www.pwc.co.uk

Intensive Planning Support to Challenged LHEs

Report 1: Summary report to national partners on the main issues and capacity including a risk assessment of the likelihood of robust, aligned plans being delivered

Cumbria

Monitor, NHS England, NHS Trust Development Authority

25 April 2014

Version 1.1

Commercial in Confidence

Contents

How we meet your requirements for report 1

Key Element	Detail	Where we provide this information	Page
Scale of Challenge Overview	Insights on the scale of the challenge in the specific local health economy and the findings from the targeted diagnostic regarding the root causes, issues and barriers driving that challenge.	Exec Summary A, B, C, D, 7	
Capacity	Insights on any major capacity challenges which will impact on the ability of the local health economy to successfully develop robust plans in the required timescale. This includes but is not limited to project management, communications and leadership capacity.	Exec Summary, E	
Resultant Challenges from Capacity Issues	Insights on any particular capacity challenges in the area (e.g. project management, communications, leadership) that may be contributing to the challenge.	Exec Summary, E, 7	
Risk Assessment	Insights on key risks and an assessment of the scale of that risk for delivery of aligned plans by June.	Exec Summary, E	
Further Analysis Required	Insights on any concerns regarding the use of analysis from the initial diagnostic stage to inform the rest of the process, including proposals for further analysis required.	Exec Summary, 8	

Glossary of terms and abbreviations

Abbreviation	Definition
BCT	Better Care Together
CCC	Cumbria County Council
CCG	Clinical Commissioning Group
CDG	Care Design Group
CPFT	Cumbria Partnership NHS Foundation Trust
CQC	Care Quality Commission
ENT	Ear, Nose and Throat department
FMOC	Future Model of Care
FY	Financial Year
IMT	Information Management and Technolgy
KLOE	Key Lines of Enquiry
LHE	Local Healthcare Economy
MB	Morecambe Bay
MBUHT	Morecambe Bay University Hospital NHS Trust
NCUHT	North Cumbria University Hospital NHS Trust
NHFT	Northumbria Healthcare NHS Foundation trust
NHS	National Health Service
OOH	Out of Hospital
PMO	Programme Management Office
QIPP	Quality, Innovation, Productivity and Prevention
SOC	Strategic Outline Case
SVT	Single Version of the Truth
WGH	Westmorland General Hospital

1. Executive summary

1.1 Key messages from Workstream 1:

The geography of the county plays an important part in the way the LHE is managed and governed.

- The CCG manages the LHE across a north / south divide and over time separate governance arrangements have been introduced for each with the *'better care together'* (BCT) programme in the south and the more recently formed '*together for a healthier future'* in the north.
- Crucially the Cumbria Healthcare Alliance has been formed to develop a Cumbria wide approach to the development of health and social care, which, if successful, will pull together the best thinking from the north and south.

The key stakeholders and leaders are on the same page

- We have found a LHE that is working together, that has a desire to solve the issues, and have some emerging ideas of how this can happen. There is no lack of ambition, desire and determination to address the challenges, and the leaders are positive and welcoming.
- The key stakeholders have a clear view of the challenges faced:
    - Dual pressure of *quality and financial shortfalls* meaning the LHE is unsustainable in its current state
    - *Demographic and geographic* situation causing *Workforce issues* in recruitment and retention
    - Difficulty in making *transformational changes* due to politics and culture

The LHE faces significant Quality issues & Financial challenge

- The three provider Trusts are forecasting a deficit position for FY15 in the region of £50m. We forecast that this will rise to c. £190m in 5 years.
- NCUHT has been in special measures since July 2013. MBUHT is only just recovering from formal action taken in 2011, is subject to an ongoing investigation into MBUHT maternity and paediatric services, and has a CQC warning notice in place. CPFT have also failed to address longer term quality issues.
- The two acute providers are required to provide services across five sites. The volume of activity at each site is relatively small which does not aid the provision of quality care. PwC has forecast that in Morecambe Bay the cost of
- It is widely agreed that the proposed acquisition of NCUHT by Northumbria Healthcare NHS Foundation Trust(NHFT) will provide a longer term solution to many of the Trust's financial problems but this transaction was put on hold when NCUHT were placed in Special Measures - though they continue to be supported by NHFT.

Demography and Geography play an important role in creating these problems

- Cumbria's population of 520,000 is spread across a land mass area greater than the size of Greater London – simply travelling between hospital sites creates issues for staff and patients alike.
- All of the demographic indicators suggest that the cost of healthcare will rise significantly over the next five years , driven predominantly by its ageing population.
- Geographically dispersed populations, such as Barrow in Furness, Workington & Whitehaven, are isolated from major population centres bringing access challenges.
- PwC has recently estimated the cost to MBUHT of operating in such a geographically dispersed environment to be in the region of £15m per annum – similar work is underway at NCUHT.

- A common driver of the finance and quality issues is the LHE's continuing failure to attract quality staff to work in Cumbria – leading to high use of Locums and agency staff, a costly resource and not one that is conducive with quality provision of healthcare.

The LHE does not have a good history of delivering plans it has developed

- The LHE has a number of good plans at service/specialty level so specific issues are being addressed – such as the emerging Primary Care Communities work, LHE wide Children's Strategy and an Out of Hospital service model for Morecambe Bay.
- The LHE has an improving record of creating and delivering operational plans to address performance issues, but has a history of non-delivery of strategic plans that require whole system delivery.
- We know already that BCT may result in fundamental changes to the system, e.g. the services delivered from WGH, and that they will be very politically sensitive and therefore difficult to implement and will require strong leadership throughout.
- A significant challenge will be to integrate the two programmes of work into a cohesive plan for Cumbria. This is recognised but as yet no clear plan to address.

A major risk is the LHE's capacity to deliver

- NCUHT focus is on moving out of special measures - very much here and now with the forthcoming inspection
- NCUHT and CPFT do not yet fully understand their deficit position - impacting capacity and speed at which they can build evidence into their options development and the strategic plan
- The BCT Programme has been very focused on delivery of the SOC in June, and continues to be as it reaches its conclusions. This has implications for moving swiftly into implementation and realising the planned benefits

1.2 Our approach

Our report has been developed from three types of analysis, drawing on data from the LHEs and our own observations

	What we did	*What this has told us*
Analysis – existing reports and new data ("Single Version of the Truth Lite")	**BetterCareTogether** • Developed a comprehensive SVT as part of the BCT work which profiled the financial, operational, quality and performance issues in MB to inform the clinical design process which has involved over 200 clinicians • Undertook a structural deficit review for MBUHT which assessed the specific structural costs of providing acute services across the three hospital sites over a large geographical area	**<u>BCT</u>** The SVT highlighted some key lines of enquiry which included: 1 **The Demographic and Geographic challenge** of a growing elderly population with variation in health outcomes and deprivation. 2 A £71m **affordability challenge** with an underlying deficit of £25-26m at MBUHT. 3 An **Operational and workforce** challenge with patients often in the wrong care setting and a workforce model that reinforces this with 82% of the system's nursing and midwifery staff working in hospitals – compared with only 32% in a mature integrated care setting The structural deficit review highlighted that MBUHT is unique given it has a smaller than average population, very low spells per site and major challenges in providing sustainable services across a large geographical area. The review also highlighted £15m in additional costs (due to duplicate management, facilities, workforce and travel costs) required to run services across the three sites.
	North Cumbria • A lite version of the SVT is in progress for the north, with a view to specifically identifying the 5 year challenge the four localities face. • The SVT will also highlight the key quality and workforce issues as well as reviewing the	**<u>North Cumbria</u>** There are some key workstreams still in progress in the north – the SVT and the structural deficit review for NCUHT will be completed by the end of April, while the deficit review for CPFT will complete in mid- May. Our stakeholder meetings and reviews of existing plans has highlighted issues in the north that

	existing plans across the patch. • We have reviewed existing plans from the key stakeholders – CCG, NCUHT, CPFT, MBUHT and CCC, with a view to assessing their alignment and how well they are likely to address the future challenges	almost mirror those in the south: • **a demographic and geographic challenge** associated with a growing elderly population. • An **affordability challenge** of a similar scale to the south – and an underlying deficit at NCUHT of £25-£30m. • An **Operational and workforce** challenge driven by recruitment and retention issues.
Plan Review	Reviewed plans from across Cumbria to identify key lines of enquiry to discuss with each organisation	**KLOEs to progress** • A need for more visible clinical ownership • Leadership of transformation – not clear; • Finance: No sense of a joint approach, and limited references to QIPP. • Joint vision not apparent; • Joint working needs to be more visible and drive changes: • Aligned Planning could be more obvious; • Unclear how transformation programmes will be governed (clinical and non-clinical governance) before and during delivery • Ambition v Delivery: While there is a lot of content in each plan about "the what", there is very little about "the how" or "the when" • Enablers: little detail about the range of enablers that must be put in place in order to realise a system wide transformation
Qualitative intelligence	• Within the BCT Programme we have undertaken extensive stakeholder engagement and have had the opportunity on a number of occasions to witness the various partners operating round the table in the form of Programme Boards and other fora. • Similar opportunities	• New leadership teams have been established in the past 12-18 months which has helped to bring a new perspective. • There is a sense that relationships across the organisations have improved in the past 6 – 12 months • There is clearly a shared view and awareness of the issues the LHE faces, across the north and south. • Whilst there will inevitably be differences in opinion about the

	have been limited in the north but we have met with most of the key stakeholders to assess their shared understanding and emerging visions.	detail of how to improve the financial and clinical quality position there is a shared understanding that the only strategy that will deliver sustained improvements is one of whole system transformation. • In the south where the CDG process has completed its three workshops we have seen professionals from all organisations delivering system wide perspectives and truly leaving their organisation boundaries at the door.

1.3 Executive summary of areas of specification

A. Summary of existing analysis regarding issues and barriers to health economy sustainability undertaken through stakeholder interviews and document review.

Key stakeholders agree on the four big issues that need to be addressed in Cumbria:

- Financial and Quality issues that inhibit progress – they recognise just how poor these issues are in Cumbria.
- Workforce issues with recruitment \and retention
- Geographic and demographic challenges that are deep rooted, and worsening
- No history of delivering change programmes across the LHE even though effective strategies have been developed

They also recognise the main barriers that need to be addressed if these issues are to be resolved through transformational change – they all recognise it is transformation that is required and not incremental change.

- The relationship between clinicians and management is improving but needs to go further to ensure all parties speak with one voice and towards one vision.
- Lack of stability over the years has not been conducive to effective change.
- Recruitment issues will not be solved overnight and this is one of the key drivers of the problems faced.
- A vocal population often supported by local politicians.
- Clarity of service models in Whitehaven and Barrow, and the acquisition of NCUHT
- Organisational sovereignty – will people really take off their organisation hat?
- Lack of skilled project support - PMO/Governance/communications
- IMT - some areas of Cumbria do not have a strong broadband service

B. Summary of future needs and demand assessment

The current model of care in Cumbria is unaffordable given the demographic and geographic challenges outlined above, the current financial position and the forecast growth in demand for health and social care.

The **financial gap across Cumbria is projected to grow significantly over the next 5 years if no action is taken to implement system-wide transformational change**. Based on population growth assumptions and current understanding of future inflationary cost pressures and revenue growth, the financial gap is projected to grow to **£189m** in 5 years if no action is taken to address provider inefficiencies and changes in commissioning of healthcare.

C. Summary of current pattern of provider provision

MBUHT is the main provider over three sites of acute services across Morecambe Bay with mental health services provided by the Cumbria Partnership FT. Both providers are proactively working in conjunction with the Cumbria and Lancashire North CCGs to co-design new service models to address the sustainability challenges they face.

Lancashire North CCG has a higher **provider concentration rate** for both inpatient and outpatient services, compared to Cumbria CCG

In the north NCUHT operates from two sites and provides all acute care, though there is as much as £23m of care provided outside Cumbria, predominantly in Northumbria and Newcastle.

For both CCGs, over 75% of inpatient episodes are in relation to **long-term conditions**, which is higher than national upper quartile

Cumbria has fewer **patients per GP** (1,595) than the national average (2,045)

D. Summary of efficiency opportunities

The BCT SVT has highlighted efficiency opportunities relating to:

- Reduction of emergency and elective admissions
- A repatriation opportunity of £6.9m ;
- Reduced Length of Stay
- Cost reductions across Obstetrics, Geriatric medicine, ENT at MBUHT, and General Surgery, Geriatric medicine, Obstetrics, Peadiatrics at NCUHT

There are also opportunities greater efficiencies, such as;

- planning measures to reduce future demand on the system
- Introduction of a system-wide PMO capability that drives as well as measures progress and maintains the SVT.

E. Summary of capability, capacity or other challenges in the area and implementation assessment

Capacity is stretched across the LHE due in part to the operational issues that the Trusts are facing on a daily basis to improve their performance around quality. This review is also taking place at a time when regulatory focus is bringing additional resource constraints such as the forthcoming CQC inspection at NCUHT.

There is no history of delivering sustainable, transformational change, and as yet no clear plan of how this will be set up across the LHE.

The main focus currently within the MB LHE is developing options to address the overall financial affordability challenge that will then inform the SC. There is a strong commitment, engagement, drive and energy from system leaders to make this happen. However, implementing a new service model on the scale that is being developed across the bay will be a major challenge for each organisation and will require investment, focus and continuing leadership from July onwards.

A key risk to the delivery of a transformational system-wide solution is the ongoing uncertainty regarding the proposed acquisition of North Cumbria University Hospital NHS Trust (NCUHT) by Northumbria Healthcare FT (NHFT). This risk affects organisations other than NCUH. For example, the risk is manifested through:

- staff leaving through concerns over job security and not being replaced
- extensive use of locum clinical staff
- Loss of corporate knowledge and NHS “know how”

The role and purpose of Public Health is not evidenced in these plans, beyond some passing references to the Health and Wellbeing Board. Public Health has a key role to play in the system-wide transformation.

1.4 What this means for the LHE

There will be a requirement for significant detailed design and implementation activity once the SC has been approved in the south which will require strong system leadership.

In the north the issues are even more demanding so transformational change will need to be more innovative and be implemented with more pace.

As a LHE there needs to be strong leadership across all organisations as there will be robust local and Political resistance to the scale of changes that are going to be needed to overcome the issues faced.

A system wide governance and delivery model must be set up in advance of implementation to provide the best opportunity for success.

1.5 Risk assessment of the likelihood of robust, aligned plans being delivered.

Our overall assessment on the deliverability of the SC in Morecambe Bay by end June is Amber/Green with some reservations around the tight timeframe to develop the short-listed options and ability of each organisation to align with the SC. This requires strong leadership throughout which is evident and in place but the complexity and political sensitivity involved is a major factor impacting on MB.

Our assessment of whether a 5 year strategic plan can be produced, signed up to by all parties and robust to deliver sustainable quality and financial stability is **Amber / Red.**

The parties are certainly capable of delivering a plan, but there are significant issues that could lead to the plan not being completed, or not being sufficient to scale the issues:

- the scale of the challenges faced – financial and quality
- two separate workstreams in the north and south that need completing and bringing together;
- the capacity in the system to develop these longer term plans while dealing with the here and now issues such as CQC inspections, acquisition plans etc.

1.6 Focus of solution development

Morecambe Bay

The key issues we are focusing on now in developing a long list of options is the In Hospital impact of the Out of Hospital model on acute services in MB and the potential to consolidate services onto one or two sites. These options are currently being modelled and reviewed through an iterative process that involves senior finance, clinical and operational leads in MB.

North Cumbria

Focus is on preparing the Care Design Groups (Urgent; Planned; Proactive care) on 6th and 15th May. These will be crucial to the development of the options, but will utilise existing strategies that have been developed across north Cumbria so pace should be possible as many of the issues have been debated in previous iterations of the clinical strategy.

1.7 Any further diagnosis required

BCT - Intensive work is currently underway to develop a long-list of system options for the Clinical Summit on 29 April. The feedback from the Clinical summit from 200+ delegates will then inform the development of a short-list of options that will be costed and evaluated as part of final production of the SC in June 2014.

In the north there is a clear plan to develop the SVT and to understand the underlying reasons for the deficits at NCUHT and CPFT. These reports are due to be finalised in the next couple of weeks so a more specific assessment can then be made of the position the north finds itself in.

A Summary of analysis regarding issues and barriers to health economy sustainability

A1 State the key issues and barriers to delivery of safe and high quality service within the affordable finances, and quantify this from evidence – including any data that backs this up

Our meetings with stakeholders have focused on exploring the challenges faced by the LHE, and the potential barriers to change. This section backs up this qualitative analysis with highlights from the SVT.

Key issues

Cumbria is a beautiful place to live and work – but this comes with extreme challenges:

- 520,000 population spread across a land mass area greater than the size of Greater London
- This population is significantly older and carries excess weight compared to the rest of England
- Geographically dispersed populations, isolated from major population centres, such as Barrow in Furness, Workington & Whitehaven.

Which leads to some poor health outcomes for its population

- Significant variation in health outcomes across the LHE - the difference in life expectancy between Moss Bay in Workington and Stainton near Penrith is 19.5 years.
- Morbidity and burden of disease is increasing, and recent reports have identified significant shortcomings in children's services.

Which means the LHE's allocation of c.£663 million must increasingly be used creatively

- Three main providers account for £426m of this, but around £25m is spent out of area.
- From a £6m deficit in FY10/11 the CCG returned surplus in 11/12 of £4m and £6m in 12/13.
- The three provider Trusts are forecasting a deficit position for FY15 in the region of £50m. We forecast that this will increase to c. £190m in 5 years. Without significant transformation this in itself will be a barrier to the provision of sustainable and safe care.

The senior management teams of the key organisations all speak about the same issues driving the problems faced in Cumbria illustrating that they have the same sense of burning platform. Without exception they highlight:

- The current financial situation whereby a deficit position exists in all three Trusts and forecasts are expecting a worsening position.
- The Quality issues faced by all three Trusts – predominantly as a result of poor leadership and financial mismanagement over a number of years. There is a sense that they have a grip on this now but that the problems are quite deep rooted so there are no quick wins to turn things round.
- The LHE's geography and demographic profile are reasons for the problems faced – they talk of an acceptance of this but a need to recognise the issues and then move on to developing solutions that are fit for purpose – the geography isn't going to change!
- A result of the Quality, geographic and demographic issues is the continuing problems the Trusts face in recruiting staff – from strong leaders to nursing staff. Its remote location, distance from a strong medical teaching facility and more latterly the poor PR the LHE has received, all serve to dissuade potential recruits from making Cumbria a choice for their career development. "Clinicians come here to walk the hills, not to progress their career" – a sweeping statement but with a sense of reality.

- An inability to get things done across the LHE – strategies have been developed and signed off but there has not been the traction to enable delivery. This has been due to a lack of universal sign off or buy in – reflecting previous issues where clinicians and management were not on the same page, and also to a lack of robust programme management structures and governance issues.

Better Care Together Programme (South Cumbria)

The key issues impacting on sustainability of the health and social care system in MB are:

- Demographic challenge – Lancs North has some poor public health outcomes such as high alcohol abuse and STI figures above average emergency admissions. South Lakes has a significantly older population than the national average with the proportion of over 65's projected to rise by 60% by 2035. Furness has significant levels of deprivation and health inequalities being the 3rd most deprived shire district council area in England
- Geographic challenge – the MB footprint covers a vast geographical area 1,800km2 which is more than double the area for the national average trust (815km2;) and the population (365,000) is less than the national average (418,000). MBUHT has a very low level of spells per site (33,700) compared to the national average (73,800) as a consequence of the lower than average population and geographical spread which means working on 3 sites rather than the national average of 1.4.

North Cumbria

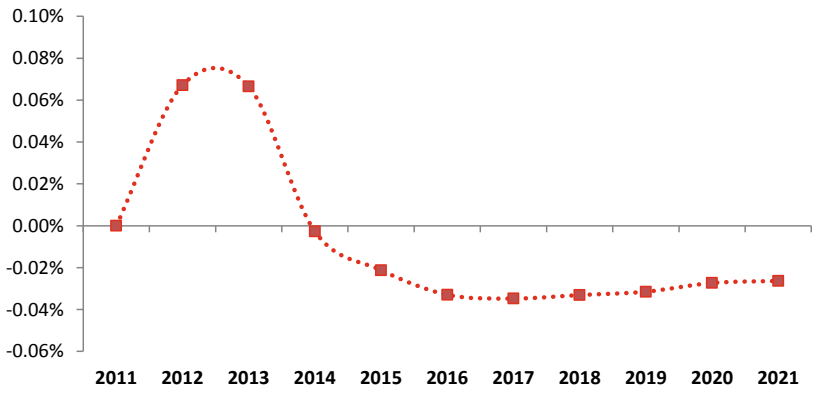
The north faces very similar demographic and geographic challenges to the south, which plays out at its most telling manner within NCUHT. In 19 specialties, the average activity per site is 35% or more below the national average; twelve of these specialties would still be below the national average even if consolidated on one site. Indeed the two sites are within the lowest quartile nationally for activity per site volumes.

Demographics

Current population overview:

- Total population: **0.51 m**
- Total male population: **0.25 m**
- Total female population: **0.26 m**
- Male vs. Female ratio (%): **49 / 51**

Cumbria population growth, 2011 – 2021



Source: Office of National Statistics (ONS)
Sub-national population projections, Interim 2011-based

- 56% of residents are in age group 40+. The **ageing society** will put pressure on healthcare expenditure in the next 5-10 years
- A higher healthy life expectancy than national average, for both at birth and at age of 65, which will put pressure on healthcare expenditure
- Higher proportion of people have long-term illness such as obesity, disability than national average.
- Issues with binge drinking and healthy eating which would result in health problems - higher percentage of binge drinkers and less healthy living style compared to national average.
- Stroke is the primary cause of death
- High percentage of residents with **long-term illness** such as obesity or with **disability**, which are the key tributes to high inpatient activities

Activity

- Large percentage (39%) of activities are in elective care for patients in **age group 60+**
- The number of activities in **midwifery and paediatrics** is higher than national level
- Lancashire North CCG has a higher **provider concentration rate** for both inpatient and outpatient services, compared to Cumbria CCG
- For both CCGs, over 75% of inpatient episodes are in relation to **long-term conditions**, which is higher than national upper quartile
- For the 2 top sites, a few specialties have low activity rates, which indicate possibility of **consolidating the services** with neighbouring sites

Quality

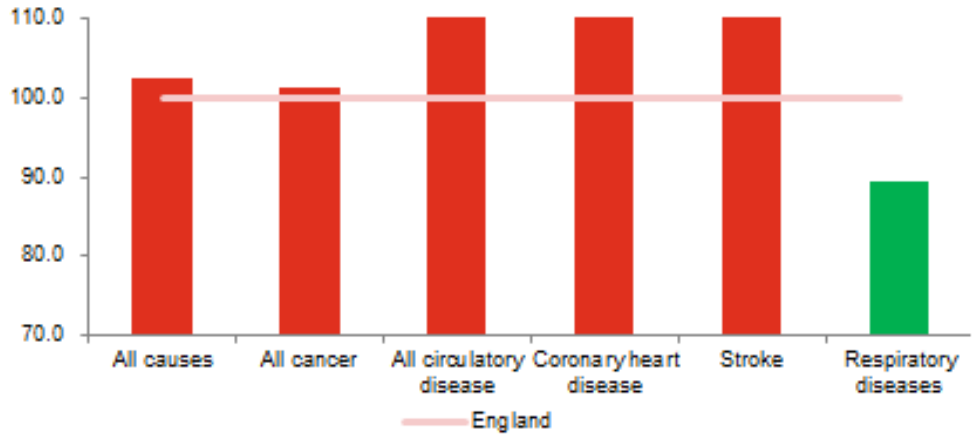
Cumbria and England: Healthy life expectancy (HLE)

Cumbria	*HLE at birth*	**63.7 years**	**65.4 years**
	HLE at 65	**9.4 years**	**9.9 years**
England	*HLE at birth*	**63.2 years**	**64.4 years**
	HLE at 65	**9.0 years**	**9.5 years**

Source: Office of National Statistics (ONS)
Healthy Life Expectancy at birth and age 65 by Clinical Commissioning Group (CCG)

- The **SHMI and HSMR** rates are slightly higher than expected

Fig.7 Cumbria and England: Causes of deaths (SMRs)*



Standard Mortality Ratio (England = 100)

Source: Public Health England

- Bed efficiency could potentially be improved. On average, the acute bed **occupancy rate** (85%) is lower than national average (87%) in period 2011 – 2014. There is a trend of increasing number of acute beds in Cumbria

Barriers to delivery of safe and high quality service within the affordable finances

Our qualitative review of plans and meetings with key stakeholders has highlighted a number of potential barriers to change, many of which were repeated by all.

- There is a history of clinician versus management clashes – "NCUHT clinicians have seen off more than one management team over years". This is improving but needs to go further to ensure all parties speak with one voice and towards one vision.
- Lack of stability – many leadership and structural changes over the years have not been conducive to effective change.
- Recruitment issues will not be solved overnight and thi sis one of the key drivers of the problems faced. Lancaster University may become a Medical School which will help, but over the longer term.
- The local population is very vocal – the slightest change to services is met with challenge, often supported by local politicians.
- Clarity of service models for Whitehaven and Barrow - until sorted will remain elephant in room.
- Clarity around the acquisition of NCUHT will also encourage more definitive forward thinking
- Organisational sovereignty – need flexibility to make solutions work - will people really take off their organisation hat?
- Lack of skilled project support - PMO/Governance/communications - clinicians have the ideas, but not the plans and previous delivery has been poor.
- IMT - some areas of Cumbria do not have a strong broadband service so this can limit some IMT solutions

A2 Review & summarise the existing analysis of strategic issues /challenges, drawing on the following measurement criteria:

Understanding of strategic issues/challenges		Outstanding **Good** Requires improvement Inadequate	**Comments**. The LHE has a very good understanding of these issues. There is still some detailed analysis required before they have an Outstanding understanding – the deficit reviews at NCUHT and CPFT are yet to report, and the north does not yet have a SVT that is accepted and bought into by all parties.
What outstanding would look like	*The LHE has a clear understanding of its system-level challenges and the drivers of these. This understanding is accepted by all and is understood by both patients and staff*		The LHE has a clear shared view of the challenges faced and the drivers of those challenges. The key leaders all acknowledge the same set of issues and all identify similar barriers to implementation.
Further detail existing analysis completed			

This overall assessment was reached following assessment of documents and stakeholder interviews, as detailed in the appendices.

Underpinning the overall assessment were the following four hypotheses, which each document or interview looked to prove.

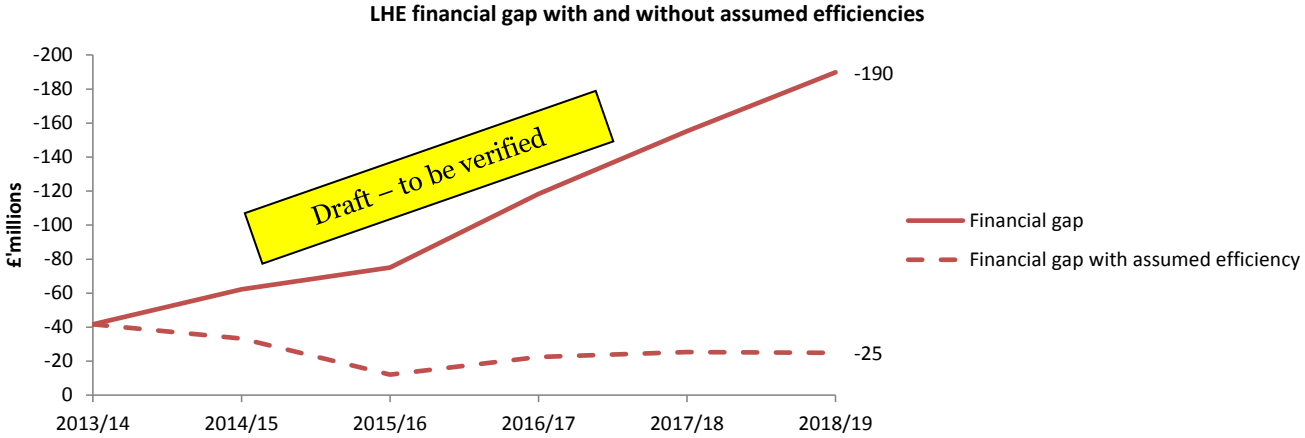
#	*Hypothesis*	*Poor*	*Good*
1.	*The LHE has a shared understanding of the scale of the challenge it faces*	• *No clear evidence of a system-level view of the challenges and their key drivers* • *Unclear how individual organisations are working together to understand the system-level issues* • *Evidence that individual organisation's demand assumptions are not aligned* • *No clear evidence of patient and/or staff involvement in understanding issues*	• *A single document/group of documents, detailing the challenges and drivers faced, exists and is accepted by all key stakeholders* • *Evidence of joint-working in the development of this document can be shown* • *A shared set of demand assumptions are in place to support this* • *Evidence that staff and patients have been engaged in the process and understand the case for change*
2.	*The LHE has a shared understanding of the drivers behind its challenges*		
3.	*This understanding and the case of change have been communicated to staff and/or patients*		
4.	*Each organisation has an understanding of how the system challenges affect their own organisation*		

B Future needs and demand assessment

B1 Restate future financial challenge, drawing on the following analysis

- The spend on health and social care in Morecambe Bay is in excess of £500m.
- UHMBFT FY13/14 shortfall is projected at £20.8m, with the underlying deficit £25-26m.
- The affordability gap is projected to rise to £71m in five years time if no action is taken.
- If all organisations deliver efficiencies across the next five years in line with national requirements a residual financial gap of c.£30m will still exist.

- In the north the full extent of the impact of future demand is still being formulated through the SVT and deficit reviews of CPFT and NCUHT.
- We know that in FY 14 NCUHT reported a deficit of £27m, against a planned deficit of £11m.
- The unfolding 5 year forecast of financial deficit is expected to be in the region of £190m across the LHE:



B2 State demand assessment, drawing on the following analysis

- Population is expected to decrease at a 0.01% annual rate, reaching 0.49m by 2021.
- Cumbria's population is not uniformly distributed across age groups. Approximately 56% of the population falls in the 40+ age group, and a third falls in the 60+ age group. Population is uniformly distributed between ages 0-36 (with a spike between ages 11-19).

- Cost inflation rates assumed in the projections reflect those calculated by Monitor as part of their "total affordability challenge" calculations for the NHS. These are blended uplifts of acute and non-acute input cost inflation, including the average impact of the Clinical Negligence Scheme for Trusts ("CNST") uplift and pensions costs.
- These cost inflation rates, when combined with the population growth forecasts, mean that the overall cost to the health economy grows faster than the income, leading to an increasing financial gap over the next 5 years.

B3 State assessment of future demand thinking, drawing on the following assessment criteria

<table>
<tr><td colspan="2">Initial analysis of future demand thinking</td><td>Outstanding
Good
Requires Improvement
Inadequate</td><td>Comments

Overall this requires improvement but in the south the picture is clearer. A FMOC is evolving but is not yet in a state that is agreed and written down in a way that can be developed into detailed plans. The CDG process has been very engaging and offered every opportunity for the right people to be involved in shaping future models, including extensive public and patient engagement.
In the north this thinking is only just emerging, and certainly is not documented. It is too early to comment on the involvement of patients and staff in the north, but the plans are in place to make this happen.

It will be a demanding process to stitch together the emerging thinking in the south with the work in the north whilst ensuring that all stakeholders remain well engaged.</td></tr>
<tr><td>What outstanding would look like</td><td>The system has a shared vision for the future, supported by robust initiatives that can be shown to tackle the key challenges. Patients and staff have been clearly involved in the process</td><td colspan="2">A shared vision is emerging in the south, backed up by some detailed modelling. In the north however there is a reliance on the existing clinical strategy that was developed 3-4 years ago but that has struggled with implementation. A revised vision needs to build on this strategy but using the most up to date baseline information.</td></tr>
<tr><td colspan="4">Further detail existing analysis completed</td></tr>
<tr><td colspan="4"></td></tr>
</table>

This overall assessment was reached following assessment of documents and stakeholder interviews, as detailed in the Appendices.

Underpinning the overall assessment were the following four hypotheses, which each document or interview looked to prove.

#	*Hypothesis*	*Poor*	*Good*
1.	*A shared vision exists across the system, articulating the future model of care (FMOC)*	• *The system-level vision for the future is unclear or poorly defined* • *Organisations are not joined-up in their understanding of the future vision* • *Clear initiatives to deliver the vision are not demonstrable , neither is detailed analysis to prove changes are meeting the particular challenges* • *Staff and/or patients have*	• *A single document/group of documents, detailing the future vision for the system exists and has the buy-in of all organisations involved* • *Vision – this is clearly defined and joint-ownership of it can be evidenced* • *Initiatives – are clearly laid out, including how they will be delivered* • *Analysis – detailed analysis exists demonstrating the expected impact of the changes*
2.	*A list of initiatives exists to deliver the FMOC and has been translated to organisation-level*		
3.	*Analysis has been completed to prove that the FMOC will address some/all of the challenges*		
4.	*The FMOC is a co-creation of staff and patients and*		

	understood by them, including their roles in delivering it	*not/are not clearly involved in the process*	*proposed* • *Evidence of staff and patient involved in the FMOC creation can be provided*

C Assessment of the current pattern of provider provision

C1 State the current pattern and issues in provider provision, drawing on what is key from the following analysis (including benchmarking data)

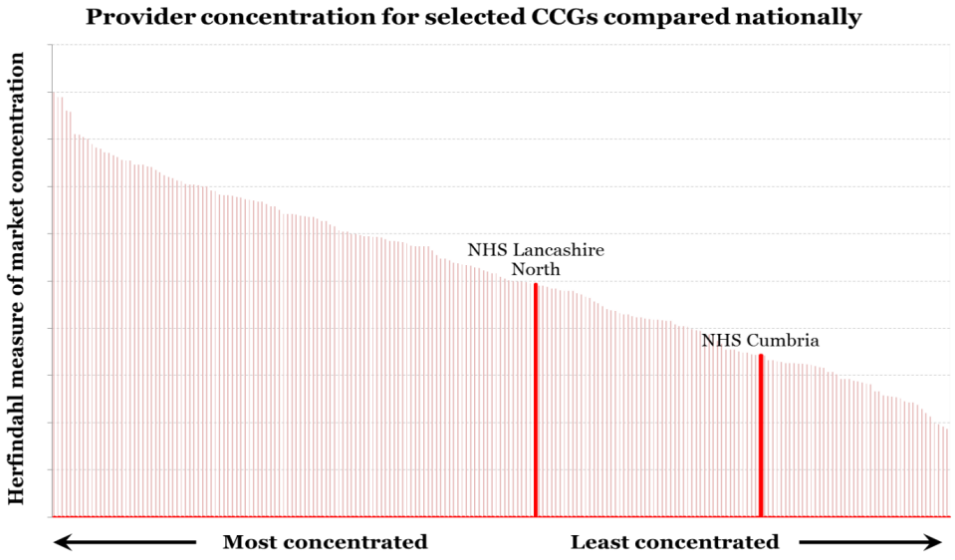
A comprehensive 'Single Version of the Truth' has been produced for Better Care Together which details all of the baseline information required. For the north an SVT is being produced so that they are able to undertake the Care Design process with similar set of baseline information. The BCT SVT summary is attached as appendix to this report.

Inpatient providers

- Cumbria CCG commissions the inpatient services to two major providers, i.e. North Cumbria University Hospital (48%) and University Hospital of Morecambe Bay (33%)
- Lancashire North CCG commissions the inpatient services to one major provider University Hospital of Morecambe Bay (67%), and some to Lancashire Teaching Hospitals (22%)

Inpatient provider concentration

- Comparing to all CCGs nationwide, both Lancashire North and Cumbria CCGs have medium to low concentration rate
- Lancashire North CCG works with a smaller number of inpatient service providers compared to Cumbria CCG. This could be for geographical reason, or be based on commissioning preferences
- The impact on negotiation power and quality of services can be further examined
- Currently, the majority of spells in Cumbria are in elective care for elderly people. This distribution is expected to remain the same by 2018
- The majority of inpatient activity in Cumbria is related to patients with long-term conditions



Outpatient providers

- Cumbria CCG commissions the outpatient services to two major providers, i.e. North Cumbria University Hospital (44%) and University Hospital of Morecambe Bay (39%)
- Lancashire North CCG commissions the outpatient services to one major provider University Hospital of Morecambe Bay (82%)

Outpatient provider concentration

- Comparing to all CCGs nationwide, Lancashire North CCG has a high provider concentration rate, Cumbria CCG has a medium/low concentration rate
- Lancashire North CCG mainly works with one outpatient provider
- The impact on negotiation power and quality of services can be further examined

Primary care – GP provision

Total

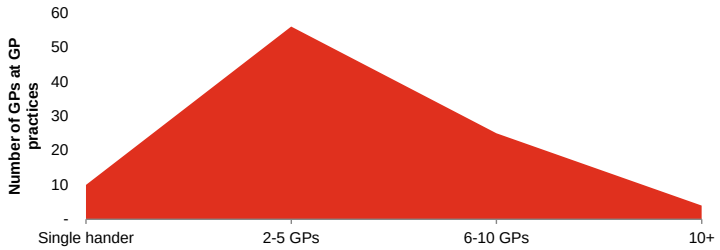
GP Surgeries: **95**

Total GPs: **427**

Total Patients: **680,922**

Patients per GP: **1,595**

UK average per GP: ***2,045***



Social Care Provision

- Cumbria has the second highest spend on social care in England. Compared to counties with similar demographics and characteristics, Cumbria has the highest spend on social care.

D Identification of efficiency opportunities

The BCT SVT has highlighted efficiency opportunities with:

- 28% of UHMB's admissions could be managed in a non-acute setting
- An opportunity in the system to reduce emergency admissions (6,053) and elective admissions (4,705)
- A repatriation opportunity of £6.9m in elective activity
- University Hospitals of Morecambe Bay NHS FT can reduce ALoS compared to peer average
- North Cumbria University Hospital NHS Trust could potentially improve bed efficiency by comparing to peer upper quartile
- Potential cost saving opportunities in the following specialties
    - University Hospitals Morecambe Bay NHS FT: Obstetrics, Geriatric medicine, ENT
    - North Cumbria University Hospital NHS Trust: General Surgery, Geriatric medicine, Obstetrics, Peadiatrics

The review of the North Cumbria partner organisations' plans demonstrated a range of opportunities for benefits to be realised through greater efficiencies. For example:

- Development of a single North Cumbria Vision for Integrated Health & Social Care Eco-system

- Risk Stratification of the entire population to identify and baseline existing demand and plan pre-emptive measures to reduce future demand on the system
- Develop a North Cumbria Roadmap that shows how the new integrated eco-system will be introduced, over time, with milestones, governance and dependencies etc
- Identify and develop a common set of North Cumbria Enablers and the plans to deliver them eg transport, technology (inc portal & ECR), novel finance & contracting, workforce, infrastructure, governance etc
- Introduction of a system-wide PMO capability that drives as well as measures progress and maintains the SVT.

E Capability, capacity and implementation challenges

Identification of any particular capacity or other challenges in the area (e.g. project management, communications, leadership) that may be impacting on a successful planning process.

E1 State initial analysis of system's capability & capacity to deliver change, drawing on the following assessment criteria

Initial analysis of system's capability to deliver change	Outstanding Good **Requires Improvement** Inadequate	**Comments** The MB LHE will require additional capacity to implement change once the SC has been approved. A recent OGC Gateway review highlighted the need to ensure sufficient skills, capacity and budget is in place to support implementation (refer OGC Health Gateway Review, 6 March 2014) Likewise in the north there will need to be strong governance around the delivery mechanism set up to manage delivery of the programme as there is a history of non delivery.
What outstanding would look like	*The LHE has the capability & capacity at all levels and in all constituent organisations to deliver a transformational change programme. It has identified the key delivery risks and is mitigating them.*	*Delivery of strategic change is not something this LHE has done well in the past and will require extensive support in developing a system and governance for implementation.* *Managing implementation risk is not something that has been done well and the LHE will need a lot of help to instigate a rigorous process.* *The LHE is frought with political, and Political, issues which will need stakeholder management to the highest order. There is some expertise within the BCT programme, but this will need to be complimented with further experienced resource.*
Further detail existing analysis completed		
Change capability • Individually each organisation has good leadership and governance around the changes it is making internally, with evidence of increasing success in delivering successful project outcomes. • There is however little evidence of there being such arrangements in place when more than one		

organisation needs to work together to achieve improvements.
- For any form of transformational change this structure must be agreed and implemented.

Capacity
- Each organisation faces significant financial and quality issues that are being addressed, though this clearly means that attention cannot be afforded in sufficient quantity to the strategic issues that will deliver sustainable change.
- It is hard to see how they will have sufficient capacity to deliver the changes that are required across the system as attention is often diverted to the more immediate operational issues that arise, or the quality concerns raised through inspections and the assurance process.

Implementation could also be hampered by the political issues across the county, with a small and capital P.

This overall assessment was reached following assessment of documents and stakeholder interviews, as detailed in the Appendices.

Underpinning the overall assessment were the following four hypotheses, which each document or interview looked to prove.

#	*Hypothesis*	*Poor*	*Good*
1.	*The system can evidence previous examples of successful delivery of change programmes*	• *Little or no evidence of joint-working to deliver the transformation to date* • *Little or no evidence of previously successful change programmes* • *No firm evidence that particular organisations understand how to deliver a change programme* • *Unclear how staff will have the required capacity to deliver the changes proposed* • *Limited evidence of cross-organisation working*	• *Evidence of a joined-up cross-system leadership team that can drive the transformation* • *Evidence of prior delivery of successful change* • *Evidence that work has been done within each organisation to understand how they can enable to proposed change* • *Evidence that staff have the capacity to deliver on the proposed changes* • *Evidence of effective joined up working between organisations*
2.	*The system's leadership structures operate in a manner as to support such a change programme*		
3.	*Each organisation can demonstrate how it would deliver such a change programme*		
4.	*The system has capacity in its staff to deliver transformational change*		

E2 State initial analysis of implementation ability drawing on the following assessment criteria

Initial analysis of implementation ability		Outstanding Good **Requires Improvement** Inadequate	**Comments** The implementation ability requires improvement and relates to the capacity point highlighted above. The scale of change required from moving to new integrated service models will draw on operational, procurement, change management skills and expertise and individuals with a track record.
What outstanding would look like	*The LHE has undertaken a robust assessment of the impact proposed changes will have upon both the constituent organisations and the quality and level of care provided. Patients and staff have been clearly involved in this process.*		In developing the SC each individual organisation will be undertaking an impact assessment and assess any gaps in implementation capability, supported by the Bettercaretogether programme team. As models are only just emerging there has been little assessment of impact undertaken.
Further detail existing analysis completed			
• Limited opportunities to undertake impact assessment as the models of care are yet to be determined.			

This overall assessment was reached following assessment of documents and stakeholder interviews, as detailed in the Appendices.

Underpinning the overall assessment were the following four hypotheses, which each document or interview looked to prove.

#	*Hypothesis*	*Poor*	*Good*
1.	*The LHE understands the impact of the proposed changes upon each of its constituent organisations*	• *No impact assessment is available at a system-level* • *No impact assessment has been completed by the LHE organisations* • *No evidence of a QIA* • *No clear evidence that staff and/or patients have been engaged and fed back on the impact of the proposed changes*	• *A robust system-level impact assessment has been completed* • *Each organisation can demonstrate their understanding of the impact* • *A specific quality impact assessment has been completed* • *Evidence can be provided that patients and staff are aware of the impact of the proposed changes and have had an opportunity to comment/feedback on this*
2.	*The LHE understands the impact of the proposed changes upon the level and quality of care*		
3.	*Each organisation can demonstrate their response to the system-level changes*		
4.	*Patients and staff are aware of the expected impact of the transformation programme*		

E3 Risk assessment of the likelihood of robust, aligned plans being delivered

Our overall assessment on the deliverability of the SC in Morecambe Bay by end June is Amber/Green with some reservations around the tight timeframe to develop the short-listed options and ability of each organisation to align with the SC. This requires strong leadership throughout which is evident and in place but the complexity and political sensitivity involved is a major factor impacting on MB.

Our assessment of whether a 5 year strategic plan can be produced, signed up to by all parties and robust to deliver sustainable quality and financial stability is **Amber / Red.**

R	highly unlikely
A/R	**possible, but with some major reservations**
A/G	likely, but with some reservations
G	highly likely

Rationale and evidence

The timeframe for BCT to develop the SC by end June is extremely demanding given the complexity of the challenge, the number of stakeholders and organisations involved and their geographical distribution.

In addition, the CQC is soon to release the results of the quality inspection of MBUHT and there is an ongoing Maternity Services Enquiry as well as alignment of the MB plans with the North Cumbria plans. This level of complexity is high and therefore impacts on the ability to align the plans. However, there is strong commitment from system leaders to address these issues as part of finalising the SC.

Similarly in the north the timescales are tight. The delay in starting a process similar to the BCT programme in the south, albeit due to the impending acquisition, means that the north does not yet have a shared baseline from which to develop its transformational models of care.

This has implications for bringing together the plans for north and south into one strategic plan for Cumbria. Delivering a well thought through coherent strategy, into which all parties are bought into by mid-June is going to be very demanding.

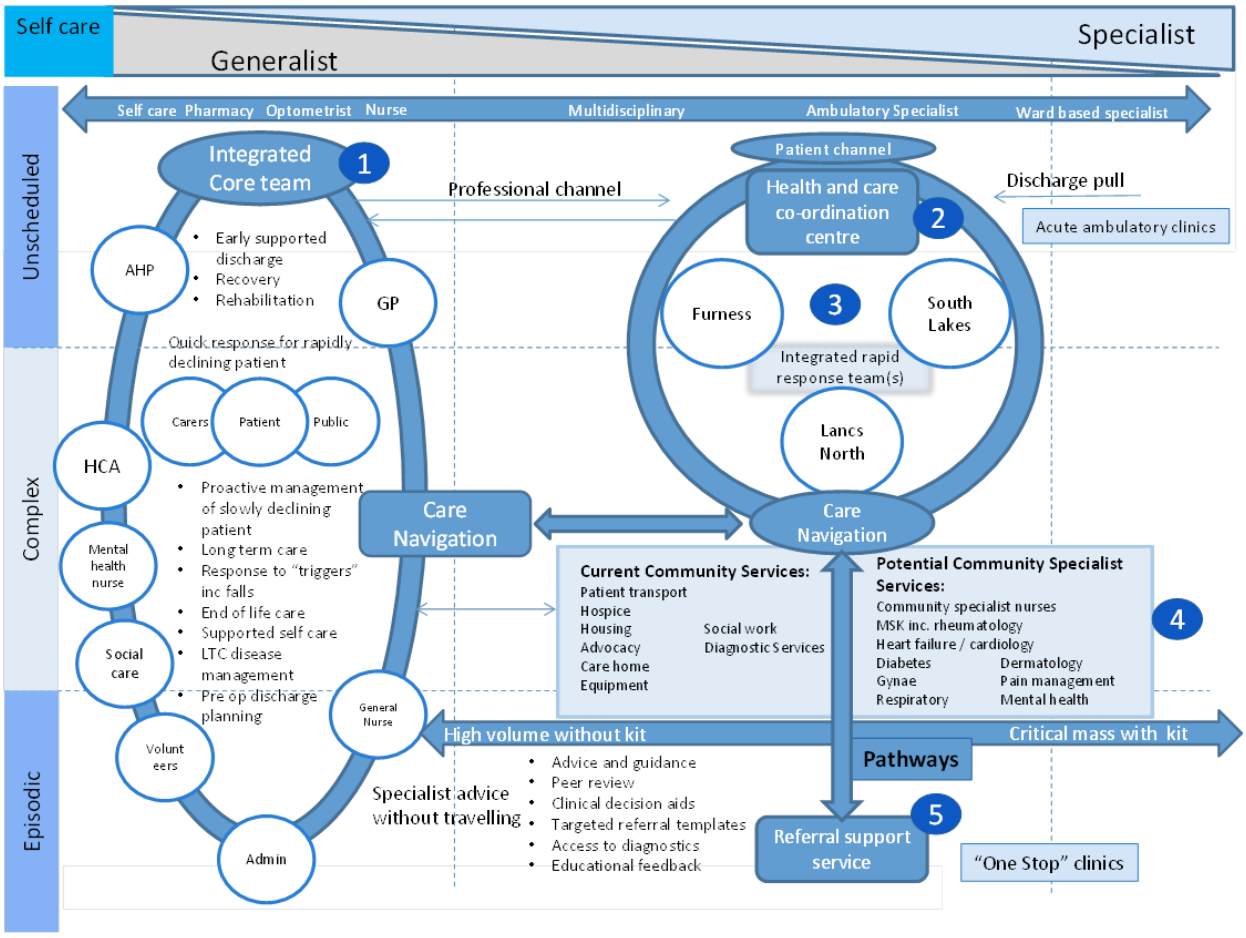
The solutions are not yet developed so it is difficult to provide assurance that the various stakeholders will buy into them.

The solutions will require rigorous stakeholder engagement and the time in which to do this is limited. There will also need to be careful engagement beyond the boundaries of the key organisations, and the local Political interest is known to be high.

7. Key issues for solutions development and options appraisal.

In the south the care design process is coming to its conclusions. An Out of Hospital (OOH) model has been developed and this will now be socialised more widely through the Clinical Summit (29th April) and ongoing stakeholder engagement. The next stage is to determine how this OOH model impacts on care in hospital and all associated parts of the system. This will be achieved through working sessions with the Clinical Reference Group and ultimately approval at the BCT Programme Board.

The Out of Hospital service model and key service changes for MB is outlined below (and included in the Appendices on a larger scale) :



In the north this model will be a key input to the CDGs together with their existing clinical strategy (Care closer to home), and other relevant service developments, such as Primary Care Communities.

The Care Design Groups in the north will focus on three care pathways – Urgent, Elective and Proactive. These choices are driven by the operational and structural issues that the LHE faces with regard access to services across the patch. This will also complement the work already undertaken in the south. The Proactive Care session will help to develop the LHEs thinking with regard Primary Care Communities.

It is important that Cumbria seeks to adopt one model of care, though it is also noted that the challenges are more significant in the north and therefore may require more innovative and far reaching changes.

8. Outstanding diagnostic work

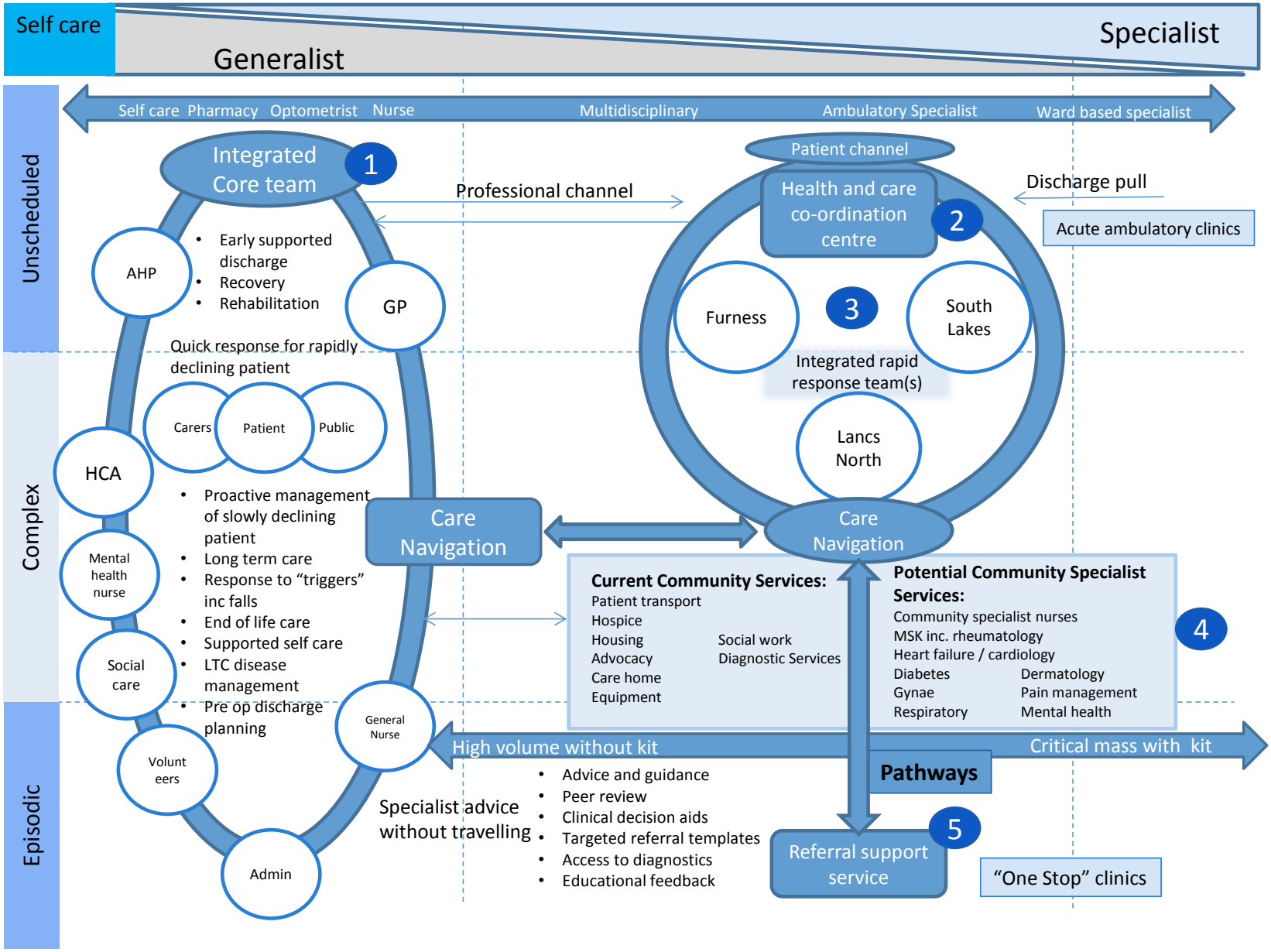
In the south no further diagnostic work is required as the SVT is complete. However, an intensive process is currently underway to model the options that are being developed following the Care Design Process and upcoming Clinical Summit.

In the north there are three ongoing pieces of diagnostic work – the two deficit reviews at NCUHT and CPFT, and the SVT for the north of Cumbria.

Appendices

#	*Document name*	*Document owned by*
1.	North Cumbria Health Care System - Clinical Strategies and Service Assessments, January 2014	*Cumbria CCG*
2.	Draft Strategic Plan 2014-15 to 2018-19, dated April 2014	*Cumbria CCG*
3.	Securing Sustainability: Two Year Plan Summary - 2014/15 to 2015/16 Final - 4th April 2014	North Cumbria University Hospital NHS Trust (NCUHT)
4.	Our operational plan 2014/16	University Hospitals of Morecambe Bay - NHS Foundation Trust
5.	Transformational Quality & Cost Improvements (undated)	Cumbria Partnership NHS Foundation Trust
6.	Operational Plan Document for 2014-16	Cumbria Partnership NHS Foundation Trust
7.	Adult Social Care Service Plan 2014-15: Disability Health & Social Care Services	Cumbria County Council
8.	Adult Social Care Service Plan 2014-15: Older People. Health & Care Services Directorate	Cumbria County Council

#	*Stakeholder name(s)* *Details of north Cumbria only. BCT has an extensive stakeholder programme underway.*	*Date of interview*	*Organisations*
1.	*Sarah Senior, FD*	*11 April 2014*	*CPFT*
2	*Michael Smillie, Director, Strategy*	*11 April 2014*	*CPFT*
3	*Ann Farrar, CX*	*15 April 2014*	*NCUHT*
4	*Amanda Evans, Director Adult Social Services*	*15 April 2014*	*CCC*
5	*Debbie Freake, Director, Strategy*	*15 April 2014*	*NCUHT*
6	*Claire Molloy, CX*	*16 April 2014*	*CPFT*
7	*Alan Swann, Acting MD*	*16 April 2014*	*CPFT*
8	*Michael Hutt, CX*	*16 April 2014*	*CPFT*
9	*Charles Welbourn, FD*	*16 April 2014*	*CCG*
10	*Nigel Maguire, Chief Officer*	*16 April 2014*	*CCG*


Self care
Generalist
Specialist
Unscheduled
Complex
Episodic
Self care Pharmacy Optometrist Nurse
Multidisciplinary
Ambulatory Specialist
Ward based specialist
Integrated Core team
1
Professional channel
Patient channel
Health and care co-ordination centre
2
Discharge pull
Acute ambulatory clinics
AHP
GP
Early supported discharge
Recovery
Rehabilitation
Quick response for rapidly declining patient
Carers
Patient
Public
HCA
Mental health nurse
Social care
Volunteers
Admin
General Nurse
Proactive management of slowly declining patient
Long term care
Response to "triggers" inc falls
End of life care
Supported self care
LTC disease management
Pre op discharge planning
Furness
3
South Lakes
Integrated rapid response team(s)
Lancs North
Care Navigation
Care Navigation
Current Community Services:
Patient transport
Hospice
Housing
Advocacy
Care home
Equipment
Social work
Diagnostic Services
Potential Community Specialist Services:
Community specialist nurses
MSK inc. rheumatology
Heart failure / cardiology
Diabetes
Gynae
Respiratory
Dermatology
Pain management
Mental health
4
High volume without kit
Critical mass with kit
Pathways
Specialist advice without travelling
Advice and guidance
Peer review
Clinical decision aids
Targeted referral templates
Access to diagnostics
Educational feedback
Referral support service
5
"One Stop" clinics