforces lack of public confidence.
- **Lack of meaningful/lasting trust** between public bodies and stakeholders and history of organisations managing public relations separately.

Contents

Success Regime approach

- *How do we start our transformation*
- *How do we measure our success*

The Success Regime will develop a transformation plan across four key phases of work



Implementation phase

Engagement and consultation phase (September 2015 to August 2016)

Short term/immediate action (August 2015 onwards)

Diagnostic and planning phase (August 2015 to December 2015)

Key components of these two phases:

- Development of the medium to long term clinical strategy
- Organisational development, including development of leadership sustainability, capability and capacity
- System Resilience Group – which will be responsible for developing and delivering the short terms against agreed quality and performance standards.

The Success Regime has tasked a number of working groups to develop the direction of travel for the health and care system

- System Resilience Group
- Organisational development
- Pro-active and Emergency Care
- Elective Care
- Children and Families
- Maternity
- Mental health
- Specialised services

A number of enablers will also support the development of the health economy's transformation plan

- Primary Care Communities
- Communications and Engagement
- Workforce and Recruitment
- Clinical Informatics and Technology
- Physical Estate
- Transport
- Finance and Information
- Organisational Form
- General Practice Development
- Commissioning Strategy for Adult Social Care

The Success Regime is aiming to achieve measurable improvements across a number of areas

The Success Regime Programme Initiation Document sets out four key areas of improvement described below and in the following slides:

Quality of care - including patient experience

Workforce - including ongoing leadership capacity and capability, long term workforce recruitment sustainability and development of financial performance

Public confidence involvement and empowerment

System-wide organisational stability

Over the next three to five years, the WNE Cumbria health and care economy will strive to achieve improvements across a range of indicators (1/2)

Quality of care

- NCUHT and CPFT to achieve an overall CQC rating of *good* or *outstanding*
- GP, dental, residential care, nursing home care, hospice care and home care services operating locally within WNE Cumbria, the overall % rated *good* or *outstanding* by CQC at local level to equal or exceed the average % rated *good* or *outstanding* across the country as a whole
- Friends and family test – results above national median
- Nil Never Events
- Mortality rates to be within expected ranges across both hospital sites
- Independent measures of excellence (e.g. national awards) in services key to operating in a rural setting such as ambulatory care

Workforce

- Substantive recruitment to the key roles required to ensure priority services that are clinically viable and safe
- Overall vacancy rates to be at or below the national average
- No local core speciality or primary care service to run with more than 50% of clinical posts filled by non-substantive staff for longer than 9 months
- Acute medicine at West Cumberland Hospital operating with no less than 50% substantive medical staffing within 1 year and 80% within 3 years
- NCUHT and CPFT to score at least at median level on the national staff survey measure that staff recommend the trust as a place to work or receive treatment
- Improvement in staff morale and engagement
- Succession plans and development to ensure a pipeline of ready and capable local system leaders

Over the next three to five years, the WNE Cumbria health and care economy will strive to achieve improvements across a range of indicators (2/2)

Public confidence

- Well established community partnerships with effective engagement and involvement of local people in the development of local health and care services and in managing their own health and wellbeing and in the development of local health and care services
- Strong public confidence in, and advocacy of local services and sustainability
- Alignment between public expectations and clinical priorities
- Accurate, fair and balanced media reporting

Sustainability

Financial

- Eradicate all but the agreed structural elements of the deficit within 3 years
- Sustained delivery by system partners of long-term financial planning and targets
- Over the following 2 years agree a trajectory based on the detailed service strategy to address the remaining deficit.

Organisational

- Implementation of future leadership arrangements for NCUHT, which will give full consideration to recent acquisition proposals and ensuring alignment with the Five Year Forward View
- Consideration of shared corporate services between NCUHT and Northumbria Healthcare NHS Foundation Trust (NHFT)
- Proposals for further organisational integration across the health & social care system agreed within 1 year, and well advanced if not completed within 2 years; this will include a clear understanding of scope and the commissioner role in relation to proposals
- Proposals for further system-wide shared back office services agreed within 6 months in advance of a second phase once integration plans are agreed
- All major providers of healthcare to be sufficiently stable to operate to agreed performance trajectories within one year (including the GP federations)
- Each work area outlined in the governance structure (section 4.2 table 2) will identity more detailed challenging outcome measures as part of their plans and this will form part of the strategy, both for the overall programme and for individual work areas.

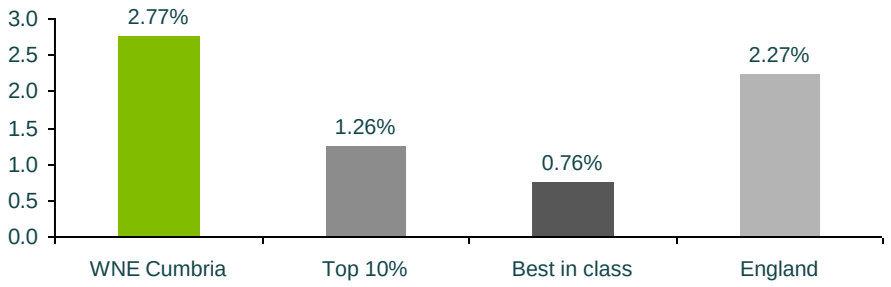
Contents

Appendix A: Detailed Pathway Analysis

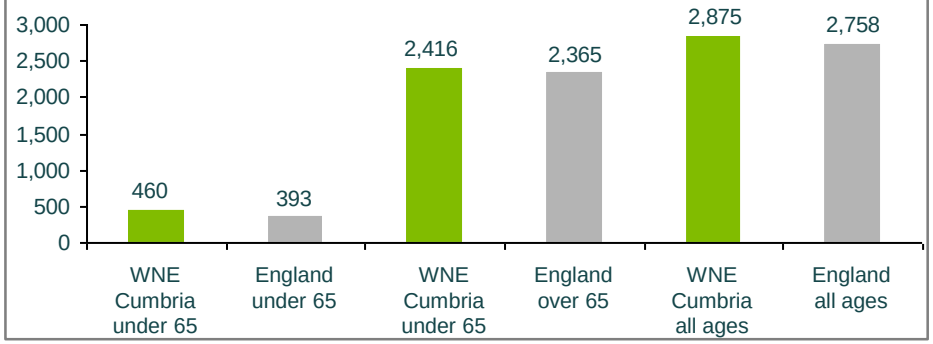
Cancer

Prevalence and mortality benchmarks

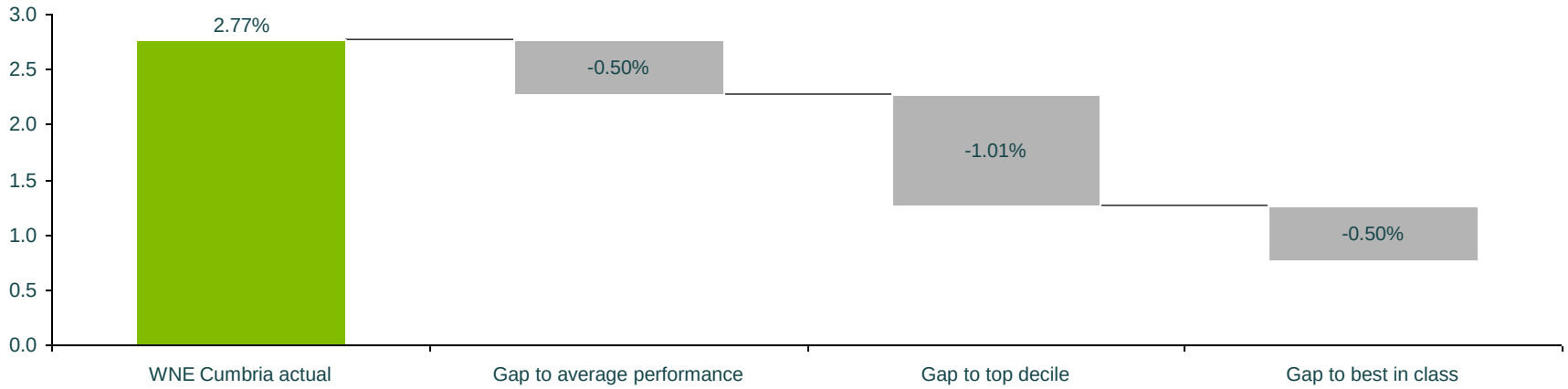
Prevalence of Cancer, 2015
Percentage of population



Cancer mortality by age-group, 2013
Per 100,000



Cancer prevalence: actual vs. best in England comparison



Source: HSCIC. Gap to top decile refers to distance from 90th percentile; top decile and best in England figures normalised

Cancer

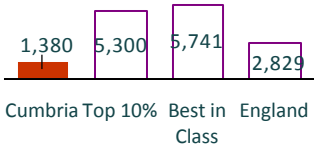
Pathways benchmarks

Performance relative to national average: *Better* *In-line* *Worse*
Outcomes within +/-5% of the national average are considered In-line

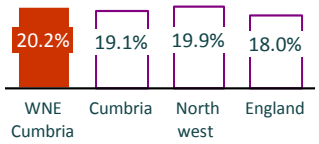
Prevention | **Diagnosis / Identification** | **Treatment** | **Cure** | **Ongoing Management**

Benchmarks

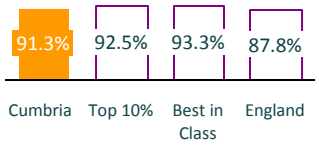
Successful smoking 'quitters' after four weeks per 100,000



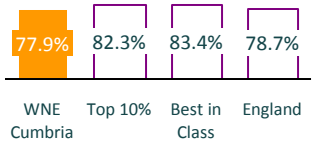
Smoking prevalence in adults



HPV vaccine rate

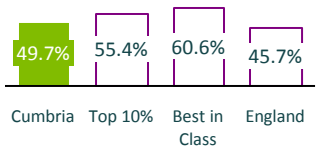


Breast cancer screening rate

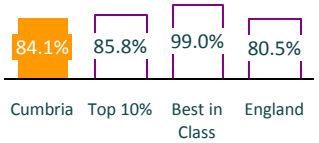


Bowel cancer screening rate

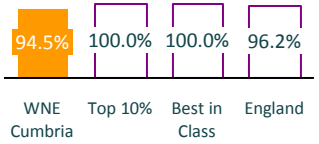
Cancers recorded at Stage 1 or Stage



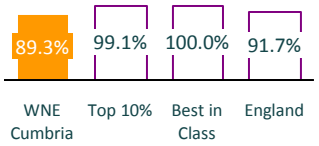
Review within 6 months of diagnoses



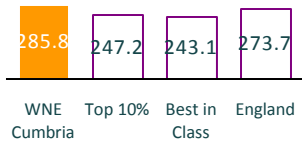
Waiting time to see specialist (<14 days)



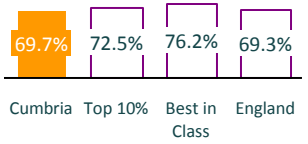
Waiting time for first treatment (<62 days)



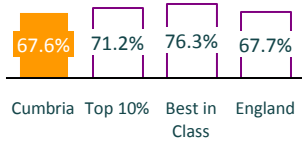
Mortality from all cancers (per 100,000) DSR



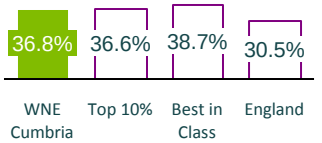
One-year survival from breast, lung, and colorectal cancers



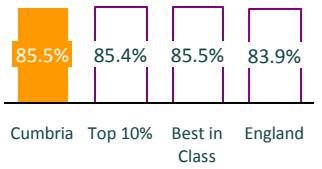
One-year survival from all cancers



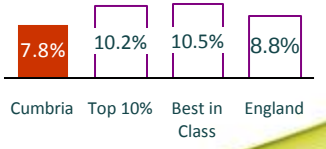
Deaths at home from all cancers



Five-year breast cancer survival



Five-year lung cancer survival

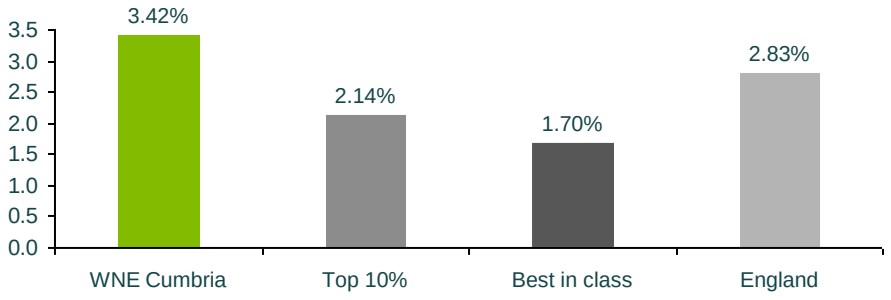


Source: HSCIC; NWPHO; PHE
All data is most recently available and taken for WNE Cumbria where possible.

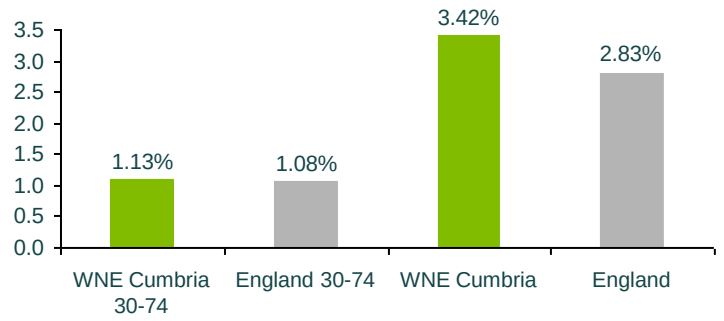
CVD

Prevalence and mortality benchmarks

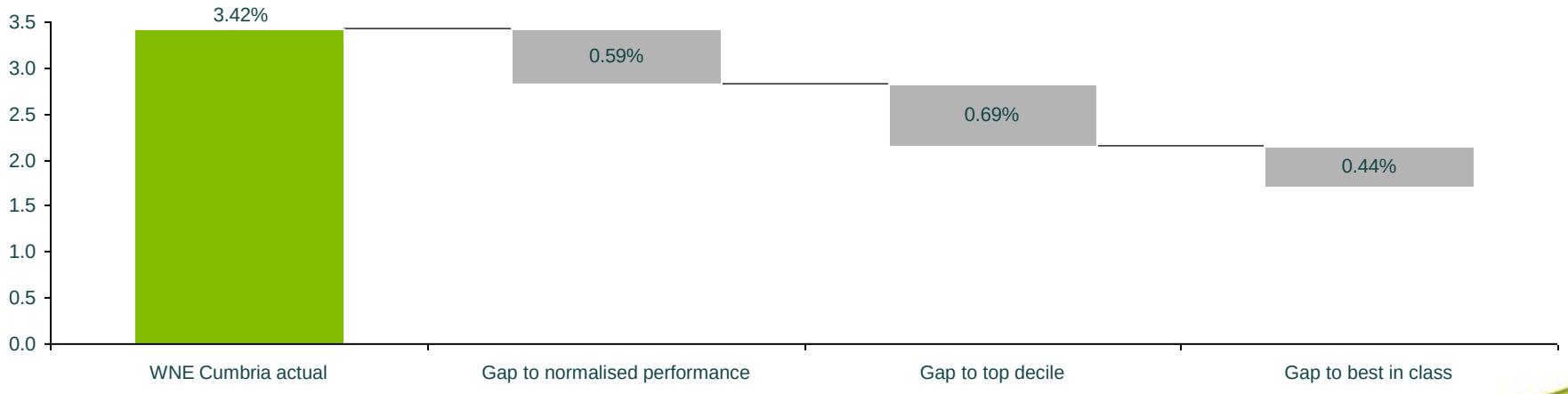
Prevalence of CVD, 2014
Percentage of population



CVD mortality by age-group, 2015
Percentage of population(1)



CVD prevalence: actual vs. best in England comparison



Source: HSCIC. Gap to top decile refers to distance from 90th percentile; top decile and best in England figures normalised
(1) Age bracket 30-74 is the primary prevention age group

CVD

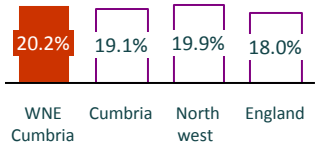
Pathways benchmarks

Performance relative to national average: *Better* *In-line* *Worse*
Outcomes within +/-5% of the national average are considered In-line

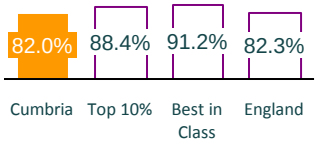
Prevention | **Diagnosis / Identification** | **Treatment** | **Cure** | **Ongoing Management**

Benchmarks

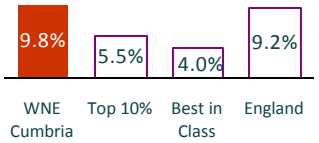
Smoking prevalence in adults



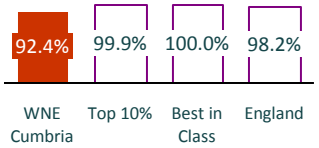
Cardiovascular risk assessment in patients with hypertension



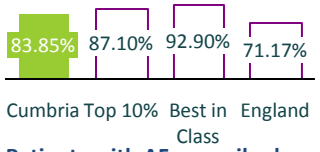
Obesity prevalence



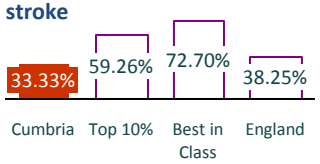
Specialist referral for patients with newly diagnosed angina



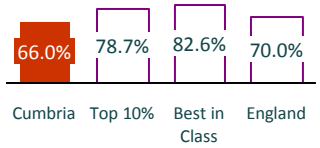
Diagnosed prevalence as a ratio of modelled prevalence



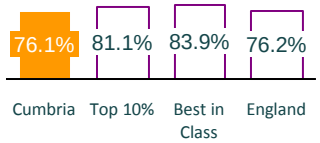
Patients with AF prescribed anticoagulation prior to a stroke



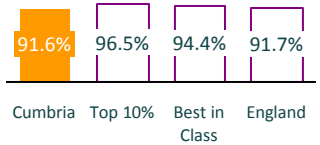
ACE inhibitor therapy for patients with myocardial infarction



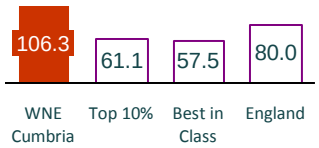
Beta blocker therapy for patients with coronary heart disease



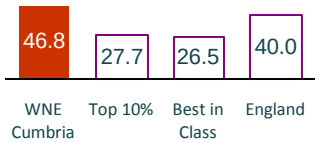
Anti-platelet or anti-coagulant therapy for CHD patients



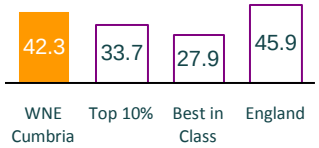
Mortality from ischaemic disease (per 100,000) (DSR)



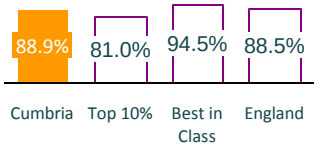
Mortality from coronary heart disease (per 100,000) (DSR)



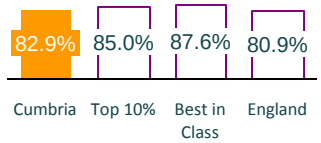
Mortality from acute myocardial infarction (per 100,000) (DSR)



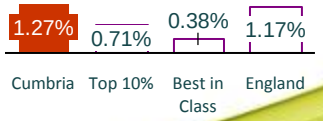
CHD patients whose last blood pressure reading is 150/90 mmHg or less



CHD patients whose last measured total cholesterol is 5 mmol/l or less



Mortality in the 30 days following admission to hospital for a stroke (SMR)

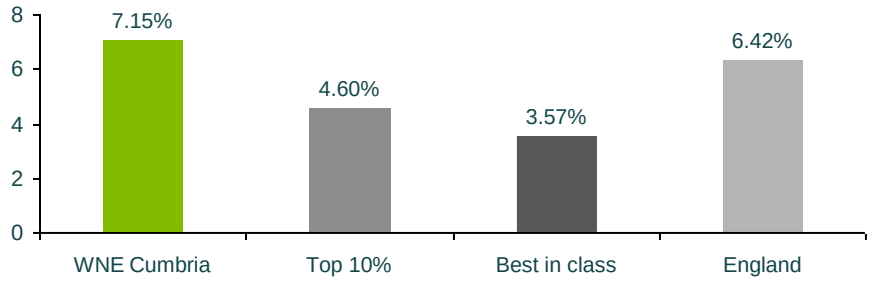


Source: HSCIC; NWPHO; NOO
All data is most recently available and taken for WNE Cumbria where possible.

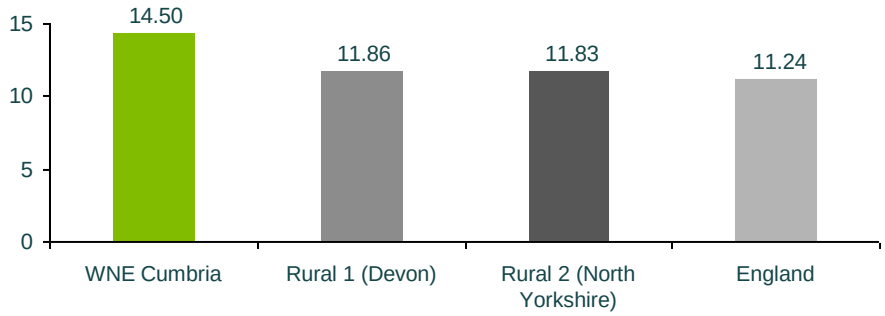
Diabetes

Prevalence and treatment benchmarks

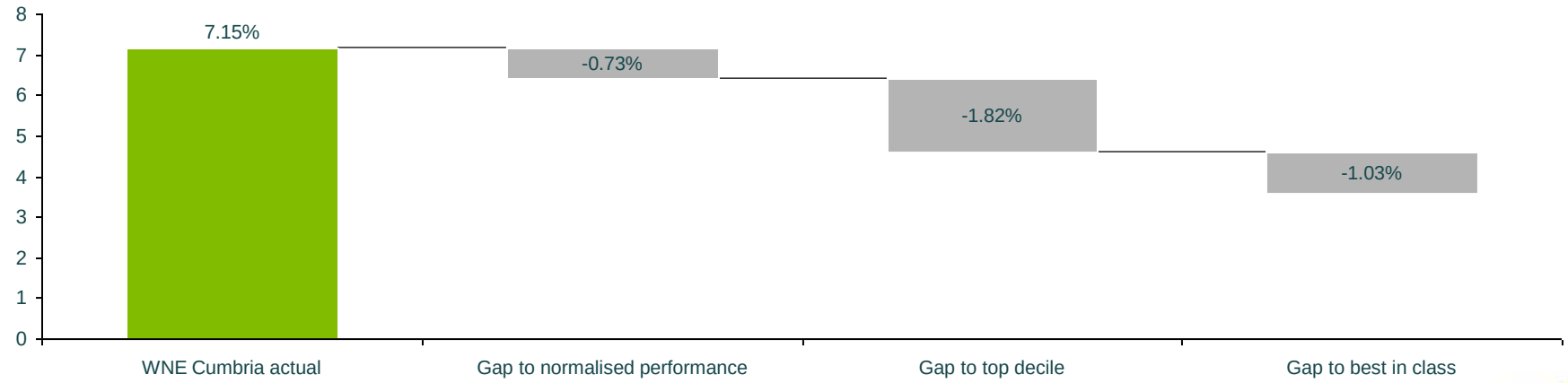
Prevalence of Diabetes, 2015
Percentage of population



Lower limb amputations in diabetics, 2013
Indirectly age standardised rate (per 100,000)



Diabetes prevalence: actual vs. best in England comparison



Source: HSCIC. Gap to top decile refers to distance from 90th percentile; top decile and best in England figures normalised

Diabetes

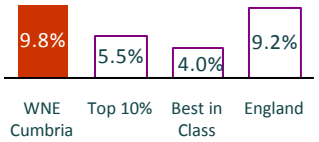
Pathways benchmarks

Performance relative to national average: *Better* *In-line* *Worse*
Outcomes within +/-5% of the national average are considered In-line

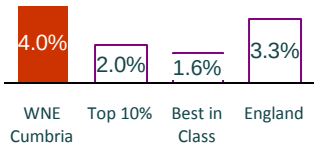
Prevention | **Diagnosis / Identification** | **Treatment** | **Cure** | **Ongoing Management**

Benchmarks

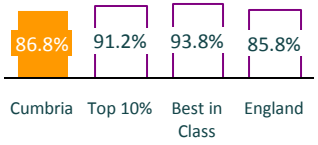
Obesity prevalence



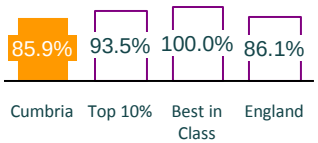
Prevalence of chronic kidney disease



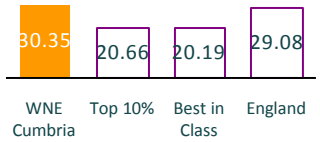
Smokers offered support and treatment within last 24 months



Testing for micro albuminuria in last 12 months

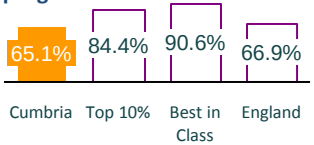


Emergency hospital admissions: diabetic ketoacidosis and coma (per 100,000)(IDR)



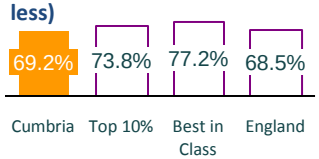
Lower limb amputations (per 100,000)(IDR)

Newly diagnosed referred to a structured education programme within 9 months

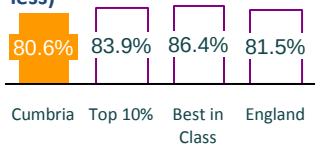


Mortality from diabetes (per 100,000) (DST)

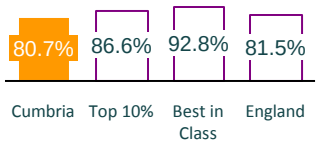
Diabetic patient controlled glucose level (64mmol/mol or less)



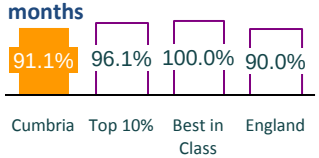
Diabetic patient controlled glucose level (75mmol/mol or less)



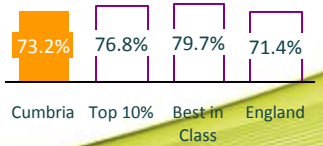
Diabetics provided foot exams within last 12 months



Diabetics provided retinal screening within last 12 months



Diabetes patients with blood pressure under 140/80

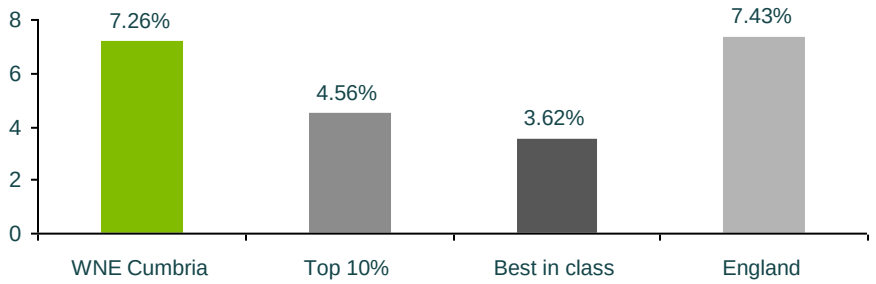


Source: HSCIC; NWPHO; NOO.
All data is most recently available and taken for WNE Cumbria where possible.

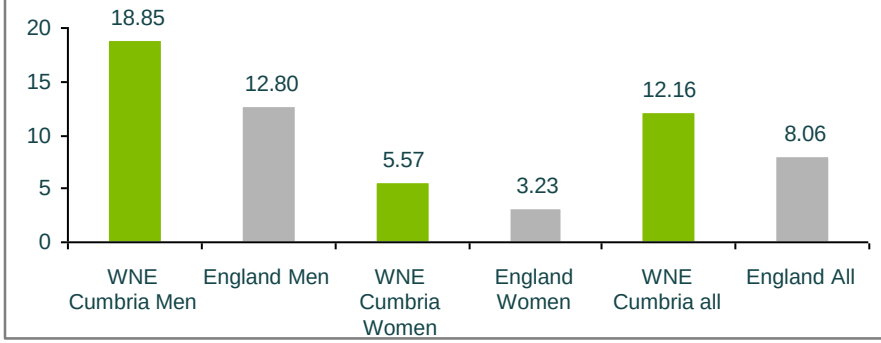
Mental health

Prevalence and treatment benchmarks

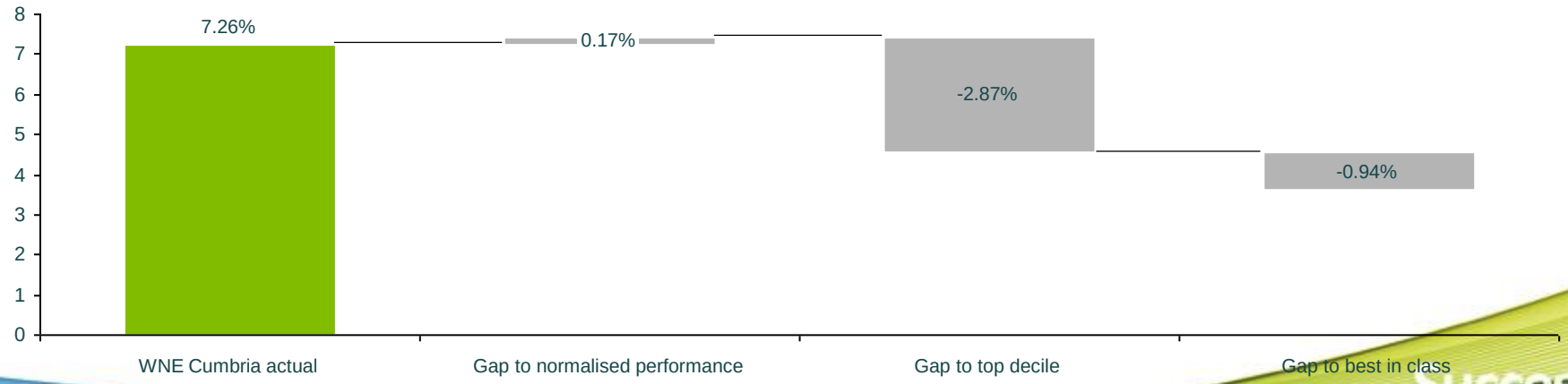
Prevalence of Depression 2015
Percentage of population



Mortality from Suicide, 2013
Directly standardised rate (per 100,000)



Depression prevalence: actual vs. best in England comparison



Source: HSCIC. Gap to top decile refers to distance from 90th percentile; top decile and best in England figures normalised

Mental health

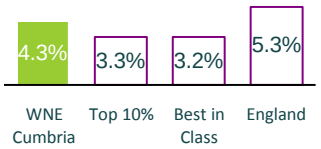
Pathways benchmarks

Performance relative to national average: *Better* *In-line* *Worse*
Outcomes within +/-5% of the national average are considered In-line

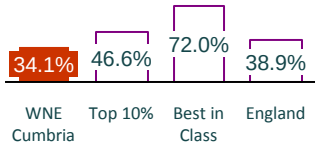
Prevention | **Diagnosis / Identification** | **Treatment** | **Cure** | **Ongoing Management**

Benchmarks

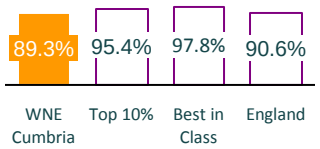
Unemployment Rate



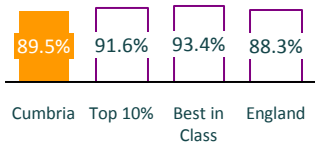
Employment Rate for people with mental illness



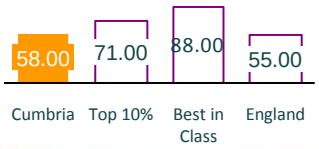
Initial depression severity assessment



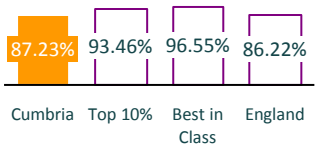
Depression screening in patients with diabetes and/or CHD



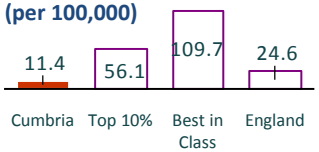
Diagnosed Dementia prevalence as a ratio of modelled prevalence



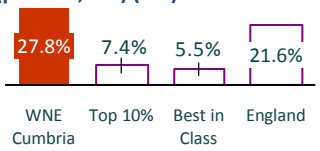
Comprehensive care plan



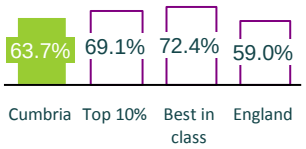
New psychosis patients with early intervention psychosis (per 100,000)



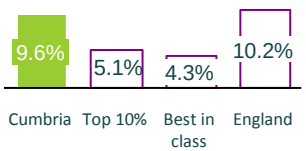
Emergency hospital admissions: schizophrenia (per 100,000) (ISR)



Improved as a result of care

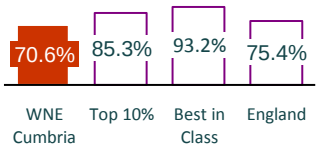


Deteriorated as a result of care



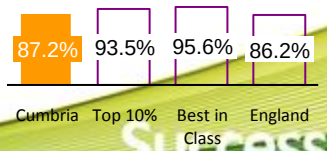
Reliably recovered as a result of care

Further depression severity assessment



Thyroid and renal function testing for lithium patients

Comprehensive care plan for mental health patients



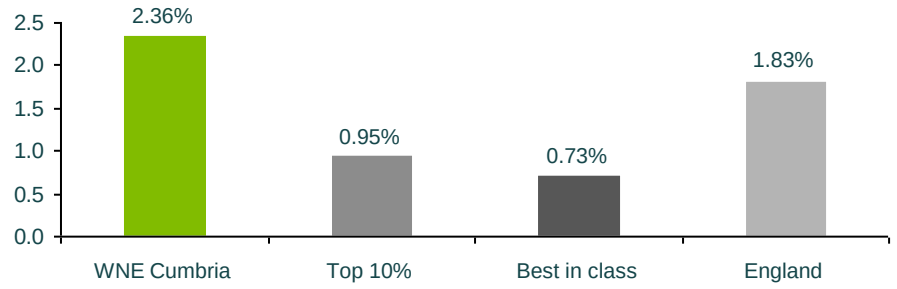
Source: HSCIC; NWPHO; NOO
All data is most recently available and taken for WNE Cumbria where possible.

Success Regime
West, North & East Cumbria

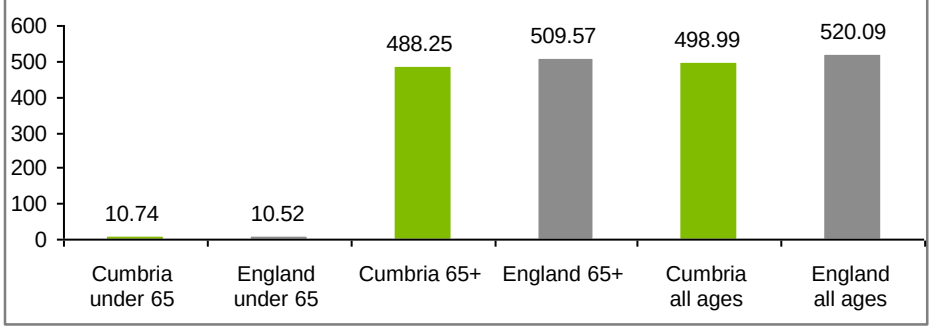
COPD

Prevalence and mortality benchmarks

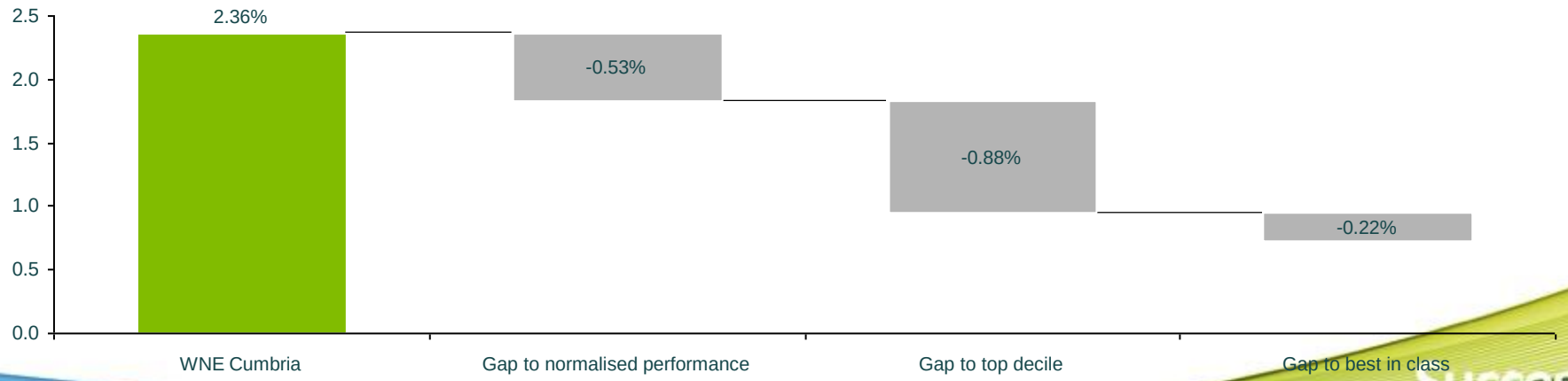
Prevalence of COPD, 2014
Percentage of population



COPD mortality by age-group, 2013
Per 100,000 of population



CVD prevalence: actual vs. best in England comparison



Source: HSCIC. Gap to top decile refers to distance from 90th percentile; top decile and best in England figures normalised

COPD

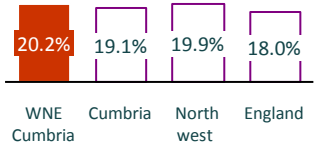
Pathways benchmarks

Performance relative to national average: *Better* *In-line* *Worse*
Outcomes within +/-5% of the national average are considered In-line

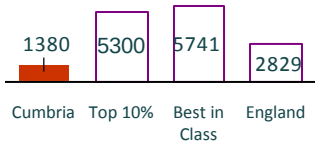
Prevention | **Diagnosis / Identification** | **Treatment** | **Cure** | **Ongoing Management**

Benchmarks

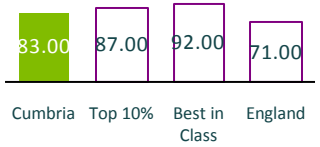
Smoking prevalence in adults



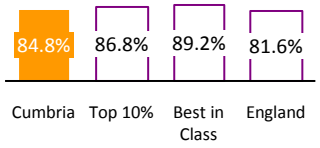
Successful smoking 'quitters' after four weeks per 100,000



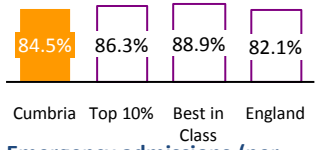
Diagnosed prevalence as a proportion of modelled prevalence



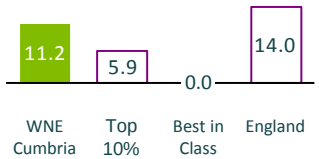
COPD patients confirmed by spirometry



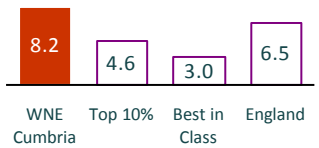
Take up of flu vaccination by COPD patients



Emergency admissions (per 100 on disease register)

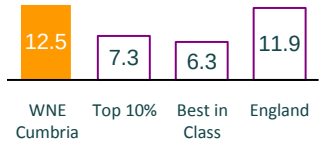


Mean stay in emergency admissions (days)

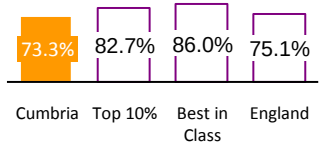


Mortality from COPD (per 100,000) (DSR)

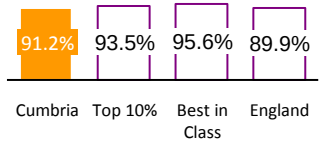
Premature mortality from COPD (average years of life lost) (DSR)



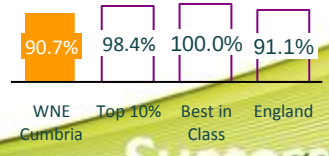
FEV1 checks for COPD patients



Annual COPD reviews performed



Patients assessed using MRC dyspnoea score in last 15 months



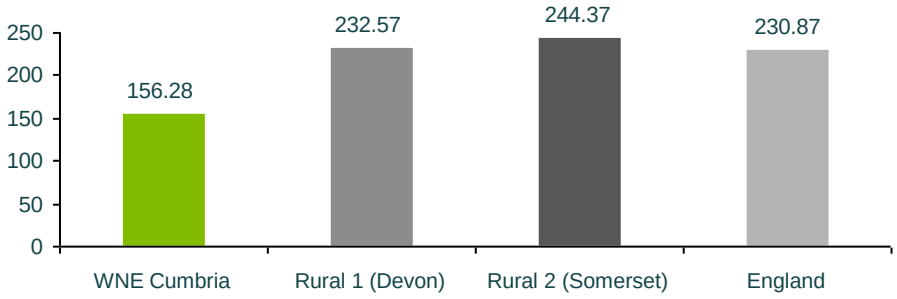
Source: HSCIC; NWPHO; NOO
All data is most recently available and taken for WNE Cumbria where possible.

Asthma

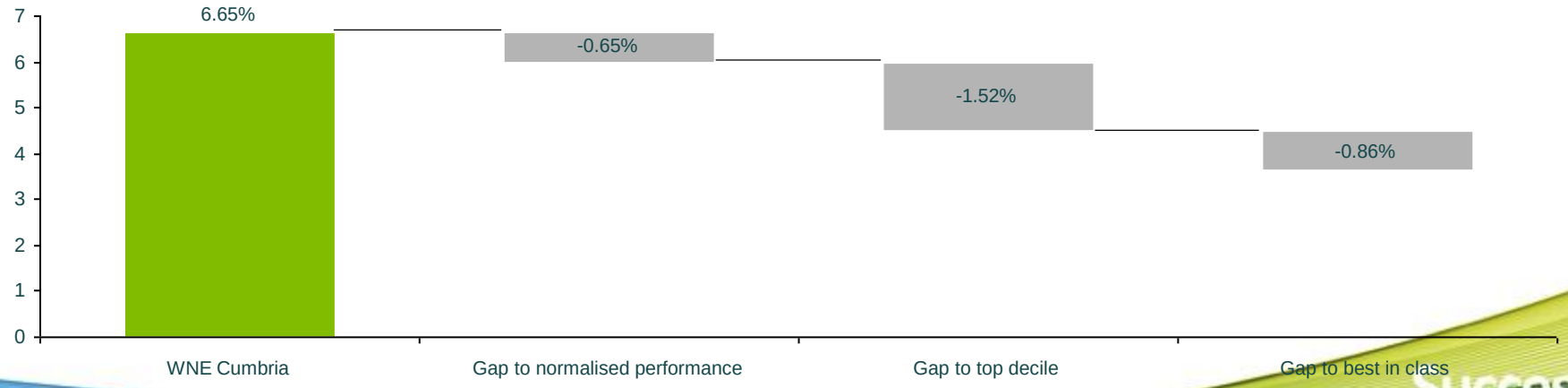
Prevalence and treatment benchmarks

Prevalence of Asthma, 2015
Percentage of population

Asthma emergency hospital admissions, under 16, 2013
Indirectly age standardised rate (per 100,000)



Asthma prevalence: actual vs. best in England comparison



Source: HSCIC. Gap to top decile refers to distance from 90th percentile; top decile and best in England figures normalised

Asthma

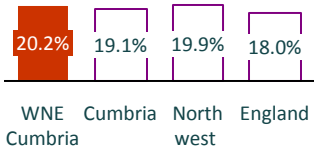
Pathways benchmarks

Performance relative to national average: *Better* *In-line* *Worse*
Outcomes within +/-5% of the national average are considered In-line

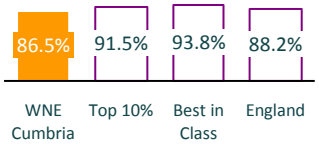
Prevention | **Diagnosis / Identification** | **Treatment** | **Cure** | **Ongoing Management**

Benchmarks

Smoking prevalence in adults



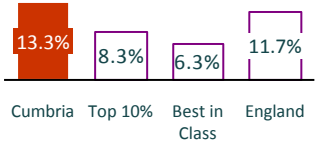
Asthma patients measured for variability and reversibility



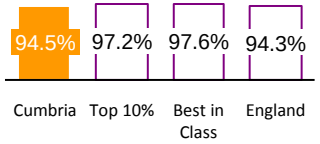
Emergency hospital admissions (per 1000)

Mortality due to asthma (per 100,000)(DSR)

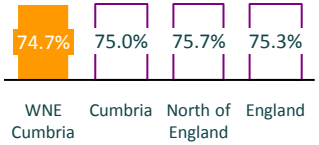
Asthma sufferers who smoke



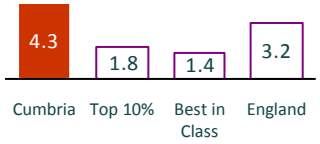
Patients given smoking cessation advice



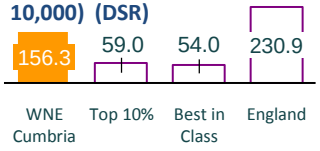
Patients reviews with 3 RCP questions within 12 months



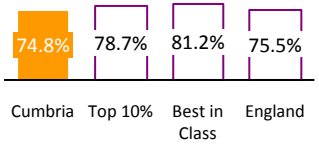
Asthma mean length of stay in hospital (days)



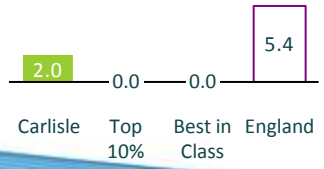
Years of life lost due to premature mortality (years per 10,000) (DSR)



Asthma sufferers who have had an asthma review



Days that air pollution exceeds safe levels

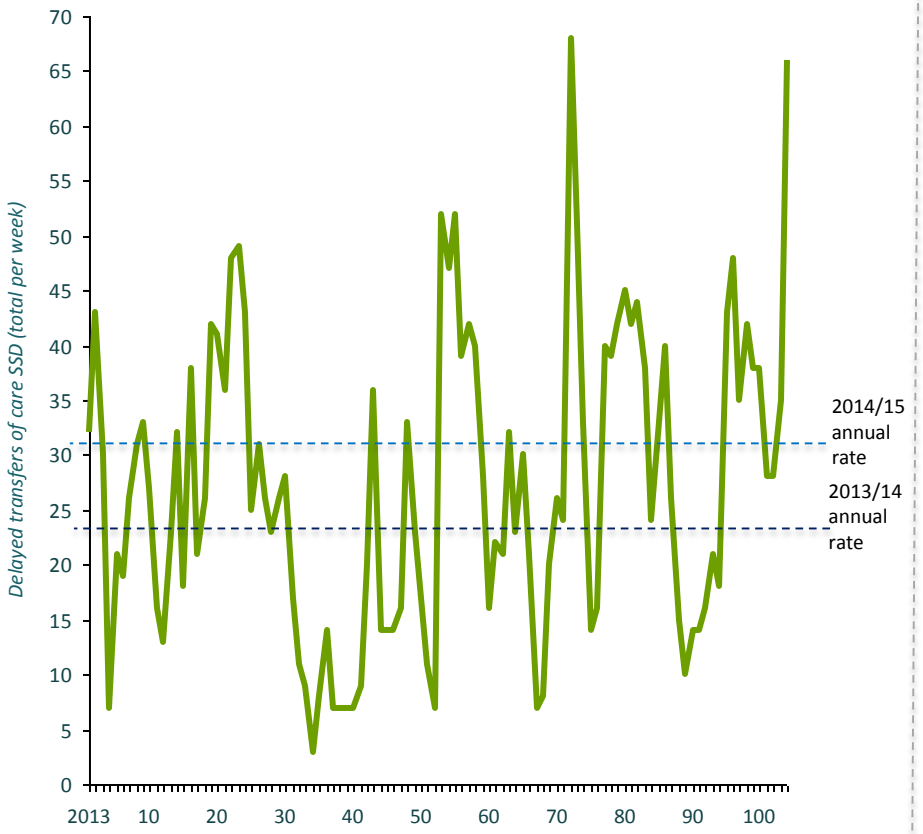


Source: HSCIC; NWPHO; NOO
All data is most recently available and taken for WNE Cumbria where possible.

Appendix B: Additional supporting graphs

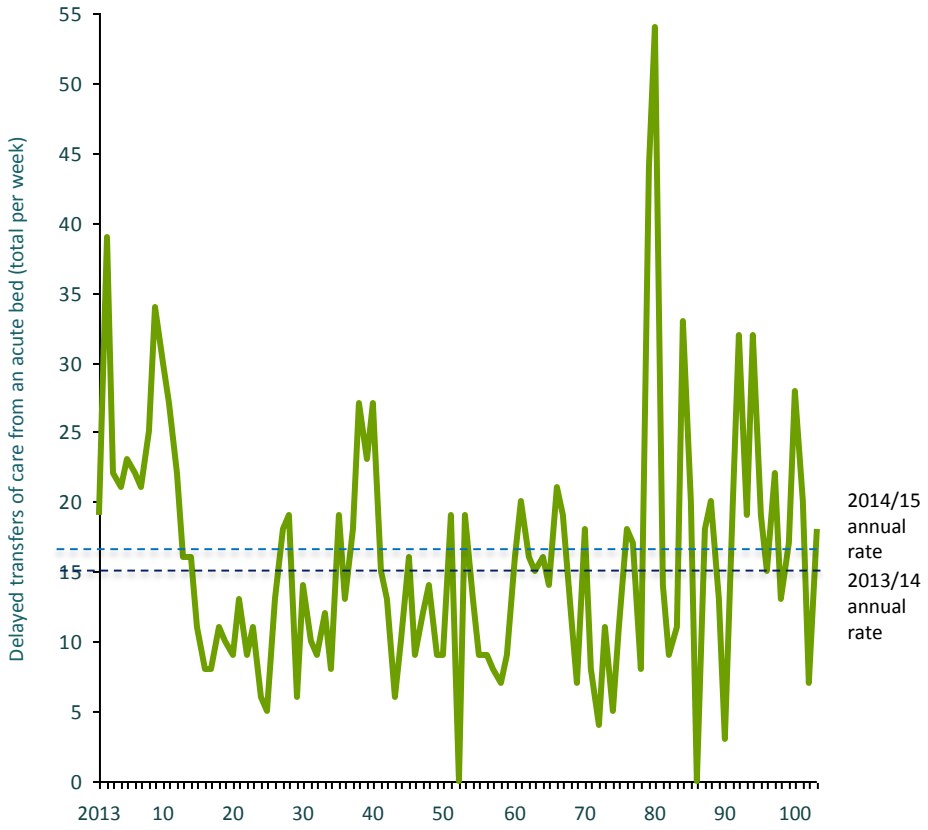
Weekly delayed transfers of care

Fig [66]: WNE Cumbria number of days delayed in period - SSD (All CPFT Community Sites)



Source: Weekly report data, Cumbria

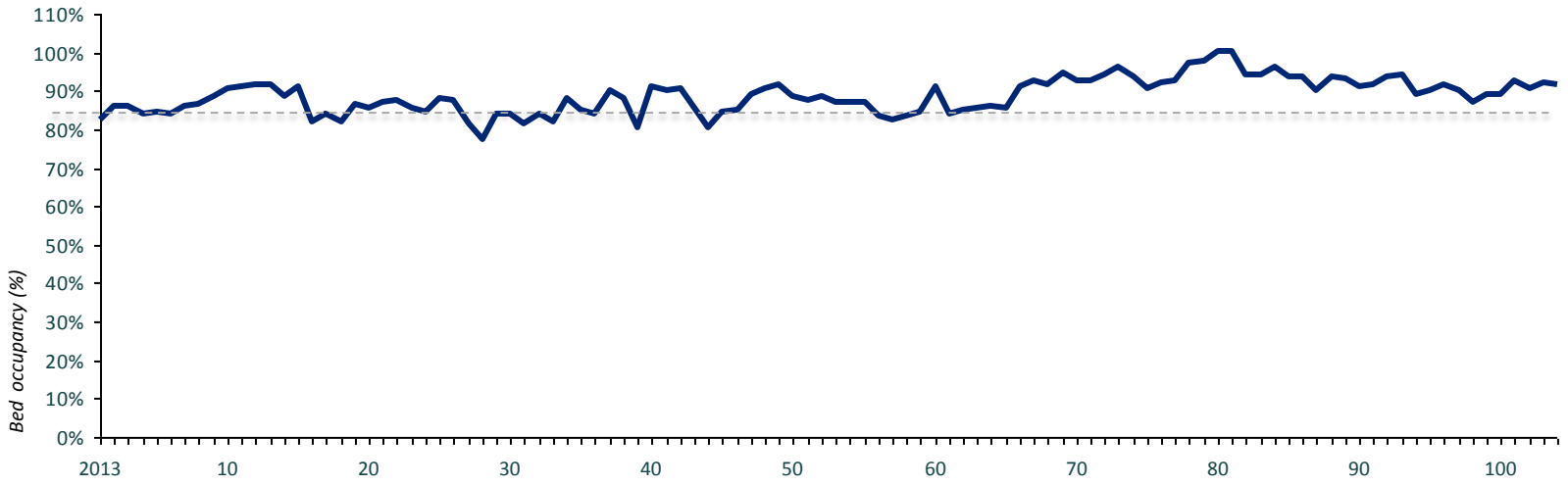
Fig [67]: WNE Cumbria delayed transfers of care from an acute bed (NCUHT)



Source: Weekly report data

Bed occupancy over time

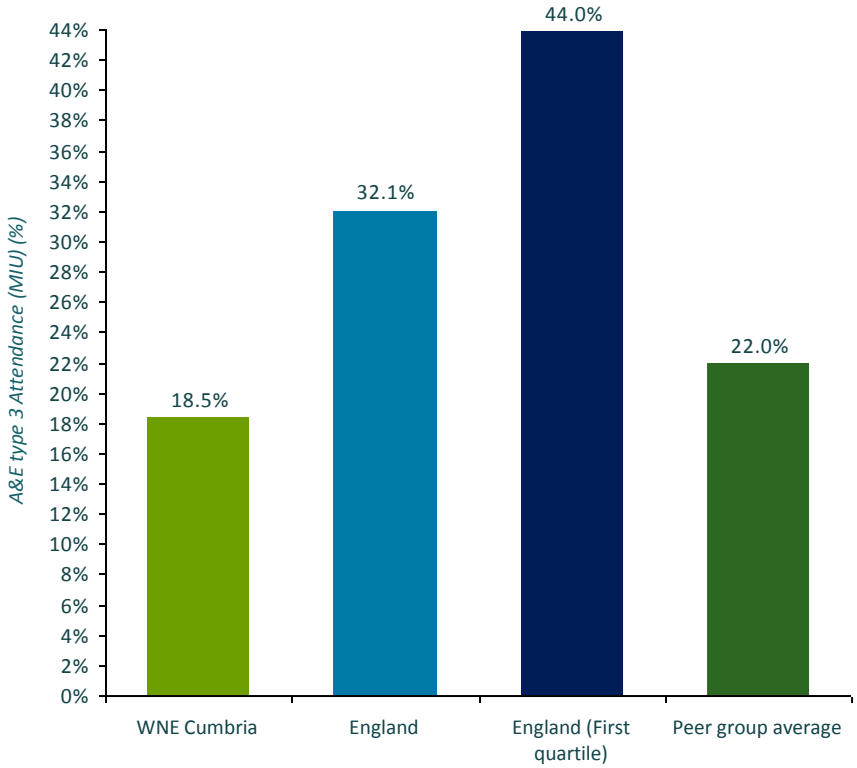
Fig [68]: Bed occupancy at all CPFT sites



Source: Weekly report data, Cumbria

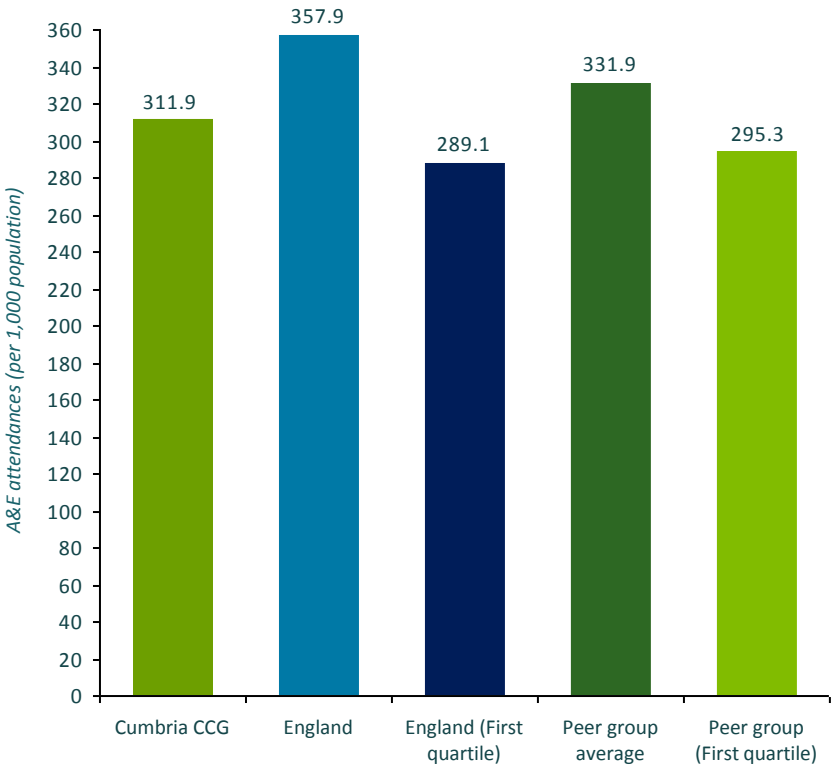
Urgent and emergency care

Fig [69]: proportion of attendances which are type 3 (MIU)



Source: A&E Activity and Emergency Admissions statistics, 2014/15

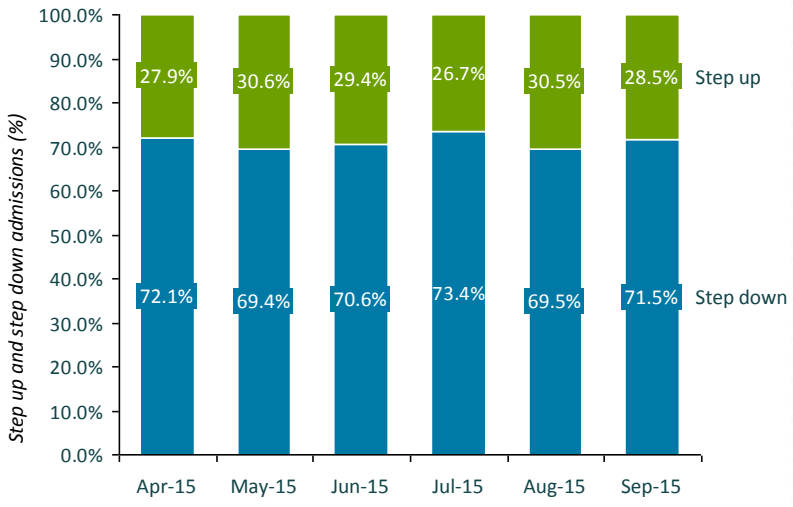
Fig [70]: A&E attendances



Source: Activity report 2015

Step up, step down admissions

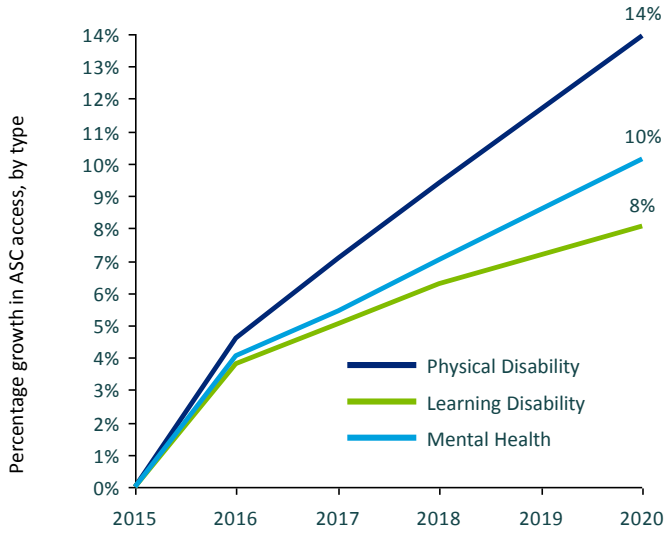
Fig [71]: proportions of step up and step down admissions to WNE Cumbria's community hospitals



Source: Community hospital performances 2015

Adult social care access

Fig [72]: Growth in Adult Social Care (ASC) access



Source: HSCIC, NHS Atlas of Variation 2015

Activity utilisation rate (1/2)

Fig [73] Total outpatients first activity per GP in WNE Cumbria

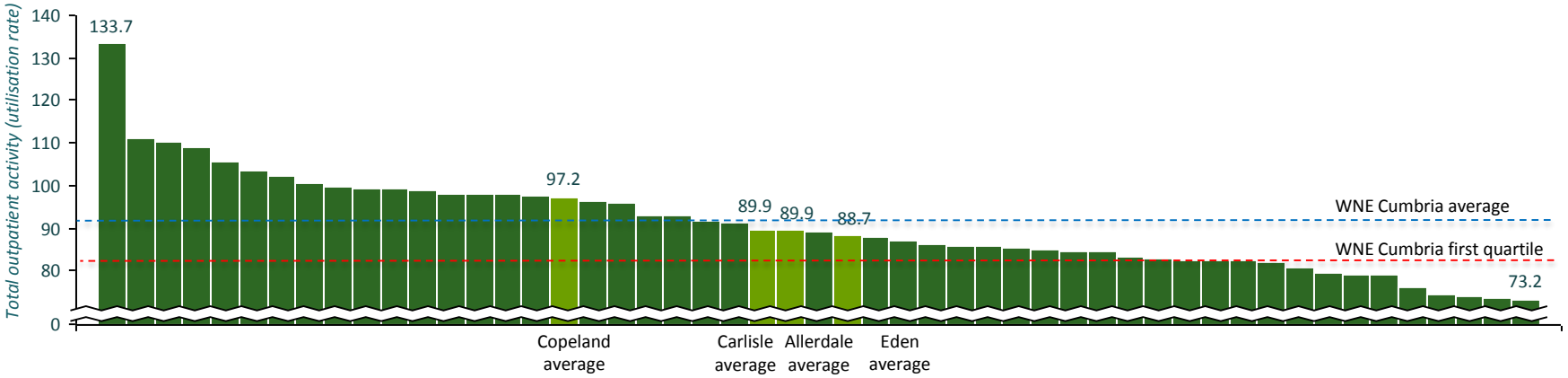
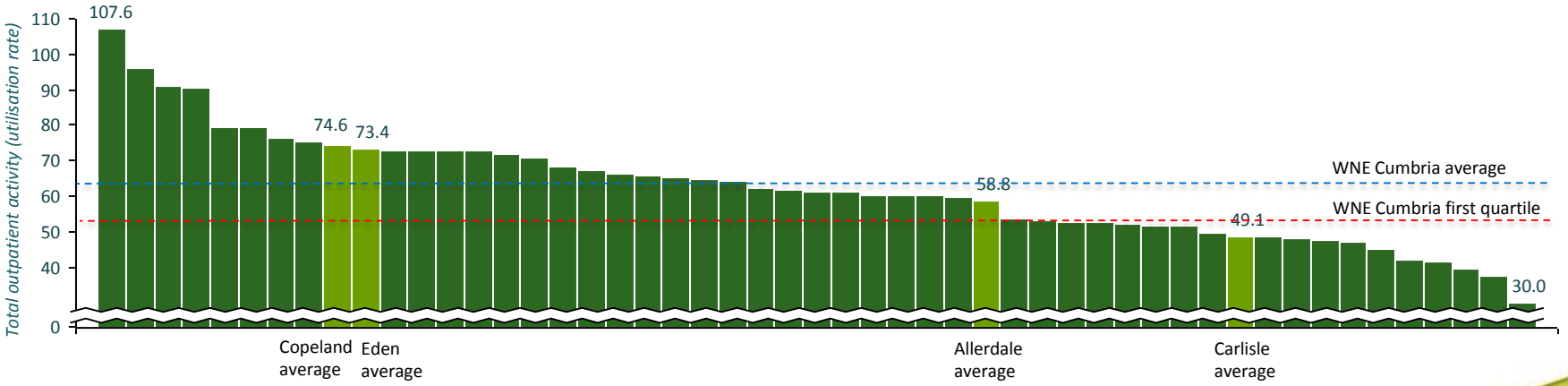
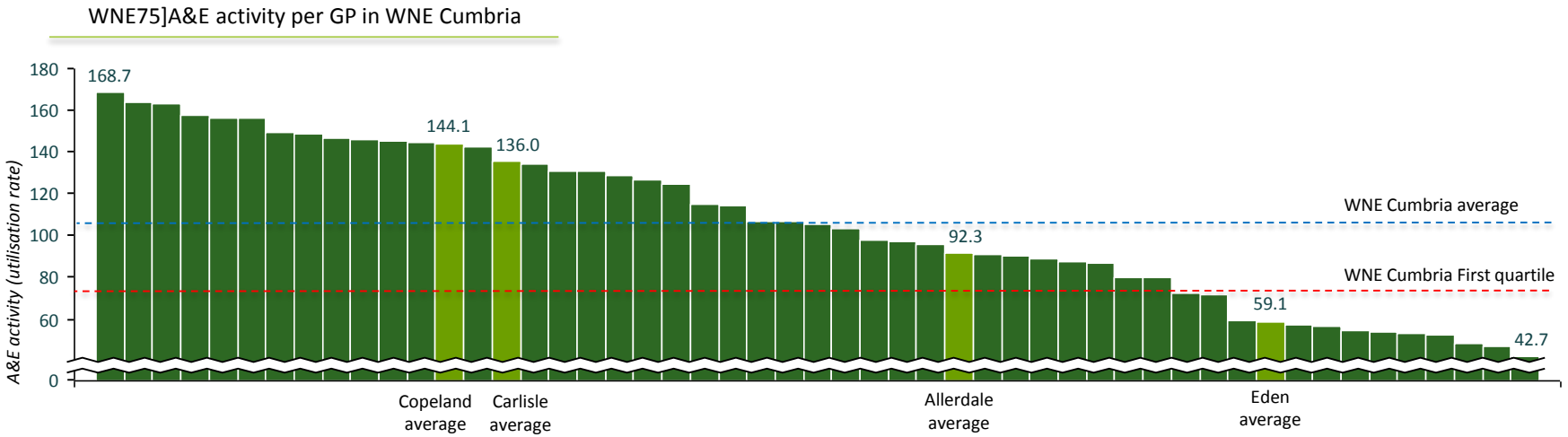


Fig [74] Total outpatient subsequent activity per GP in WNE Cumbria



Source: health evaluation data 2013.

Activity utilisation rate (2/2)



Source: health evaluation data 2013.

Appendix C: Other relevant information

System Resilience Group outputs

North SRG Performance Report

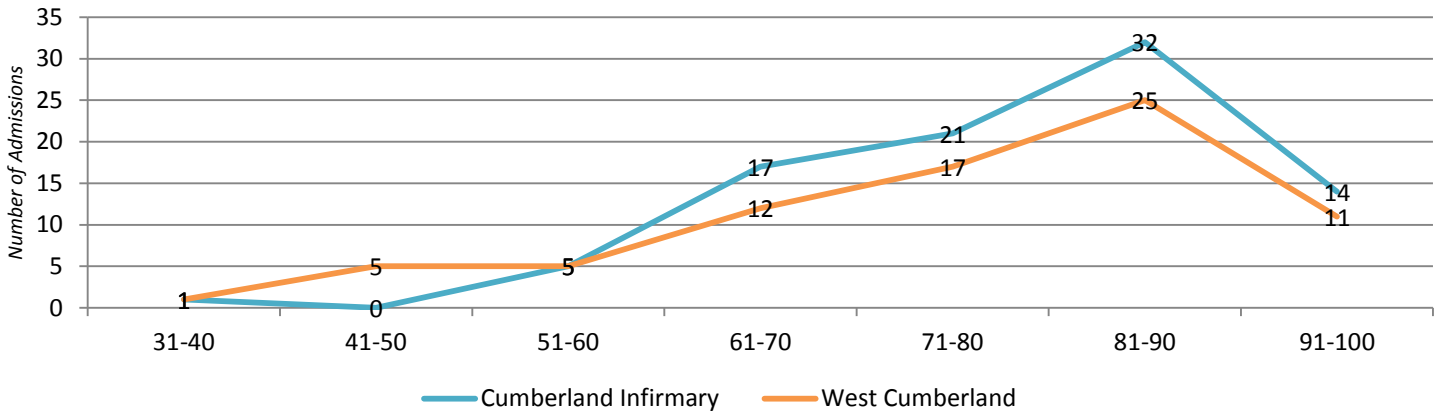
	Site	Target	Amber Tolerance	Actual this period	Actual last period	Latest Month (Nov-15)	Date of this period
HEADLINE PERFORMANCE AND ACTIVITY							
A&E Performance - performance for most recent week	CIC	95%	91%	78.0%	76.5%	77.2%	week ending 29/11/15
	WCH	95%	95%	94.3%	87.9%	90.9%	
	NCUHT	95%	93%	84.3%	81.0%	82.5%	
Emergency daily A&E Attendances - average for most recent week	CIC	TBA	TBA	144.4	141.4	147.8	
	WCH	TBA	TBA	90.3	91.3	90.2	
	NCUHT	TBA	TBA	234.7	232.7	238.1	
Emergency daily Admissions - average for most recent week	CIC	TBA	TBA	61.3	77.3	66.4	
	WCH	TBA	TBA	29.3	26.6	27.2	
	NCUHT	TBA	TBA	90.6	103.9	93.7	
ACUTE 'BAROMETER'							
All patients with LOS over 20 days - Sunday snapshot	CIC	50	+5	66	72	Not applicable	29/11/2015
	WCH	14	+2	27	24		
	NCUHT	64	+7	93	96		
Overall LOS not to exceed 4.1 days (excl DC and RA patients)- average for most recent week	CIC	4.1 days	+0.5	5.26	5.18	4.95	week ending 29/11/15
	WCH	4.1 days	+0.5	4.48	5.27	4.45	
	NCUHT	4.1 days	+0.5	5.02	5.21	4.79	
General and acute beds open and available at midday - average for most recent week	CIC	TBA	TBA	394.6	390.9	391.6	
	WCH	TBA	TBA	164.4	168.9	166.4	
	NCUHT	TBA	TBA	559.0	559.7	557.9	
Average A&E wait (mins) for a doctor	CIC	TBA	TBA	147	180	218	
	WCH	TBA	TBA	59	66	65	
	NCUHT	TBA	TBA	113	135	160	
Average A&E wait for Mental Health Assessment	CIC	TBA	TBA	Not available			
	WCH	TBA	TBA				
	NCUHT	TBA	TBA				
Average A&E wait (mins) to be sent for X-ray	CIC	TBA	TBA	57	71	65	
	WCH	TBA	TBA	51	63	55	
	NCUHT	TBA	TBA	55	68	61	
COMMUNITY SERVICES							
Number of beds open and available - Thursday midnight for most recent week	North Cty Hosps	128	122	127	127	Not applicable	22/11/2015
DTOCs - ACUTE							
Number of Social Care DTOCs - daily average for most recent week	CIC	TBA	TBA	19.3	11.5	12.1	week ending 29/11/15
	WCH	TBA	TBA	11.3	5.5	8.2	
	NCUHT	TBA	TBA	19.3	17.0	20.4	
Number of Community DTOCs - daily average for most recent week	CIC	TBA	TBA	22.0	43.3	27.2	
	WCH	TBA	TBA	34.0	37.5	21.6	
	NCUHT	TBA	TBA	22.0	80.8	48.8	
Total number of DTOCs recorded on Thursday count	CIC	TBA	TBA	43	50.0	Not applicable	26/11/2015
	WCH	TBA	TBA	48	63.0		
	NCUHT	TBA	TBA	91	113		
DTOCs COMMUNITY							
Number of Social Care DTOCs recorded on Thursday count	North Cty Hosps	TBA	TBA	27	28	Not applicable	22/11/2015

Note: monthly A&E performance from weekly and daily data

TBA = to be arranged

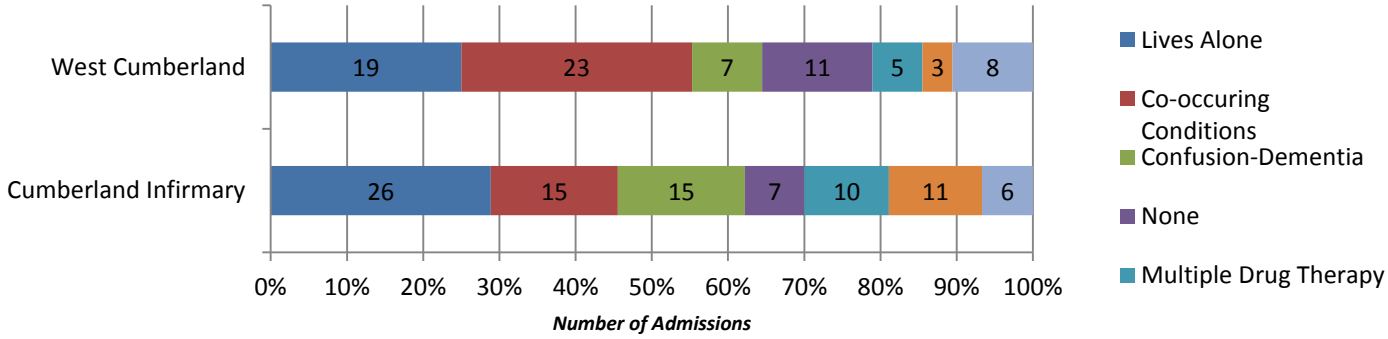
Oak group report – patient profile

Fig [76]: Total number of admitted patients by age



72% of patients were over 70 years of age for both facilities. This is typical for hospital care in the UK.

Fig [77]: Patient complexity



89% of patients had significant risk factors, the most prevalent of which were lives alone at 27% and co-occurring conditions at 23%.

Source: Oak group report 2014

Oak group report – Acute audit summary (1/2)

Fig [78]: Bed Audit.

Facility	Admissions				Continuing Days of Stay				Total Reviews			
	Qualified	Non-Qualified		Total	Qualified	Non-Qualified		Total	Qualified	Non-Qualified		Total
Cumberland Infirmary	68	22	24%	90	63	114	64%	177	131	136	51%	267
West Cumberland	60	16	21%	76	62	90	59%	152	122	106	46%	228
Grand Total	**128**	**38**	23%	**166**	**125**	**204**	62%	**329**	253	242	49%	**495**

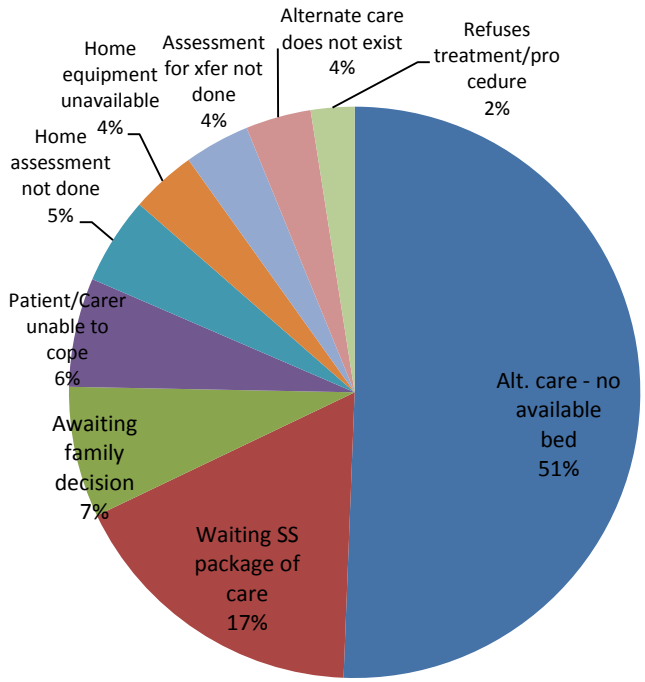
In all, there were 166 patients studied. Cumberland Infirmary had both the greatest number of non-qualified admissions and continuing days of stay.

Source: Oak group report 2014

Oak group report – Acute audit summary (2/2)

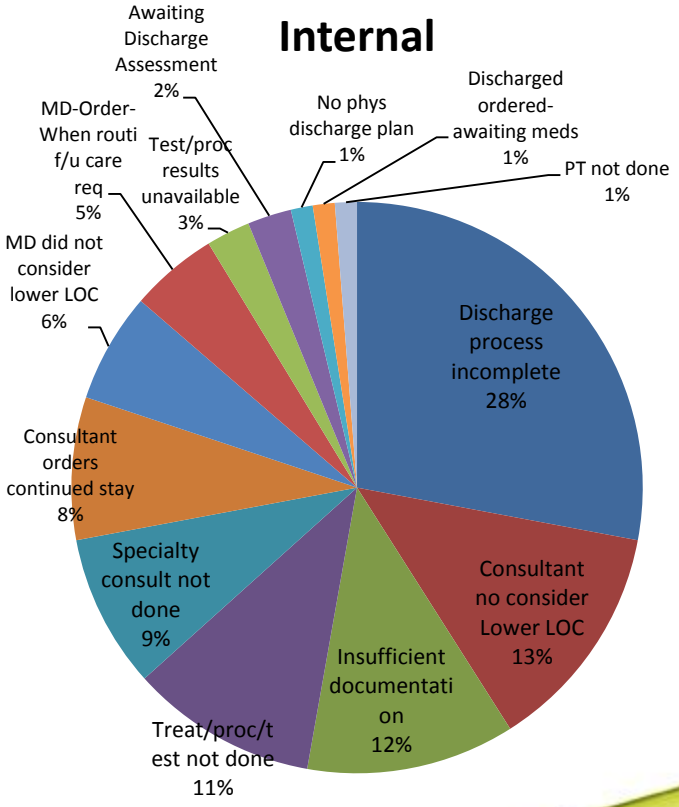
33% of non-qualified days were due to external reasons, whereas 67% were within the gift of the facility. Of the external reasons, 51% of the non-qualified days were due to no alternate care bed available. Of the reasons within the gift of the facility, 53% were related to consultant issues.

Fig [79]: External reasons for delayed transfer of care



External Reasons = 81 of 242 or 33%

Fig [80]: Internal reasons for delayed transfer of care



Internal Reasons = 161 of 242 or 67%

Source: Oak group report 2014