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Intensive Planning Support to Challenged LHEs

Report 2: Summary report to National Partners on preferred solution including an updated risk assessment of delivery

Cumbria

Monitor, NHS England, NHS Trust Development Authority

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Version 1.1

Commercial in Confidence

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Glossary of terms and abbreviations

Abbreviation	Definition
BCF	Better Care Fund
BCT	Better Care Together
CCC	Cumbria County Council
CCG	Clinical Commissioning Group
CDG	Care Design Group
CIC	Cumberland Infirmary Carlisle
CPFT	Cumbria Partnership NHS Foundation Trust
CQC	Care Quality Commission
CRS	Commissioner Requested Services
ENT	Ear, Nose and Throat department
FMOC	Future Model of Care
FY	Financial Year
IMT	Information Management and Technology
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
RLI	Royal Lancaster Infirmary
SOC	Strategic Outline Case
SRO	Senior Responsible Officer
SVT	Single Version of the Truth
WCH	West Cumberland Hospital
WGH	Westmorland General Hospital

1. Executive summary

The geography and demography of Cumbria play an important part in the way the Local Health Economy (LHE) is managed and governed. There are six localities. Four of these are aligned to the North Cumbria University Hospitals NHS Trust (NCUHT) which has sites in Carlisle and Whitehaven. The other two localities are aligned to Morecambe Bay University Hospitals NHS Foundation Trust (MBUHT), and together with the Lancashire North CCG make up the Morecambe Bay health economy.

The CCG manages the LHE across this north / south divide with a Network Director for each region and over time separate governance arrangements have been introduced for each.

- In the south the whole system *'better care together'* (BCT) programme was instigated in October 2012, aiming to produce a new clinical strategy to address both service viability and financial challenges. One of its core objectives is to design and implement new integrated models of care across the LHE that meet agreed local and national clinical standards and can deal with changes in the population and their needs.
- In the north plans were in place for NCUHT to be acquired by Northumbria Healthcare NHS Foundation Trust (NHFT). This transaction was put on hold when NCUHT were placed in Special Measures, though they continue to be supported by NHFT.
- Cumbria CCG are in the process of extending the principles of the BCT programme to north Cumbria, to ensure a cohesive plan is developed that provides equitable health care for all of its population. A Programme Board and governance arrangements are in place for the north under the banner '*together for a healthier future'*.

In autumn 2013 the Cumbria Healthcare Alliance was formed as a body to develop a Cumbria wide approach to the development of health and social care.

Our work in the LHE has also been split across this north / south divide as we have supported the BCT Programme since January 2014, and in March were commissioned to provide similar support for the north. This report presents our findings, thoughts and conclusions on both the BCT Programme and the emerging work in the north.

1.1 Summary of our approach

- At the heart of our care economy reset approach is helping to build the confidence of the local clinical (care professional) leadership in the development and ownership of sustainable solutions through involvement of clinicians, patients, carers and the public in the care design process.
- We take an organisation agnostic approach, facilitating the design of services around the patient and working back from that point to address the 'fixed points' in the system. At the core of this approach is our Care Design Process, involving Care Design Groups, as outlined in Appendix 1.
- This approach has been followed in both Morecambe Bay and North Cumbria.

1.2 Summary of solutions

The emerging solutions in the north and south make full use of work that was already in train within each locality.

In the south a 'Clinical Reference Group' was established to oversee the development of care models for Planned Care, Unscheduled Care, Complex, Children and Young People and Maternity. Workstreams were also established to develop Out of Hospital/Integration and Hospital Service change.

In north Cumbria they were similarly looking at Primary Care Communities and appropriate acute configuration based on Planned, Unscheduled, Complex and Children's and Maternity workstreams.

The Care Design Groups (CDGs) were informed by existing thinking. The emerging solutions across Cumbria are based around the concept of an Out of Hospital model being delivered with various In-Hospital options for the future provision of services across the health and social care economy.

The major changes associated with the new OOH model are designed to integrate the provision of health and social care in a more effective way for patients, based on multi-disciplinary teams working to reduce admission rates to hospital and provide care closer to home. These link in directly to the challenges identified through the initial analysis of a dispersed population, the need to treat more people out of acute settings and the challenges around recruiting into the main acute sites.

The concept has been adopted in the south and north, with slightly different language being used to recognise previous work in each part of Cumbria, and to account for the south solution being shared with Lancashire North CCG.

The key elements to the future model of OOH care are:

- **Integrated Core Teams**: multidisciplinary teams which have a geographical footprint based around a group of practices. The essential functions are to proactively manage patients, to prevent hospital use and to allow early hospital discharge and recovery at home. (Referred to as **Primary Care Communities** in the north)

- **Urgent Health and Social Care Co-ordination Centre**: a single point of access for professionals who have a patient with an urgent health and/or social care need (or require hospital discharge) to negotiate the appropriate response, using "real time" system capacity data to ensure that the best package of care is delivered in the best place

- **Integrated Rapid Response Team(s):** a multidisciplinary team whose aim is to avoid hospital admission and to enable hospital at the very earliest opportunity, using the principles of "Discharge to assess"

- The team is part of the urgent care co-ordination centre and is designed to supplement the core team through assessing the patient's medical, nursing and care needs

- **Community Specialist Services**: by defining a set of care pathways, specialist advice can be secured in a non-acute hospital setting. The elements of this community service are direct patient care, professional education and responsibility for population outcomes

- **Referral Support Service**: a service that works jointly with the core team to bring together all of the elements of referral support, advice and guidance, booking, referral template, referral navigation and decision support aids with the active involvement of core team clinicians. This service will be targeted to those specialities and practices where there is highest volume / demand and variation

- **Children's Specific Interventions – Integrated Health Team and Children's Care Pathways**: the children's integrated core team will function in a very similar multidisciplinary way to the adult integrated core teams, whilst still maintaining some hubs of children's specialists

Having developed the Out of Hospital model the current focus is now on the impact this will have on hospital provision, and the subsequent reconfiguration options, including the provision of community services. To inform the acute reconfiguration options development, some 'stakes in the ground' have been established by the BCT leadership in the South around Urgent care and Maternity services at Furness and Royal Lancaster Infirmary sites (see appendices).

We are also undertaking a Commissioner Requested Services (CRS) process that will provide robust evidence to support the required fixed points in system in both the North and South which the end solution will be configured around. The outcome of these will be presented to the Programme Boards in early June.

Whilst not pre-judging the formal evaluation process that the Better Care Together programme is about to undertake, the more favoured solutions in the south could potentially include:

- The deployment of the Out of Hospital model to integrate care around the needs of the patients, increasing proactive care and prevention
- Development of integrated acute, primary and community services on both Furness and Royal Lancaster Infirmary (RLI) sites
- Elective services currently delivered at the Westmoreland General Hospital (WGH) site being strategically consolidated based on appropriate clinical groups at Furness and RLI
- Access to a consultant-led maternity service at RLI and Furness

In the north, the potential in-hospital solutions are still in development and a preferred solution has not yet emerged. The focus of the second CDG on 15th May will be the consideration of the options for in-hospital provision.

The thinking behind possible options for in-hospital care revolve around the services to be delivered at West Cumberland Hospital (WCH) and Cumberland Infirmary Carlisle (CIC), together with a clear vision for out-of-county provision, and the provision of care at the eight community hospitals across the patch.

For maternity services there is a parallel workstream in the north that will utilise the findings from the SVT, the CRS and the existing clinical strategy to form a view on what level of services should be provided from which site. This involves an extended CDG for maternity and also a review of services by an outside agency, currently being sourced with the help of Sir Bruce Keogh. As this review will take place in June/July the conclusions will not be included in the strategic plan, but there will be a strong steer as to the preferred solution.

The in hospital design work for both north and south links directly to the issues highlighted in the SVT analysis around affordability gap, inefficiencies and low spells numbers.

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

Position in April		*Position today*	
A/R	**possible, but with some major reservations**	**A/G**	**likely, but with some reservations**

The LHE has moved forward in:

- collectively recognising the challenge of the situation
- acknowledging and acting upon the need to work together as one LHE
- understanding the consequences of not working together as a joined-up LHE
- developing a commonality of purpose and a more pronounced North Cumbria identity
- evidence of clinical engagement and mobilisation
- evidence of public, patient and carer engagement and mobilisation

However, there are still risks to delivery. These are very similar risks across both north and south, with slightly different actions to mitigate these risks. They are shown in detail in sections 6 and 8, and the highest risks, and our actions to mitigate these, summarised here:

Risk	**Impact**	**Mitigating Action**
There is insufficient time before 20th June to fully develop the options and agree on a preferred solution to take into the 5 year plan - and the SC in the south.	• Less time for stakeholders to review and get buy in to the solution • A solution is forced into a pre-determined timeline rather than following a	- Additional Programme Board sessions have been diarised between now and 20th June to oversee the plan development in both the north and south

	natural course. • The strategic plan is not completed in time (SC in the south)	- A clear day by day plan in the run up to Plan delivery - Briefing all key stakeholders and the internal team on the timescales and the importance of adhering to them - Developing the plan in a way that work in progress can be accounted for
Financial risks – emerging options do not reach the 75% threshold.	• The resulting plans would not meet the needs of the local health economy, NHS England, TDA and Monitor. • Financial problems would remain in situ, presenting further pressure on the system	- Model financial impact of solutions early so that potential gaps in the solution are identified quickly - Development of quick wins (e.g. scaling the integrated hub at CIC across the whole of north Cumbria), additional efficiency initiatives (radical redesign of outpatients) and assessment of structural cost analysis - In the **south**, modelling will be taken to the options evaluation group on 20th May to inform discussion and draft iterations are being considered by the DOFs on 9th May
Without a proven delivery vehicle for change and focus on implementation, the plans will remain solid on paper, but weak in delivery. The challenge is implementation rather than planning	As with previous 'strategic' plans they will not be delivered – either at all or only in part, leading to the non-achievement of the benefits the plans advocate.	There is acceptance across the LHE that implementation is a key issue, which will require strong leadership, appropriate resource and dedicated delivery to achieve the scale of change currently being designed. We are working with both programme boards to help develop the governance and delivery structure to support implementation as part of the plan development.

1.4 What this means for Cumbria

In terms of the submission of a 5 year strategic plan on 20th June, the work across both north and south is culminating in a similar solution that the county can take forward into implementation – a clear OOH model that helps to support reconfiguration of in-hospital services to improve patient care and reduce the financial burden.

The significant work across Cumbria to engage with the right people, to listen to the views of patients, carers and the public, and most critically to involve the clinical professionals in the design of the future models care, means that the LHE will be able to articulate a clear vision for how they will improve the provision of health and social care across Cumbria. This vision of an OOH model of care supporting well defined in-hospital provision is Cumbria-wide and overcomes a previous concern that the different work streams in the north and south could emerge with two different models that the CCG would need to balance – this risk appears to be dissipating.

Intensive work is currently underway to develop the system options and financially model their impact in order to establish the front running option in both the north and south. To support effective implementation, further detailed modelling and design will be required beyond 20th June.

Next steps

In the **south,** work is more advanced and is reaching a critical part of the Options Development process, with a long-list of potential in-hospital configurations completed and awaiting approval, before consolidating down to a shortlist to undergo detailed modelling and costing analysis.

The Strategic Case for change is also under development, and will contain a more detailed description of the OOH and in-hospital models for future care provision, and will demonstrate the commitment of South Cumbria to closing the financial gap.

Once the Strategic Case has been written and approved by the Programme Board, the next phase of work will require public and further clinical engagement to determine which of the shortlisted options will be progressed. Detailed implementation design will then need to take place, outlining clear steps for implementing the new OOH and in-hospital service provisions.

The **north** has been able to accelerate the design process due to the previous work around a clear clinical strategy and the development of Primary Care Communities. In fact, much of the OOH model emerged initially from the north of Cumbria.

However, the most contentious design element will be the reconfiguration of in-hospital services, which will include the nine existing community hospitals. We are entering this phase against a back drop of uncertainty and ongoing reviews - the recent national inspection of NCUHT, the conclusions of which will not be known until early July; an ongoing review of Mental Health provision; a forthcoming review of maternity services; and of course the on-going potential acquisition of NCUHT by Northumbria Healthcare NHS FT. All of which will make the short listing of options a complex process.

The second CDG on 15th May will provide a better indication of how far away from an agreed solution of in-hospital provision the north of the county is. Thereafter the development of a short list of options will be modelled and presented at the Programme Board meeting on 5 June.

In 2013 the Better Care Together programme agreed with NHS England and Monitor a due date of 30 June for their Strategic Outline Case (SC). All plans for the Morecombe Bay Health Economy are shaped around meeting this deadline and they are not in a position to bring this forward without impacting key elements of the solution design. The LHE Strategic Plan delivered on 20th June will include the elements of the due SC though these may not be formally approved by this date.

2 Introduction and context for solutions development work

2.1 Key Lines of Enquiry from the Single Version of the Truth (SVT)

A number of significant themes have emerged from the baseline analysis work. These formed lines of enquiry that inform the Care Design and Options Appraisal work for the five year strategic plans. Whilst the emerging themes are similar across the north and south, the detail is different in each patch, driving a different set of actions and investigations.

A summary of the Key Lines of Enquiry emanating from each SVT is included in Appendix 1, but the headlines are:

North Cumbria

- *The north Cumbria Affordability Gap* is of the order of £90m in 2019/20 if no efficiencies or changes are made.
- *The Demographic & Geographic Challenge* includes a population that is ageing faster than the rest of England.
- *Changing the Care delivery setting* is a real opportunity as an analysis finds that 24% of admissions and 62% of days at NCUHT could be managed in a non-acute setting.
- *Workforce transformation* is needed as there are high levels of temporary staff usage cost North Cumbria up to £10m annually driven by major gaps in medical staffing

Morecambe Bay

- The Bay Wide Affordability Gap is of the order of £71m in 2019/20 if no efficiencies or changes are made.
- Demographic and geographical challenges. The Morecambe Bay footprint covers a significant 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).
- The Trust has a very low level of spells per site (33,700) compared to the national average (73,800).
- Changing the Care delivery setting is again a significant opportunity as point of prevalence analysis shows 28% of UHMBFT admissions could be managed in a non-acute setting assuming Out of Hospital investment as a result of Bettercaretogether

The estimated Affordability Gaps assume no efficiencies or benefits from any intervention, CIP or BCF initiative. When we model bridging the gap we will include the impact of BCF schemes including the return from the investment.

2.2 Hypothesis, approach and objectives

To meet the vision of making a real difference to people's lives by improving the health and wellbeing of individuals and their families, adding years to peoples' lives, and quality life to those years, the LHE is working towards four system wide strategic objectives. These inform our hypothesis for design:

a) Radically increase the scale and integration of out of hospital services, based around Primary Care Communities.
b) Achieving sustainable, high quality provision, by delivering a programme of Hospital Services Consolidation.
c) Deliver a modern model of integrated services, ensuring an optimal use of resources for patient pathways across community and hospital services and for cross cutting priorities across the system. Deliver the Cumbria Wellbeing Strategy, and re-focus our system to promoting population outcomes as a health system, rather than just a healthcare system.

The two work programmes, Bettercaretogether (BCT) in the south and Together for a Healthier Future (TFHF) in the north, have clear objective linked to this LHE wide strategy. These objectives guide the work in developing options across Cumbria.

In the **south** Bettercaretogether has the following objectives:

- To design and implement new integrated models of care across the local health economy that meet agreed local and national clinical standards and can deal with changes in our population and their needs
- To design and implement a system which recognises the specific geographic characteristics of our area and enables the population to access the most appropriate settings of care for their health needs within reasonable travel times. The emphasis will be on providing these services in, or as close as possible to, people's homes
- To design and implement a system which encourages the improvement of health and wellbeing, clinical outcomes and patient experience, in a way which is sustainable,
- To enable the development of a flexible, integrated and productive workforce across our health economy
- This approach will enable staff to develop continuously, realise their potential and achieve greater job satisfaction
- To design and implement a future healthcare system for our area that makes best use of the money and resources available.

The objective of this programme is to deliver a Strategic Case that meets the requirements of the local health economy, is in line with the latest NHS England guidance and has been developed through the extensive engagement of all stakeholders.

In the **north** Together for a Healthier Future's objectives are to develop a strategy for the North Cumbria health and social care system which:

- Reduces harm through high quality, clinically sustainable services
- Is financially sustainable
- Is founded on patient, public, practitioner and clinical engagement

3 Our approach to Future Service Design

Our overall approach to care design is shown in the diagram in appendix 2 – the use of care design groups to build understanding of the problem and then future service configurations to meet this. The care design groups were run with reference to innovative models of service delivery, for example through clinical networks or approaches adopted in other LHEs. These designs are intended to meet a large proportion of the clinical and financial objectives of the Local Health Economy but do not obviate the need for additional interventions and efficiencies to meet the identified gaps and aspirations.

Within Cumbria we followed two parallel paths in developing the solutions.

North Cumbria

The north is further behind in its development of service redesign but good progress is being made as much of the thinking has been done previously as part of the Care Closer to Home strategy in 2007 and more recently the Clinical strategy in 2011.

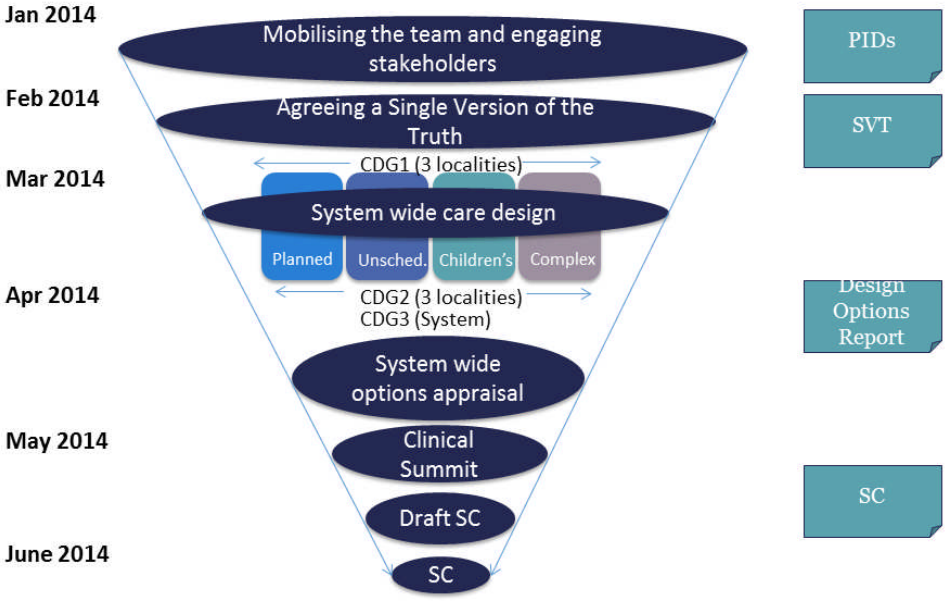
The first CDG in the north of Cumbria was held on 6th of May. The group was well attended, with 86 people attending, including medical professionals, the wider care community, carers and members of public bodies, details of which are in appendix 4.

The focus was on out-of-hospital care and the development of a care model that could drive transformation of service delivery. The work used the out-of-hospital care model developed in the south of the county as a starting point and reviewed its potential impact from three perspectives (Urgent; Planned/Episodic; Proactive care).

In summary, whilst further work is required to arrive at a final, agreed OOH model, all delegates expressed an appetite for change and were well engaged in voicing their views. The underlying principles behind an out-of-hospital model such as the one proposed were agreed with by the majority of delegates and now require further work to shape into acceptable language and a well thought through action plan.

Morecambe Bay, south Cumbria

The Strategic Case (SC) phase of the Bettercaretogether programme is being developed using an integrated delivery approach. The desired outcome, deliverable and products produced in each programme stage are set out in the diagram below.



Public and Patient Engagement

In addition to the engagement provided through the CDG and Clinical Summit process there has been extensive engagement with the public and patients across both north and south Cumbria. The latter, as part of BCT, has a comprehensive programme and has used the output in the CDGs. In the north the programme is in its infancy but will have collected a substantial tranche of evidence in time for the development of the preferred solutions.

North Cumbria - Communications and Engagement Plans

Objectives

- To ensure there is a coordinated and consistent approach to communications and engagement across all organisations so that the exercise is seen as the health and care economy in North Cumbria coming together to address some major challenges.
- To ensure sound internal communications and engagement so that all internal audiences are fully informed and given opportunities to be part of the discussion.
- To have an honest discussion with key stakeholders and the public so that no one is in any doubt that local health and care organisations are committed to developing more responsive services for local people but also to do this, that no change is not an option (and to do this without damaging patient confidence over current services).
- To ensure that key stakeholders and the public are given opportunities to comment and to help shape services that are more responsive to the needs of local communities.
- To conduct a robust process of engagement which provides sound evidence to help inform future proposals about the way services should be provided.
- To ensure that organisations work together so there are robust arrangements in place to handle any negative media or stakeholder interest and that they maximise opportunities to explain any positive developments taking place to improve health and healthcare.

Better Care Together Communications and Engagement Plans

Objectives

- Our aim has been to have an ongoing dialogue with our local communities and to strive to meet best practice in this area. Engagement has therefore been an integral part of the work of the bettercaretogether programme over the last eighteen months
- During March, bettercaretogether organised multiple engagement events to capture the views and opinions of staff, the public and partners including third sector organisations regarding out of hospital services, including the emerging clinical model so that this could be fed into the Clinical Summit at the end of April.

Summary

- There were over 250 attendees across all the events and these included Council OSC and MP representatives, local media, third sector representatives, members of public and a broad spectrum of colleagues
- Feedback is still being received and we will ensure this gets factored into our final reports, but a summary is provided in the following slides

Detail from both north and south communication and engagement plans are included in Appendix 2.

4 Future Service Design options

In the north the emerging in hospital options will be the subject of CDG 2 on 15th May. They are still being developed and agreed within the governance process, with sign off at the Planning Group on 13th May. The options will include the As is configuration, the configuration on which the West Cumberland Business case was constructed, and two further options for more transformational reconfiguration, and will include the provision of community care in hospitals. These will need to address the issues highlighted in the work to date around inefficiencies, the affordability gap and low spells issues.

The OOH model of care is illustrated in the section below as the Morecambe Bay language is more advanced. In the north the output from CDG1 will help to adapt the OOH model so that it represents the work already undertaken in the north. This model addresses the geographic dispersion of the population, the need to treat more people out of acute settings and follows on from the LHE's "Closer to Home" strategy. It is anticipated that moving more work out of hospitals will help to address the workforce issues as recruitment across the LHE will be easier.

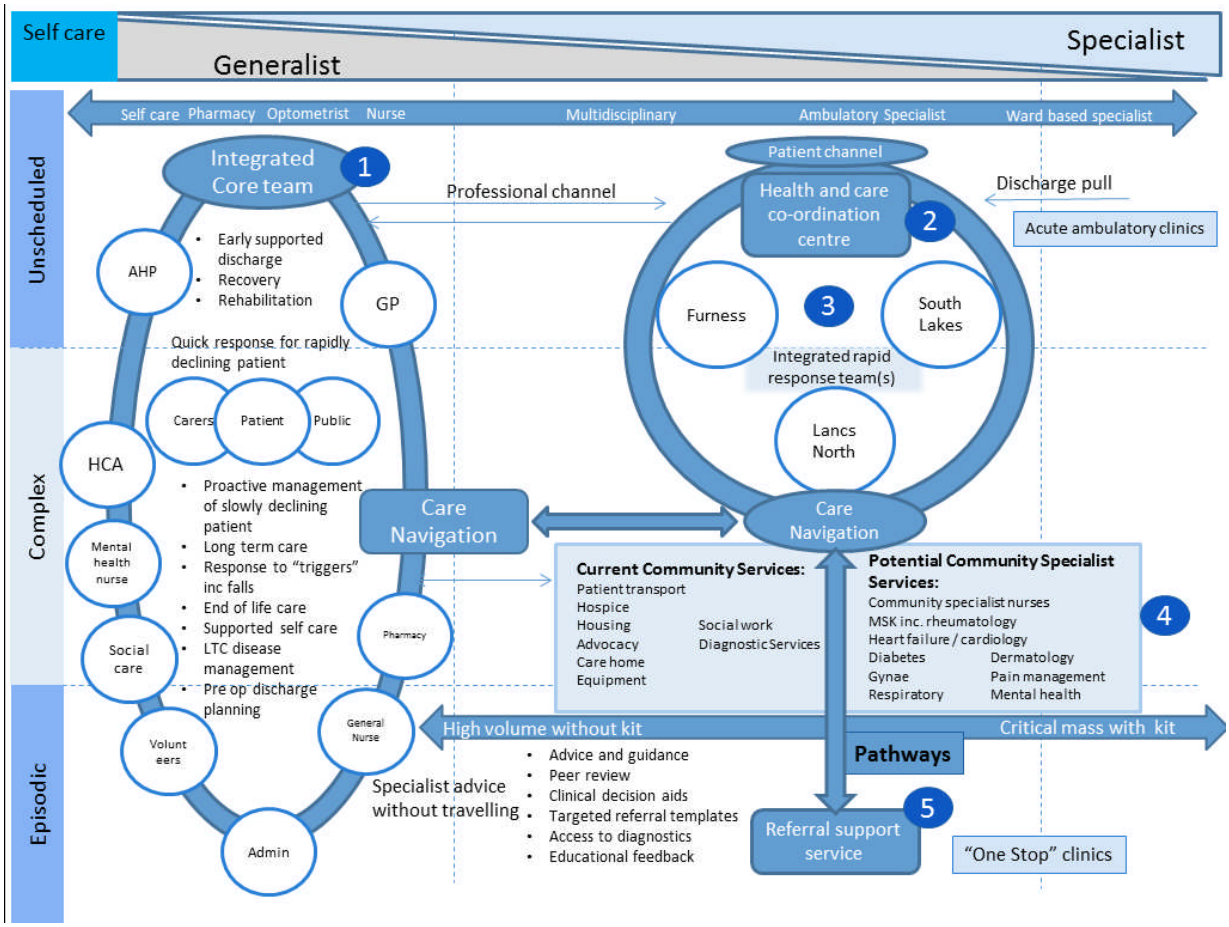
In the south, as part of BCT, the outcome of these discussions was a short / long list of potential solutions, as shown in the table below. In this we show the results of the modelling of the impact of proposed service configurations upon the local provider health economy. A similar analysis will be completed following the CDG on 15 May looking at the in hospital options.

The details shown overleaf were presented to the BCT Programme Board on 8th May:

#	Option Title	Out of Hospital Model	Urgent Care Stakes & dependencies	Urgent Care Centre + stabilise & transfer	Children's & maternity stakes + dependencies	Elective in-patients & day cases*
1	• Maintain existing hospital configuration • Deploy the Out of Hospital model (OOH) in each locality	Deployed in each locality	n/a	n/a	n/a	n/a
2	• Deploy OOH model • Maintain stakes in the ground for Urgent Care, Children's & maternity • Consolidate elective on to RLI and FGH	Deployed in each locality	RLI & FGH	Retain MIU at WGH	RLI & FGH	Split on RLI and FGH
3a	• As 2, but consolidate elective onto RLI	Deployed in each locality	RLI & FGH	Retain MIU at WGH	RLI & FGH	Consolidate on RLI
3b	• As 2, but consolidate elective onto FGH	Deployed in each locality	RLI & FGH	Retain MIU at WGH	RLI & FGH	Consolidate on FGH
3c	• As 2, but consolidate elective onto WGH	Deployed in each locality	RLI & FGH	Retain MIU at WGH	RLI & FGH	Consolidate on WGH
4a	• Deploy OOH model • Maintain Children's & maternity stakes • RLI becomes major acute site with type 1	Deployed in each locality	RLI	FGH Urgent Care Centre Retain MIU at WGH	RLI & FGH	RLI

	A&E and elective care • Urgent care centres at FGH and WGH					
4b	• Deploy OOH model • Maintain Children's & maternity stakes • FGH becomes major acute site with type 1 A&E and elective care • Urgent care centres at RLI and WGH	Deployed in each locality	FGH	RLI Urgent Care Centre Retain MIU at WGH	RLI & FGH	FGH
5a	• Deploy OOH model • Maintain Children's & maternity stakes • Type 1 A&E at RLI and a streamlined A&E at FGH • Elective split over RLI and FGH • Urgent Care Centre at WGH	Deployed in each locality	RLI Streamlined at FGH	Retain MIU at WGH	RLI & FGH	RLI & FGH
5b	• Deploy OOH model • Maintain Children's & maternity stakes • Type 1 A&E at FGH and a streamlined A&E at RLI • Elective split over RLI and FGH • Urgent Care Centre at WGH	Deployed in each locality	FGH Streamlined at RLI	Retain MIU at WGH	RLI & FGH	RLI and FGH

The design options for the South comprise the OOH model developed during the Care Design Group process that will be deployed in South Lakes, as well as the In-hospital options that are still currently being completed. This OOH model is set out and described below.



Element 1: Integrated Core Team

The integrated core team is a multidisciplinary community based team which has a loose geographical footprint serving all adult patients on registered lists of GP practices. The essential function is to identify and proactively manage complex patients to optimise independent living, prevent hospital and care home use, and to allow early hospital discharge and recovery at home.

In order to model the financial impact of the change we have assumed an average core team of registered patients of around 25,000, meaning there are likely to be 14 core teams working across the bay.

Element 2: Health and Social Care Co-ordination Centre

The urgent health and social care co-ordination centre provides a single point of access for professionals who have a patient with an urgent health and social care need (or require hospital discharge) to negotiate the appropriate response, using "real time" system capacity data to ensure that the best package of care is delivered in the best place.

The Care Navigator will play a key role for this team, providing the link between the Integrated Core Team, ensuring patients receive their optimal care package.

Element 3: Integrated Rapid Response Team(s)

The Integrated Rapid Response Team are a multidisciplinary team who aim is to avoid hospital admission and enable hospital discharge before the patient has fully recovered. The team is part of the urgent care co-ordination centre and is designed to supplement the Integrated Core Team through

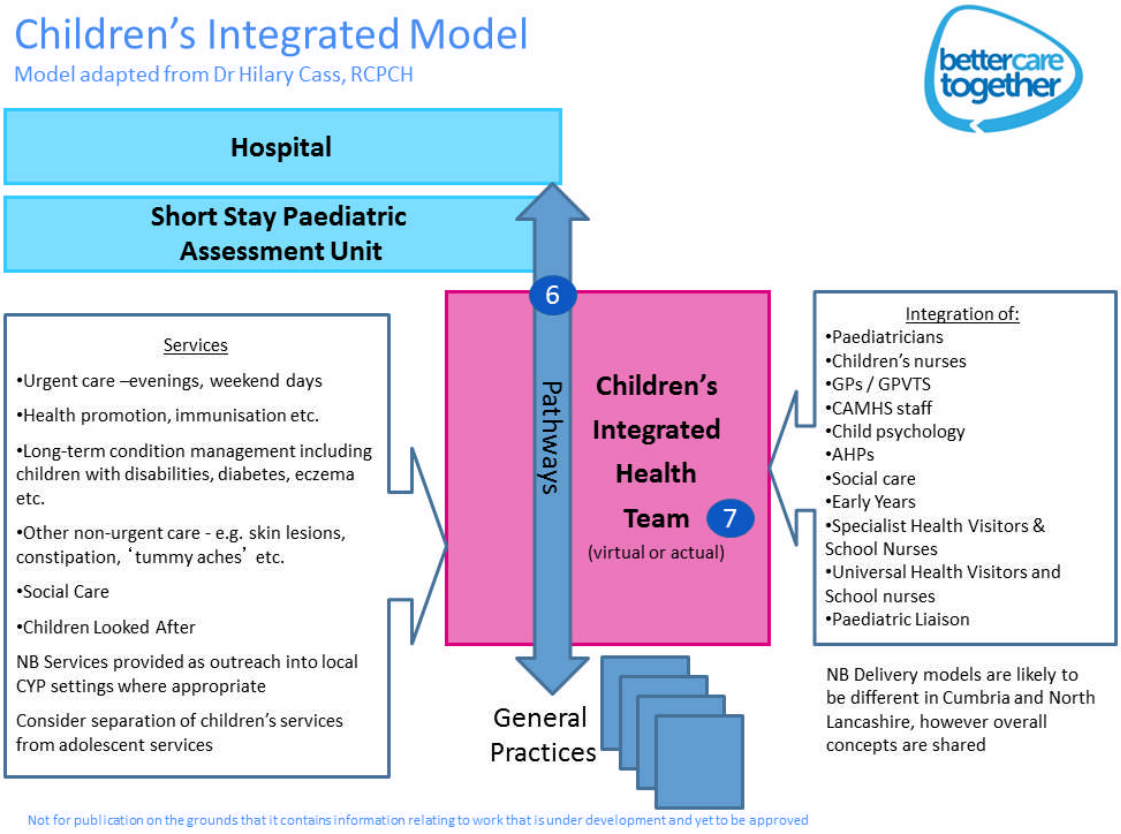
assessing the patient's medical, nursing and care needs. The team then delivers a package of care. (REACT in Lancs North and STINT in South lakes are examples of how this could work across the wider Bay).

Element 4: Community Specialist Services

By defining a set of care pathways, specialist advice can be secured in an out of hospital setting. The elements of this community service are direct patient care, professional education and responsibility for population outcomes.

Element 5: Referral Support Service

A service that works jointly with the Integrated Core Team to bring together all of the elements of referral support, advice and guidance, booking, referral templates, referral navigation and decision aids with the active involvement of a core team of clinicians. This will be targeted to those specialities and practices where there is highest volume and variation.



The children's model was developed prior to the Bettercaretogther programme and is widely accepted as an appropriate model of care provision for Morecambe Bay, and therefore this model has not been altered during the Care Design process. A description of the two parts of the children's model are set out below:

Element 6 and 7: Children's specific interventions

The children's integrated care team should function in a very similar way to, and be integrated in some way with, the adult integrated care team whilst still maintaining some hubs of children's specialists to ensure appropriate care services and pathways are provided across the localities.

Specialised Commissioning in Cumbria LHE

Specialised commissioning is under-represented in existing LHE plans, with Cancer Services being the exception. It would appear that services subject to specialised commissioning are generally provided in acute hospital settings. In the context of the move to an out-of-hospital care model in Cumbria, consideration must be given to how such services are included in the model in order to account for changes to supply and demand. The LHE's relationship with NHS England's specialised commissioning function will be critical in bringing this about.

By way of addressing this situation, we would seek to bring together Cumbria CCG and the Area Team's Specialised Commissioning leads in order to baseline the current position, identify how specialised commissioning can play into the proposed future Out of Hospital strategy and seek to align plans accordingly.

This has been escalated for discussion at the next Programme Board and the creation of an action plan to support the alignment of the provider and commissioning plans.

5 Preferred solution within the LHE

The Care Design Process has helped to bring their thinking together and to focus the solutions development on defining models of care that meet the challenges highlighted and agreed in the Single Version of the Truth. However, it is too soon in the process to state a preferred solution across Cumbria. This will come in early June as system solutions are shortlisted and evaluated

In North Cumbria CDG 2 will provide wide ranging input into the development of the short list options, which will then be presented to the Programme Board on 5th June for evaluation.

To help inform the in hospital options we are running a Commissioner Requested Services process that will identify the stakes in the ground with regard to core services. This will help to shape the possible provision of services across the two main sites, and also identify other providers that could deliver services within the scope of travel distances and capacity.

We are also running additional workshops to supplement the CDGs looking at four areas where the LHE has made good progress but require help in defining the way that the care model will develop alongside the OOH and In Hospital models. These are being facilitated by PwC at the request of the CCG, and will cover: Primary Care Communities (23 May); Maternity (3 June); Children and Young People (4 June); and Mental Health (TBC).

In the south the BCT programme has defined the preferred solution for the Out of Hospital model which will be rolled out at scale and pace within the South Lakes locality. In parallel to this the programme has a formal process in place to evaluate the options for hospital reconfiguration, designed to close the funding gap in the health and social care system.

The evaluation will be both qualitative and quantitative and will be undertaken by a broad spectrum of stakeholders, including primary, secondary and community care clinicians, system leaders and social care professionals. The four qualitative criteria (set out below) to be used have been agreed with the Programme's Delivery Group, Clinical Reference Group and Programme Board are set out below:

1. Contribution to clinical outcomes
2. Sustainability and future-proofing
3. Patient experience and access
4. Ease of Implementation

In addition to establishing a formal process to facilitate options appraisal, the programme has run three strategic workshops with senior system leaders to move towards consensus for transformation. These sessions have been facilitated by PwC with the intention of surfacing the 'elephant in the room' issues that need addressing to ensure effective implementation of the new models of care

There is a clear timeline for developing these options into an agreed solution, as shown in appendix 5. The LHE will agree solutions by 26 June.

6 Updated assessment of capability and capacity of LHE to develop and deliver aligned plans to time.

6.1 Assessment of capability and capacity of LHE to develop and deliver aligned plans to time

Position in April		*Position today*	
R	highly unlikely	R	highly unlikely
A/R	**possible, but with some major reservations**	A/R	possible, but with some major reservations
A	likely, but with some major reservations	A	likely, but with some major reservations
A/G	possible, but with some reservations	**A/G**	**possible, but with some reservations**
G	highly likely	G	highly likely

Rationale and evidence

Plan element	***Rationale and evidence***
Current position	The LHE has moved forward in: • collectively recognising the challenge of the situation • acknowledging and acting upon the need to work together as one LHE • understanding the consequences of not working together as a joined-up LHE • developing a commonality of purpose and a more pronounced North Cumbria identity • evidence of clinical engagement and mobilisation • evidence of public, patient and carer engagement and mobilisation
System vision and statement on vision for integration	The LHE presented its proposed vision for the system at CDGs and clinical summits for comments and views. • this was largely well received by the attendees, with only some of the anticipated challenge and requests for caveats • the overarching message from CDGs and the Summit was that the vision is sound and is welcomed by those who attended to represent the LHE • a stronger direction of travel has emerged • strong consideration is being given to workforce: staff mix and recruitment & retention, across care settings • particular emphasis is being placed on the need to operate in an integrated way, 7 days a week, and with care delivered at or closer to home Next steps include: • clarity on in hospital provision • further detail on implementation planning • more detail required on actual impact of workforce implications • acknowledgement of reconfiguration guidance as best practice and a robust process for engaging with local communities • impact of QIPP and BCF need to be articulated fully • evidence of full engagement with Northumbria NHS FT, preferred bidder for the acquisition of NCUH, in the LHE planning processes
Improving quality and outcomes	Strengths:

	• improving patient, carer and public engagement • improving clinical engagement and drive from across the community • good range of benchmarking data used • improving alignment between partner organisations • engagement with local authority throughout process Priority areas for further development: • further articulation and demonstration of how the evidence base has been/will be used for plans • quantifiable metrics for key objectives • more detail on impact of the vision – quantification of ambition required • evidence of plans to align best clinical practice across all sites
Improvement interventions	The LHE would benefit from: • clear implementation plan with timelines of plans, including confirmation of cost savings and other benefits • recognition of impact and challenge of significant levels of transformation in one system • sense of what is being prioritised for years one and two at an LHE-wide level
Sustainability	The LHE would benefit from: • generating further evidence about impact of implementation on sustainability and cost envelope • quantifiable objectives
Governance overview	• Programme boards in both north and south Cumbria are driving the development of the strategic plans with senior leaders across the system represented. The intent in the south through BCT is to broaden representation at the programme board to include Cumbria Partnership Foundation Trust, North West Ambulance Service and Blackpool Teaching Hospitals NHS Foundation Trust • The Cumbria Healthcare Alliance is key to the sustainability of the plans being developed, and it must have the supporting infrastructure to help oversee implementation in both north and south Cumbria. It currently does not include representation from Lancashire North CCG which is inextricably linked to Morecambe Bay. This may need to be addressed as part of moving into implementation
Values and principles	• The values and principles of integrated/multidisciplinary working are essential to supporting a behavioural change in attitude required by staff across all care settings in Cumbria. There has been acknowledgment through the CDG process that in addition to addressing the demographic, geographic and financial challenges, an equally important challenge is creating a positive, can-do attitude to underpin implementation

Specific observations in the period since the publication of Report One include:

- the creation and publication of the SVT has engendered a commonality of purpose across the breadth of the LHE
- the clinical and managerial leaders in the LHE have moved forward on their intellectual journey through agreeing a common understanding of the challenge, the proposed future model they require and the challenges associated with realising their vision
- The LHE is more readily demonstrating a willingness and indeed an appetite to act, and now actively expects to implement a major, LHE-wide transformation programme
- In the **north** the number of attendees at Care Design Group 1 on 6th May exceeded expectations with 80+ professionals, managers, carers and patients in attendance. This level of engagement in

a geographically dispersed patch such as North Cumbria reflects well on the LHE and its efforts to mobilise clinical and public engagement

- There is clear evidence of greater clinical leadership emerging. As well as playing a leading and public role in CDG 1, Drs Jeremy Rushmer and John Howarth both report a strong sense of readiness for change amongst Trust clinicians and the new CCG Medical Director, Dave Rogers, has established a robust dialogue with the GP community.
- In the **south** the consultation with the Clinical summit has provided an endorsement of the OOH model of care, and generated helpful clinical insight into the options for in hospital provision, though this remains a contentious issue that will require careful navigation during the prioritisation process.

Assessment of capability and capacity of LHE to implement the plan:

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

Rationale and evidence

- Further to the evidence articulated above, there is a growing acceptance that successful implementation is the greatest issue facing the LHE
- The LHE recognises that they have consistently failed to deliver transformational plans in the past and there is therefore recognition of the need to implement a robust programme delivery mechanism, supported by an appropriate incentive framework that addresses the affordability gap and encourages innovation and collaborative working.
- There is action on PwC to support the LHE in developing its solution to this challenge. PMOs have been set up previously and have not been successful. The LHE is likely to need external support to help establish a transformation programme delivery vehicle.
- 75% of major change programmes fail, and the most important insurance against this is building ownership amongst those at the heart of change. This does not mean engagement; it is easier to disengage but harder to disown.
- The system leaders in Cumbria have come together to form the Cumbria Health and Care Alliance to act as the 'guiding coalition' for change. One of their first commitments was to create 'CLIC' (the Cumbria Learning and Improvement Collaborative) which all organisations, including the county council, are contributing to either financially and/or in kind. CLIC is pursuing three strategies:
    - Collaborative education and learning (a programme of teaching and learning in teams which are place or subject based, not sovereign organisation based)
    - 'The Cumbria Production System' (a common set of improvement tools – based on Toyota Production System as used, for example by the North East Transformation System but drawing from all successes in NHS and world-wide- that all Alliance organisations will use to ensure place and pathway based continuous improvement / transformational project planning & delivery

- Leadership development – a value added programme to ensure the aligned culture we require for success is embedded at every level in the 14000 staff we have in health and care across Cumbria

- The Alliance (via the CCG) has employed Professor Stephen Singleton OBE to be the clinical lead for this process.
- CLIC will coordinate with and maximise the impact of resources already in place, like AQuA, NHS Leadership Academy, the local Universities and HENW, NHSIQ etc.

In summary, the key to Cumbria delivering transformational change seems to lie in:

a) the Alliance and consistent leadership for change
b) the wide and strong engagement in the clinical design process
c) the creation of an experienced and fit for purpose programme delivery vehicle. In both the north and south, work is underway on creating a draft System-level Memorandum of Understanding for all key delivery partners to agree, in order to provide the initial framework for developing the detailed delivery vehicle. In addition, a system compact for all staff to refer to will be established, based on the core values and principles of integrated working to support implementation – more than a PMO, and general readiness for the concept that 'it has to be different this time'
d) the 'never waste a good crisis' principle: i.e. that by coming from behind, Cumbria has more incentive to be genuinely transformational in both service design and delivery, commissioning models and whole system partnership working.

Our reservation lies in the infancy of the relationships that are in reality still being built across the LHE, the tough challenges ahead, and the high risk of political challenge which could slow down the delivery process unless it is proactively managed.

7 Governance and Leadership summary

Governance

Cumbria is well served by its governance structures that have been put in place over the past 12 months as new leadership teams have emerged.

The system leaders in Cumbria have come together to form the **Cumbria Health and Care Alliance** to act as the 'guiding coalition' for change. These leaders have met on a number of occasions and collectively agreed a shared commitment to work together under this banner.

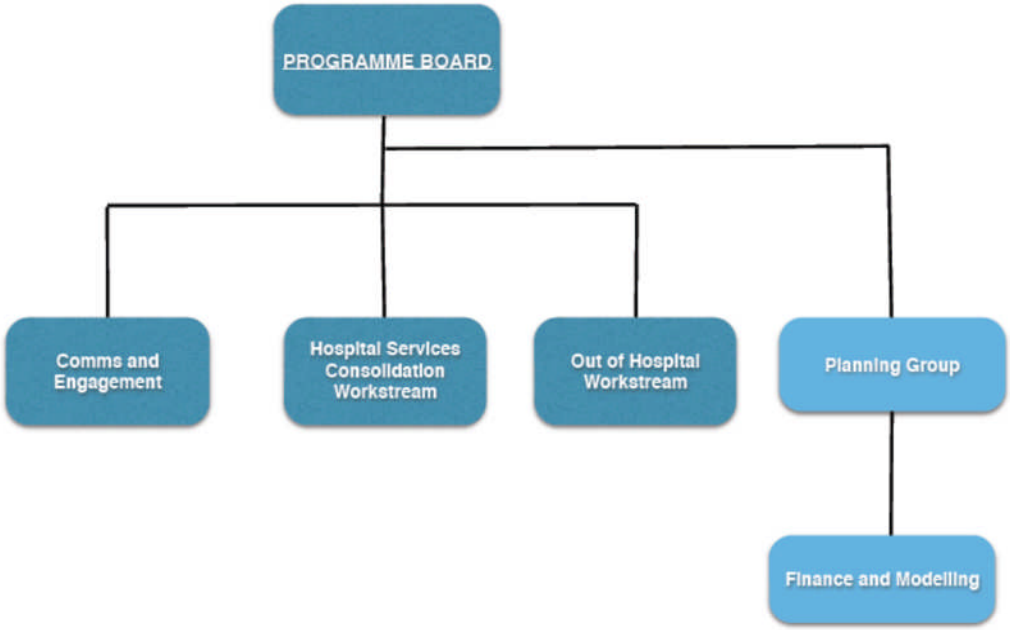
The Alliance is a commitment to work together, and not a new organisation or any formally constituted arrangements, though it will continue to develop joint governance arrangements including participation and oversight from Trust Non Executives and Chairs and from Cumbria County Council elected members.

We have not witnessed this group and it is early days to provide a view on its effectiveness, but the concept is undoubtedly the right thing to help develop health and social care across Cumbria. An issue to consider as part of implementation will be whether Lancashire North CCG should be represented on the Alliance given it is inextricably linked with the Morecambe Bay health economy and future solution.

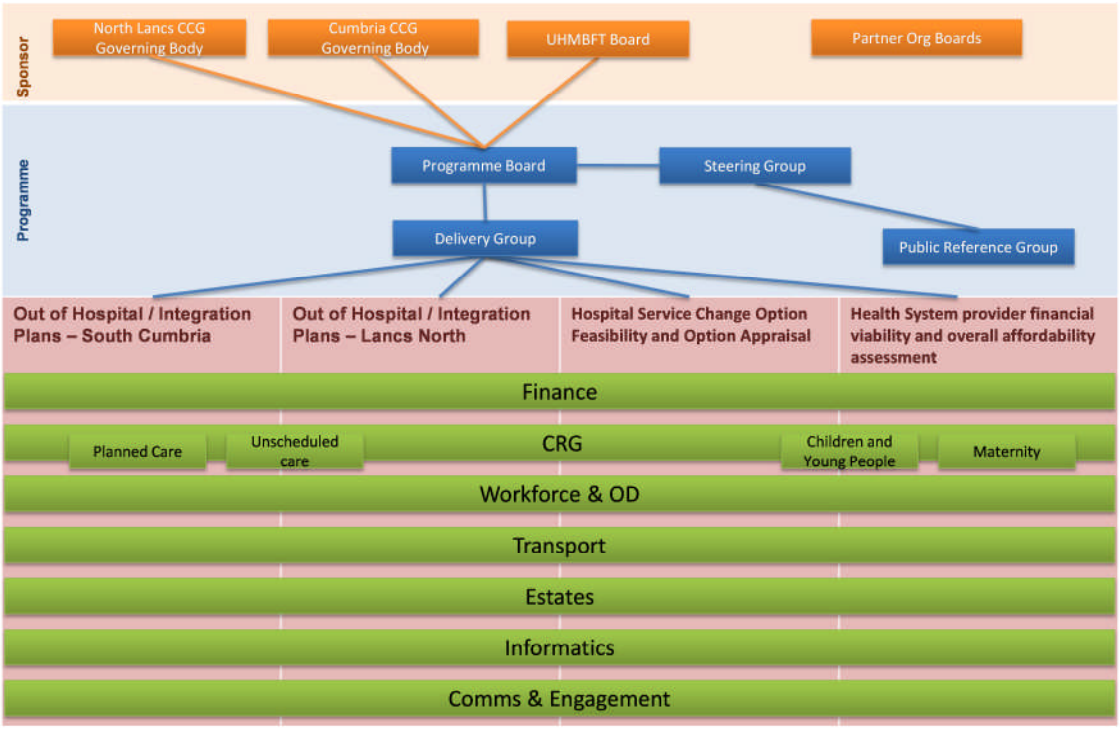
A consistent theme in Cumbria is the inability to deliver strategic plans in the past. There is clearly evidence of operational plans being developed and delivered within organisations, but very little evidence of such occurrences when multiple organisations have to work together to effect a transformation.

It is important that the governance structures in place mature in a way that enables them to oversee effective delivery of the strategic plan. This will necessitate the creation of some form of programme delivery vehicle that will need to be held to account. PwC is working with the CCG to determine what this might look like.

The **North Cumbria** Programme Board, and governance structure is a relatively recent creation but demonstrates the same robust principles as we have seen in BCT. It is too early for us to comment on its effectiveness as this will become apparent as the more tricky discussions evolve around detailed options development.



In the **south** Better Care Together's Governance Structure is shown below and is a mature example of how governance can help to guide and challenge a complex programme of work. It manages well the diverse set of stakeholders and ensures the overlap in Morecambe Bay between Cumbria CCG and North Lancs CCG is well managed in a transparent way.



The key principles of the model include:

- Oversight from the CCG Governing Bodies and Trust Board
- A Programme Board with representation from key commissioners and providers
- An operational delivery group with representation from all of the cross-cutting technical working groups
- A Clinical Reference Group for senior clinical engagement from secondary, primary and community care
- Technical cross-cutting workstreams, e.g. Workforce, Estates, Finance, Comms and engagement
- A South Cumbria out of hospital working group to oversee the development of the out of hospital clinical model in Cumbria

The model is fit for purpose for the current phase of the transformation, and mature working relationships are in place between commissioners and providers, particularly evidenced in the Programme Board's strategic planning workshops, or "stakes in the ground" sessions. Challenges remain with the model, that will need to be resolved in the next phase of the programme, including:

- Differing viewpoints from South Cumbria and North Lancs of those services that are stakes in the ground, for example, around the sites consultant-lead obstetrics could be delivered from
- A lack of representation from the Council, ambulance service and community provider at the Programme Board which is now being addressed
- Whilst the technical working groups are in place, there needs to be a greater delivery capacity to serve these groups – currently largely being provided by BCT's strategic partner (PwC)
- The separating of commissioners and providers where appropriate. For example, commissioners to focus on the commissioning and contractual implications of the services changes and for providers to consider the impact of the changes on their current operations

Leadership

There is a real opportunity, partly because of the new chief executives on the patch, to avoid the behaviours and culture of Cumbria in the past. The energy and commitment to lead sustainable change is becoming increasingly evident, both through our conversations and anecdotally across a broad range of stakeholders.

Clinical leadership in Cumbria has not been one of its past strengths. Dr Jeremy Rushmer, Mr George Naysmith and Dr John Howarth all report a strong sense of readiness for change amongst the Trust clinicians, and the new CCG Medical Director, Dave Rogers, has a steeliness about change that the GPs find refreshing. We find these leaders good people with the right intentions and a desire to make the change that others have not managed in the past.

We are finding generally good relations between all organisations and a commitment to address the underlying challenges in the LHE, whilst obvious tensions will arise as the options become more developed and the organisational impact is identified.

8 Detailed risk assessment and mitigating actions

The table below shows the detailed assessment of the risks, and the mitigation / intervention actions in place. These have been separated into risks impacting the development of a strategic plan by 20th June, and the subsequent delivery of the plan.

The majority of the risks are jointly recognised by the LHE and PwC and most are jointly owned. Our role is to prompt and push for the solutions, helping where clear guidance is required.

The major risks remain the pace at which the plans are being developed, the sheer size of the financial gap to be filled and the capacity of the LHE to firstly deliver and then implement the plans.

Category	Risk	Impact	Likelihood	Impact	RAG	Mitigation	Owner	Due Date
Risks related to the delivery of robust and aligned strategic plans by 20th June (and the SOC in the south by 30th June)								
Timing	There is insufficient time before 20th June to fully develop the options and agree on a preferred solution to take into the 5 year plan -and the SC in the south.	- Less time for stakeholders to review and get buy in to the solution - A solution is forced into a pre-determined timeline rather than following a natural course. - The strategic plan is not completed in time (SOC in the south)	4	5	Red	- Additional Programme Board sessions have been diarised between now and 20 June to oversee the plan development in both the north and south - A clear day by day plan in the run up to plan delivery - Ensuring all key stakeholders and the internal team are aware of timescales - Developing the plan in a way that work in progress can be accounted for	Hamish Clark / Paul Wood/ Peter Rooney	20 June
System wide agreement	The LHE is not able to obtain sign off to the preferred solution by all key stakeholders due to the contentious	- The plans will not be aligned. - There will not be an agreed solution before 20th / 30th June.	4	5	Red	- Utilising all local networks to socialise the changes early to provide sufficient time for discussion and debate on the preferred solutions.	Hamish Clark / Paul Wood/ Peter Rooney	20 June

	nature of the solutions. Whilst agreement is already in place in principle there may be divisions once specific services are named for specific provider sites.	- Impacts the ability to implement the proposed change.				- Continue to develop the solutions based on clear evidence and remind stakeholders of the burning platforms. - In the **south** the SRO has proposed to send the draft SC to the family of organisations to take through their board processes from June 13th.		
Solutions development	Financial risks – emerging options do not reach the 75% threshold.	- The resulting plans would not meet the needs of the local health economy, NHS England, TDA and Monitor. - Financial problems would remain in situ, presenting further pressure on the system	4	5	Red	- Model financial impact of solutions early so that potential gaps in the solution are identified quickly. - Development of quick wins (e.g. scaling the integrated hub at CIC across the whole of north Cumbria), additional efficiency initiatives (radical redesign of outpatients) and assessment of structural cost analysis - In the **south**, modelling will be taken to the options evaluation group on 20th May to inform discussion and draft iterations are being considered by the DOFs on 9th May.	Nigel Coates / Kevin Parkinson / Aaron Cummins / Charles Wellbourn	20 June
Capacity	There is insufficient capacity in the system to fully develop and deliver a plan as there are numerous other issues the LHE is	The plans are not as fully developed as they need to be as the right people haven't had sufficient input	4	5	Red	- Programme Board focus on driving the development of the plans - Good stakeholder management. - Recognition of operational issues when developing the	Andrew Bennett / Nigel Maguire	20 June

	managing – such as fall out from national inspections. Acquisition of NCUHT etc					plans and allowing for day to day business to be conducted.		
Solutions development	Quite different solutions could emerge in the north and south – while there is agreement on the OOH model the delivery of services at providers may drive differing solutions – such as maternity where the south may emerge with a consultant led service, but the north feels otherwise.	The plans would not be county wide, and would effectively be an LHE with two solutions.	2	4	Amber	- The CCG are keen to ensure equity across north and south and we will help to develop similar solutions. CRS is being used as an evidence base for this.	Andrew Bennett / Nigel Maguire	20 June
Public opinion	The public not being engaged on their views of the long list of options, and subsequent preferred option as this process is happening very quickly.	- Lack of buy-in from the public, leading to campaigns against change. - A worst case is that a judicial review is called as due process is not seen to be followed.	4	4	Red	- Public engagement has been strong and needs to continue. - All engagement to be well documented as evidence.	LHE Comms leads	20 June
Solutions developme	Estates – this is not within the PwC	The final option not being viable from an	4	4	Red	- In the north the Planning Group will address this	Peter Rooney / Paul Wood	19 May

nt	scope. There is not a regular Estates group that meet. Risk of not having the estates impact on each of the options.	estates perspective. This could also impact upon the viability of the financial case.				issue. - In the south Paul Wood and Kevin Parkinson are addressing	/ Kevin Parkinson	
Risks related to the ability of Cumbria to implement the plans once produced and agreed.								
Public opinion	Public and political pressure will make the implementation of the preferred solution difficult, or at the very least protracted. There is a history of successful campaigns against change.	Delivery would be delayed, or even stopped.	4	5	Red	Stakeholder engagement has been strong across the county. This will continue with evidence being shown of string public engagement also. Leaders will need to play their part in engaging the local government and local politicians	BCT and Healthier Together Programme Boards	20 June
Capability	Without a proven delivery vehicle and focus on implementation the plans will remain solid on paper, but weak in delivery.	As with previous 'strategic' plans they will not be delivered – either at all or only in part, leading to the non-achievement of the benefits the plans advocate.	4	5	Red	There is acceptance across the LHE that implementation is a key issue, which will require strong leadership, appropriate resource and dedicated delivery to achieve the scale of change currently being designed. We are working with both programme boards to help develop the governance and delivery structure to support implementation as part of the plan development.	BCT and Healthier Together Programme Boards	20 June

9 Specific updates following points raised at Programme Board 2 May 2014

Further to Report 1 the following issues were highlighted. An update is provided here for completeness.

1. The Risk Rating for delivery of an aligned and robust plan has been revised to Amber/Green.
2. Include the scale of the impact if a consultant-led maternity unit at Whitehaven is chosen.

   This is one of the key decisions that the options development process will need to address. There is currently a consultant led maternity service at West Cumberland Hospital (Whitehaven). The Treasury approved business case for the £90m investment in new hospital infrastructure was predicated on the continuation of a consultant led service. This will be one of the options that is considered at the CDG on 15th May, and then taken forward for modelling.

   It is too early to state the financial scale of the impact of retaining this service. Further, given it is subject to an ongoing review process not expected to publish its findings until July, the Strategic Case submitted in June will not take into account the final decision on provision of maternity services in the north of Cumbria.
3. Recommend whether the NCUHT transaction should be unstalled; and 4. Following the NCUHT transaction what would be the scale of the problem left and how would it be filled (it is understood by the Programme Board that the detail may not be fully gathered by D2).

   The potential acquisition is the subject of ongoing discussions with the local partners and a verbal update on this issue will be provided at the Challenged Health Economy Programme Board.
4. Include information about the delivery of plans in the South, and confirm if plans are still on track.

   The BCT Programme has been on a trajectory to deliver a Strategic Outline Case on 30th June and the table in section 5 of this report illustrates the timeline to reach that target, all of which remains on track.

Appendix 1: Key Lines of Enquiry from the Single Version of the Truth (SVT)

A number of significant themes have emerged from the baseline analysis work. These formed lines of enquiry that inform the Care Design and Options Appraisal work for the five year strategic plans. Whilst the emerging themes are similar across the north and south, the detail is different in each patch, driving a different set of actions and investigations.

A summary of the Key Lines of Enquiry emanating from each SVT is included below.

North Cumbria

- *The north Cumbria Affordability Gap* is of the order of £90m in 2019/20 if no efficiencies or changes are made. This is equivalent to a year on year saving of approximately 4.5% for every organisation in the system with recent average efficiencies being closer to 3% for the NHS trusts.
- *The Demographic & Geographic Challenge* includes a population that is ageing faster than the rest of England, and the rural and dispersed nature of the population makes the provision of healthcare costlier than in many other economies.
- *Changing the Care delivery setting* is a real opportunity as an analysis finds that 24% of admissions and 62% of days at NCUHT could be managed in a non-acute setting and there are established precedents for community care services across north Cumbria, e.g. neurology.
- *Operational indicators* show some key indicators within the expected range (eg bed occupancy and SHMI) but highlight a low utilisation with less than half the national average of spells per site. It must be noted that the geographically dispersed population makes it hard to target the national average.
- *Workforce transformation* is needed as hospital based nursing and midwifery staff are 75% of the total (compared to one third in mature integrated care economies) and comparatively high levels of temporary staff usage cost North Cumbria up to £10m annually driven by major gaps in medical staffing

Morecambe Bay

- The Bay Wide Affordability Gap is of the order of £71m in 2019/20 if no efficiencies or changes are made. 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.
- Demographic and geographical challenges. Lancashire North has some poor public health outcomes such as high alcohol abuse and STI figures and above average emergency admissions. South Lakes has a significantly older population than the national average and ageing at a faster rate in future. The proportion of over 65s is the highest in the area and is 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. This leads to high levels of hospital admissions (30% above national average) and poor health outcomes.
- The Morecambe Bay footprint covers a significant 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).
- The Trust 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 geographic spread which means working on 3 sites rather than the national average of 1.4.
- Changing the Care delivery setting is again a significant opportunity as point of prevalence analysis shows 28% of UHMBFT admissions could be managed in a non-acute setting assuming Out of Hospital investment as a result of Bettercaretogether
  - Primary care analysis suggests high admission rates for both elective & emergency admissions
- *Primary and Community Care*. The key findings around Primary care were:
  - GP practices in all three localities have higher than average elective admissions rates.
  - Furness and Lancs North have a much higher than average emergency admissions rate

- If the system moves to national averages, there is an opportunity to reduce emergency admission (6,053) and elective admissions (4,705)
- Driving times to the nearest major hospital site (RLI or FGH) are short (under 20 mins) for the majority or practices in Furness and Lancs North
- The key findings around Community and social care were:
- The most significant reason (33%) for "non-qualified" stays in the Oak Group analysis was a lack of beds available in alternative settings
- The spend per head on social care is at the top of the spread of comparators and the outcomes on all measures are not best in class
- Treatment is generally good but potential improvements include increasing the number of complaints responded to in 25 days (4 out of 13.), four week smoking quitters and reducing the number of Serious Untoward Incidents which has increased month-on-month since CPFT came into being in 2013

- *Elective care*. Following the elective care repatriation analysis the following conclusions / issues were raised:
  - A total repatriation opportunity of £6.9m in elective activity was calculated of which £6.3m is in trauma and orthopaedics which is reduced to £5.3m when accounting for any HRG where UHMB has zero or low activity due to specialist referrals.
  - No account is made of patient choice; thus, the total opportunity will likely be below the figures listed here as it is unlikely that all activity can be repatriated.
- *Technology*. The IM&T landscape within the Morecambe Bay health economy as it stands today, has the potential to enable integrated care. The current technology landscape is diverse and complex, but this complexity is manageable as a result of, convergence in electronic patient record (ePR) systems and adoption of standardised technologies to interoperate. There is an opportunity to further exploit and leverage Care planning and management capabilities across primary, acute, community and social care.

Appendix 2: Our approach to Future Service Design

Our approach to the development of solutions to address these needs was based on consultation. The critical elements to our approach were:

- Building of local clinical (care professional) leadership and ownership of the solutions
- Involvement of patients and the public in the care design process and large scale engagement events with the public and a broader group of clinicians, managers and other care professionals
- Starting with a provider agnostic approach, designing services around the patient and working back from that point to compensate for the fixed points in the system

Our overall approach to care design is shown in the diagram at the end of this appendix – the use of care design groups to build understanding of the problem and then future service configurations to meet this. The care design groups were run with reference to innovative models of service delivery, for example through clinical networks or approaches adopted in other LHEs.

Within Cumbria we followed two parallel paths in developing the solutions.

North Cumbria

The north is further behind in its development of service redesign but good progress is being made as much of the thinking has been done previously as part of the Care Closer to Home strategy in 2007 and more recently the Clinical strategy in 2011.

The first CDG in the north of Cumbria was held on 6th of May. The group was well attended, with over 80 delegates from a wide variety of backgrounds.

86 people attended CDG1, including medical professionals, the wider care community, carers and members of public bodies:

- Care professionals attended from 14 organisations, including paediatrics, mental health and diabetes
- British Red Cross
- Carlisle Carers
- Carlisle County Council
- Citizens Advice Bureau
- Copeland Borough Council
- Cumbria Care Commissioning Group
- Cumbria County Council
- Cumbria Health on Call
- Cumbria Partnership Foundation Trust
- North Cumbria University Hospitals Trust
- GPs
- North West Ambulance Service
- Royal College of Nursing
- West Cumbria Leukaemia & Lymphoma Research
- There were 13 attendees from Health Watch, representing the public and patients

Appendix 4 lists the attendees.

The focus was on out-of-hospital care and the development of a care model that could drive transformation of service delivery. The work used the out-of-hospital care model developed in the south of the county as a starting point and reviewed its potential impact from three perspectives (Urgent; Planned/Episodic; Proactive care).

CDG 1 in North Cumbria was introduced by Dr David Rogers, Clinical Director of Cumbria CCG who outlined the challenges faced and need for a transformation of the service model to meet the needs of the 21st century.

Dr Jonathan Steel (PwC) then talked through the ways of working required and was followed by Dr John Howarth, Partnership Trust, Director of Service Improvement, who explained the model and its relevance and origins in the north of Cumbria.

The larger group was then broken into smaller focus groups with Dr Tim Wilson, Dr Jonathan Steel and Hamish Clark. Using the three lenses of 'proactive',' planned/episodic' and 'unplanned' care the groups were asked if they accepted the underlying model, the impact it would have on key activities and metrics, and to agree fixed points in the system.

Two of the three groups (planned/episodic and unplanned care) were readily able to agree the model in principle although with some caveats around implementation and the fact that the model was at a high level rather than detailed. The third group, proactive care, raised more challenges but largely these were questions about 'how' rather than 'if'. The model was not directly opposed by this group but more questions were raised that will require consideration.

The financial impact of the model was assessed at a high level in all groups and thought given to 'fixed-points' in the planned and unplanned groups.

Unplanned Care

- The model was well received. Group saw how the proposed model would help, subject to certain issues being addressed
- Older People's Assessment Team (OPAT) established recently at the front door of CIC proves that integration can be done in North Cumbria.
- Priority areas for integrated care. There are gaps in provision in three key areas that must be addressed as priorities: Care Planning; End of Life (EoL); Community (i.e. provided away from the acute trust) MSK Service

Planned/ Episodic Care

- Model accepted as a target way of working. There are North Cumbrian examples of using this model (e.g. Neurology) and proposed a number of additional services that could be delivered in this format
- Strong appetite to make changes happen. The group noted the longstanding conversations and deliberations and called for a clear direction, practical solutions and visible action.
- The journey is not without challenges. Among top concerns: current funding mechanisms; inadequate technological infrastructure; lack of time to make change happen; maintaining patient trust & support through the change; and how certain services like Mental Health would fit into the model

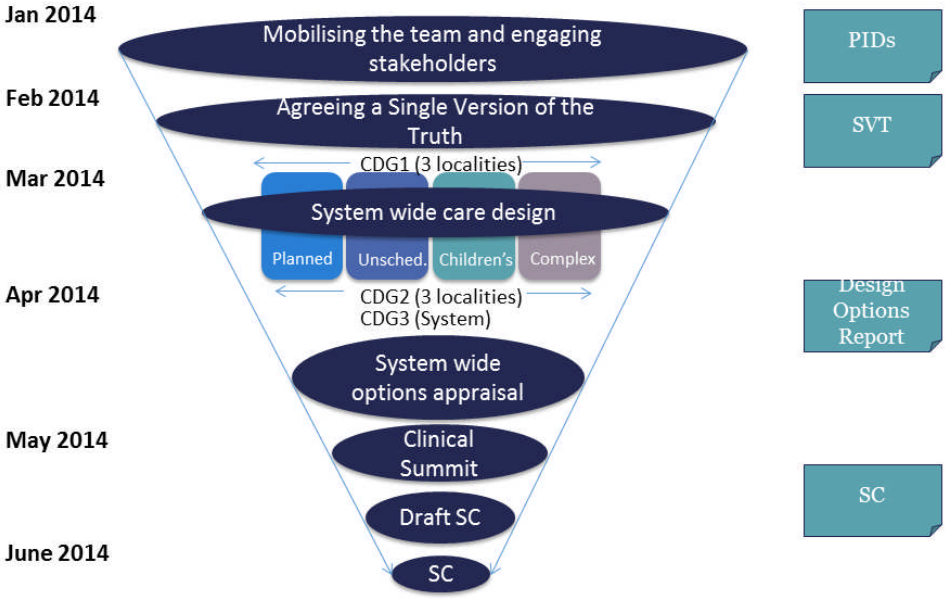
Care for Frail Elderly, LTC & Complex

- No direct opposition to the model itself but there were many suggestions and criteria proposed in order for it to work.
- A clear sense of opportunity and appetite for change. Wide collection of concerns and opportunities
- Some resistance. Largely at a practical 'how to' level. Also against language used; need for new language that reflects a change of culture and focus. E.g. 'people who are sometimes patients'

In summary, whilst further work is required to arrive at a final, agreed OOH model, all delegates expressed an appetite for change and were well engaged in voicing their views. The underlying principles behind an out-of-hospital model such as the one proposed were agreed with by the majority of delegates and now require further work to shape into acceptable language and a well thought through action plan.

Morecambe Bay, south Cumbria

The Strategic Case (SC) phase of the Bettercaretogether programme is being developed using an integrated delivery approach. The desired outcome, deliverable and products produced in each programme stage are set out in the diagram below.



Design Options

The Design Options process is split across two main pieces of work, the System Wide Care Design process and System Wide Options Appraisal.

1) System Wide Care Design process

This process was used to develop an integrated care system solution for out of hospital care and in hospital care. The Care Design Groups (CDGs) focused on three localities (Lancaster, Furness and South Lakes) and four service groupings: Planned, Unscheduled, Children's and Complex.

The groups were clinically led, facilitated by PwC specialists, however they were supported by commissioners, finance, workforce, ICT, estates and transport to ensure there was consistency between the design and appraisal work.

The approach was predicated on clinicians owning the service change, therefore the groups had a strong focus on articulating the contribution to clinical outcomes and potential activity and financial improvements, such as reduced A&E admissions.

Once ideas for improvement had been identified, the approach grouped the ideas into quick wins or transformational where further system detailed planning is required.

The objectives for each CDG are set out below:

- **25–27th February CDG 1:** The first CDG identified potential options for system redesign. CDGs 1 & 2 will be locality focussed and will have breakout sessions into the 4 Clinical Workstreams that have done work to date on potential new models
- **11-13th March CDG 2**: This CDG took the options for system redesign that were proposed in CDG1 and considered them in greater depth, including trying to quantify those that seem more workable and beneficial

- **09th April CDG 3**: System Wide Integration- This CDG took the long list of 'fleshed out' options that have been generated by the locality CDGs and combined them for a system-wide view along with considering in-hospital implications of any broader redesign of services

The Clinical Summit on 29th April brought together all the clinicians engaged in the process to date, as well as further colleagues from across the health and social care economy of Morecambe Bay. The Clinical Summit was a stakeholder engagement event attended by 200 clinicians with several key objectives:

- Share the proposed OOH model
- Give participants a chance to comment on the new in-hospital options
- Outline the next steps towards implementation
- Set in the context of the Morecambe Bay challenge

2) System Wide Options Appraisal

At the start of this process two facilitated workshops were held with the Programme Board to enable system leaders to share views on potential system options and input positions on services that need to be location specific.

Once these Stakes in the Ground had been developed and fed into the Care Design Group process, a concise set of evaluation criteria were developed. These were agreed up front and included: Ease of implementation, Contribution to desired clinical outcomes, Clinical quality risk, Patient experience, Affordability, Any significant travel impacts, and Workforce impacts (including 7 day working).

A number of inputs will support the options work including:

- Prior work undertaken
- Clinical engagement prior to the CDGs
- The CDG sessions
- Stakes in the Ground sessions
- Public engagement undertaken in parallel with the CDGs

Although the intention is to prioritise analysis for the 3 shortlisted options to be defined in the Strategic Case, high-level analysis will be undertaken to support the options work, including activity, finance, workforce and travel.

Stage 3: SC Reporting

There are four key stages to developing the Strategic Case for change outlined below:

3) Financial impact analysis for shortlisted options. The short-listed options will be evaluated and costed against the overall affordability position for the whole system. This financial impact analysis will be informed by the profitability analysis conducted recently for UHMBT, new commissioning requirements, demand / capacity assessment and impact on final costs within the system.
4) Workforce impact analysis for shortlisted options. The short-listed options will consider potential new workforce models and workforce benchmarking against other integrated healthcare systems. The analysis will include the workforce impact of new multidisciplinary roles within the locality team and enhanced management of patient flow across the system.
5) IM&T impact analysis for shortlisted options. This activity will consider the 2-3 shortlisted options from an information management and technology perspective. The work will consider the strategic changes in architecture required to support the proposed changes and will also estimate revenue and capital costs to be included in the Strategic Case.
6) Implementation Planning. For each shortlisted option, this activity will create a roadmap for implementing the shortlisted option. This phase of work will also develop a short term plan by locality for any quick wins identified in the Care Design Groups.

Public and Patient Engagement

In addition to the engagement provided through the CDG and Clinical Summit process there has been extensive engagement with the public and patients across both north and south Cumbria. The latter, as part of BCT, has a comprehensive programme and has used the output in the CDGs. In the north the programme is in its infancy but will have collected a substantial tranche of evidence in time for the development of the preferred solutions.

Noted below are the overall plans for the engagement.

North Cumbria - Communications and Engagement Plan

Completed and Planned Activity

Date	Communication	Audience
7 April	Share written media briefing	Local area team – communications and reconfiguration lead
8 April	Face to face briefing/ share written media briefing	Brief journalist from News and Star, Cumberland News and Whitehaven News Radio and TV
9 April am	Share media briefing **Note comms leads responsible for sharing within their own organisations as per the comms and engagement plan**	NHS internal audiences Members of programme board (inc Healthwatch) County Council District councils Town and parish councils CVS
11 April	Draft exec summary of five year plan (work in progress) and info re engagement	Health and Well-being Board
14 April	Draft exec summary of five year plan (work in progress) and info re engagement	Overview and scrutiny committee
16 April	Road show Market, Pow Street, Workington (10am to 2pm)	Members of public
17 April	Road show Market, Criffle Street, Silloth (10am to 2pm)	Members of public
26 April	Road show Farmers' market, Market Place, Brampton (10am to 1.30pm)	Members of public
1 May	CCG staff development session	Staff
2 May	Road show, Farmers' market, English Street, Carlisle (10am to 2pm)	Members of public
2 May	10 – 10.30am meeting with Dep CE of Carlisle City Council and Health Portfolio member	Representative from Carlisle City Council
6 May	Clinical Design Group – Castle Inn Hotel, Bassenthwaite 3pm – 9pm	Health and Care Professionals and Patient Representatives
7 May	Allerdale Council Exec Members 10am	Allerdale Council Exec Members
8&9 May	Three focus groups in Allerdale	Members of public
13 May	CVS event (venue to be confirmed)	Community and voluntary sector
14 May	CVS event (venue to be confirmed)	Community and voluntary sector
14&15 May	Three focus groups in Copeland	Members of the public
15 May	Road show Moot Hall area Market, Keswick (10am to 2pm)	Members of public
15 May	Two focus groups in Allerdale	Members of the public

15 May	Clinical Design Group – Greenhill Hotel, Wigton 3pm – 9pm	Health and Care Professionals and Patient Representatives
17 May	Road show Market Place, Whitehaven (10am to 2pm)	Members of public
19 May	Bolton PC AGM 7.30pm Memorial Hall, Bolton	Parish councillors
19 May	Two focus groups in Copeland	Members of public
20 May	Road show Farmers' market, Clock Tower, Penrith (10am to 2pm)	Members of public
20&21 May	Three focus groups in Eden	Members of public
22 May	Kirby Stephen roadshow TBC	Members of public
22 & 23 May	Three focus groups in Carlisle locality	Members of public
23 May	Road show Market, Town Square, Cleator Moor	Members of public
26 May	Road show Bank Holiday Plant Market, Wilkinson Car Park, Cockermouth (10am to 2pm)	Members of public
2 June	Alston PC meeting -Nenthead Village Hall 7pm	Parish councillors
2 June	Alston Rural Partnership shop roadshow 3.30 to 6pm	Members of public
4 June	Allhallows PC meeting 7.30pm Allhallows Centre, Fletchertown TBC	Parish councillors

Better Care Together Comms and Engagement Plans

We used a variety of methods including:

- Workshops in Barrow, Lancaster and Kendal facilitated by TNS – BNRB (formerly Gallop) an independent market research organisation who had also worked with us on the out of hospital engagement. All participants were asked for their views on the different scenarios/elements of the emerging out of hospital model and the design principles which had emerged from each of the CCG out of hospital workstreams. TNS have provided some "top line" themes which are included
- Presentations and Q&A style 5 drop in events for both hospital and community based staff to brief them on the latest position and the public engagement events that would be taking place.
- 12 public "drop in style" events with two each taking place at Barrow, Kendal, Lancaster, Morecambe, Millom and Ulverston. Attendees were invited to complete a number of activities to give us feedback. There were also opportunities to complete comment cards, to take the activities away and complete at home, to complete the activities online, and to participate in a Q&A session.
- We also put the engagement activities on "Citizen's Space" so that people could take part in the engagement activities on-line.
- For the TNS events personalised invitations were sent out to a range of organisations within the three localities including the voluntary sector, governors, OSC members and action groups
- The public 'drop-in' style were advertised in newspaper adverts, press releases, emails to our database contacts and our networks, and an "ad-bike"

Other Relevant Events/Meetings

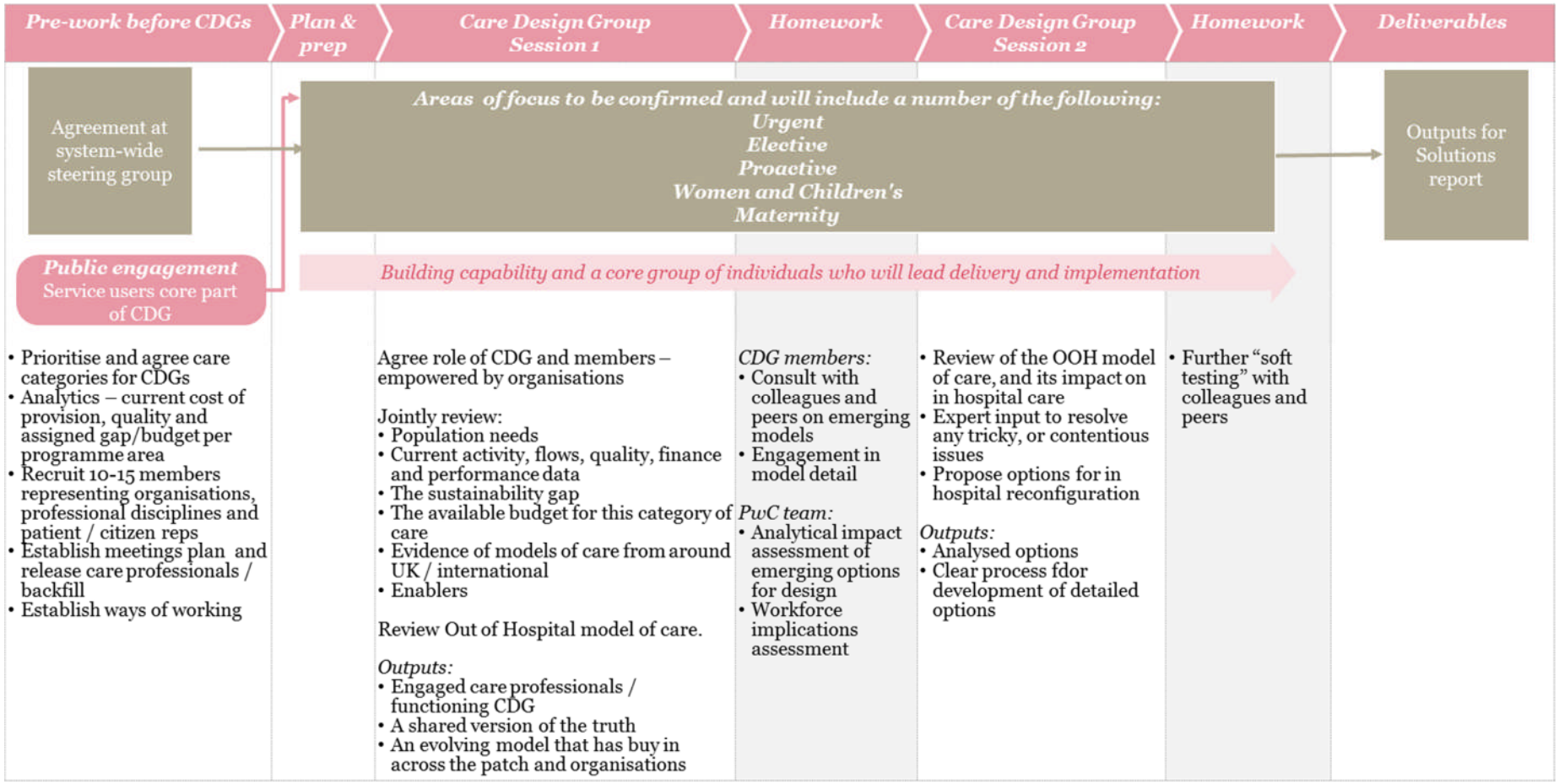
- Lancashire North CCG held a voluntary sector event in March and participants were asked to take part in some of activities above. GP led listening and engagement events were also held in Barrow and Millom
- Local MPs have had either had a face to face or telephone briefing with a further cross party meeting being arranged following the Clinical Summit

- The Joint Cumbria and Lancashire Overview and Scrutiny Committee were advised of our proposed engagement in advance and we have had a follow up meeting with them earlier this month

Summary

- There were over 250 attendees across all the events and these included Council OSC and MP representatives, local media, third sector representatives, members of public and a broad spectrum of colleagues
- Feedback is still being received and we will ensure this gets factored into our final reports, but a summary is provided in the following slides

Appendix 3: Our approach to care design groups



Appendix 4: Record of persons consulted with over solution design

Care Design Group 1 Attendees – Morecambe Bay

Aaron Cummins	UHMBT
Alex Proffitt	Healthwatch Cumbria
Amanda Boardman	Cumbria CCG
Ameeta Joshi	UHMBT
Andrew Higham	UHMBT
Anthony Gardner	Cumbria CCG
Arun Thimmiah	Cumbria CCG
Ash Kale	UHMBT
Asish Chatterjee	UHMBT
Bob Wilkinson	Mencap
Camilla Hardy	Lancashire County Council
Cathy Hay	Cumbria Partnership Trust
Chris Snell	Lancaster Children and Young People's Trust Board
Chrissie Hunt	Cumbria CCG
Christiane Shrimpton	UHMBT
Clare Rice	Cumbria Partnership
Cliff Elley	Lancashire North CCG
Corrine Ralph	Cumbria CCG
David Wilkinson	UHMBT
Dr Highley	UHMBT
Dr Krishnaprasad	UHMBT
Eleanor Hodgson	Cumbria CCG
Elizabeth McDougall	UHMBT
Emily Griffiths	Cumbria Partnership
Esther Kirkby	Cumbria Partnership
Gary O'Neill	Lancashire North CCG
Gary Wilson	Cumbria County Council
Geoff Jolliffe	Cumbria CCG
George Dingle	Lancashire North CCG
George Nasmyth	UHMBT
Gill Cook	UHMBT
Gill O'Connell	UHMBT
Gill Speight	Blackpool Fylde & Wyre Teaching Hospitals
Hazel Smith	Cumbria CCG
Helen Deacon	Lancaster Children and Young People's Trust Board
Helen Fogg	FCMS
Hilary Fordham	Lancashire North CCG
Ian Chadwick	UHMBT
Jackie Forshaw	NHS England
Jane Dickinson	Cumbria Partnership
Janet Lavelle	UHMBT
Jeremy Marriott	Lancashire North CCG
Jo Newsham	Cumbria Partnership
Joann Morse	UHMBT
Joanna Hunt	The Children's Society
Joanne Brown	Cumbria County Council
Joanne Keen	Cumbria County Council
John Bannister	UHMBT
John Howarth	Cumbria Partnership
John Keen	Cumbria CCG
John Miles	Lancashire North CCG
Julia Westaway	Lancashire North CCG
Julie Featham	Cumbria County Council
Julie Knowles	Cumbria County Council
Justine Anderson	Cumbria Partnership
Kairen Creighton	Lancashire Care NHS Foundation Trust
Karen Slade	Lancashire County Council
Karen Ennis	Lancashire County Council
Kevin Parkinson	Lancashire North CCG
Kristyna Bohmova	UHMBT
Lesley Tiffen	Lancashire County Council
Liz Holt	Blackpool Fylde & Wyre Teaching Hospitals
Liz Dover	Cumbria CCG
Lorraine Berry	Cumbria County Council
Louise Freeman	Cumbria County Council
Marie Harris	Cumbria County Council
Martin Clayton	NHS England
Mary Moore	UHMBT
Mike Kingston	Lancashire North CCG
Neela Shabde	Cumbria CCG
Nigel Courtman	UHMBT
Nigel Grunshaw	UHMBT
Owen Galt	UHMBT
Paul Grout	UHMBT
Paula Evans	UHMBT
Rahul Keith	Lancashire North CCG
Ray McGlone	UHMBT
Rick Shaw	NWAS
Salman Desai	NWAS
Sarah Arun	Cumbria CCG
Sascha Wells	UHMBT
Shadaba Ahmed	UHMBT
Shaun Kenny	Cumbria Partnership
Sheelagh O'Brien	Cumbria Societies for the Blind
Sonia Mangan	Age UK South Lakeland
Steven Naylor	
Stuart Chaplin	The Children's Society
Sue Harding	UHMBT
Sue Lott	Lancashire County Council
Sue McGraw	St. John's Hospice
Suzanne Lodge	Lancaster City Council
Terry Drake	Lancashire Care NHS Foundation Trust
Tim Reynard	UHMBT
Tina Harris	UHMBT
Tristram Reynolds	UHMBT
Wael Abdelrhman	UHMBT
William Lumb	Cumbria CCG

Care Design Group 2 Attendees – Morecambe Bay -

Aaron Cummins	UHMBT
Alex Gaw	Lancashire North CCG
Alistair Mackenzie	Cumbria CCG
Amanda Boardman	Cumbria CCG
Amanda Brooks	n-compass Northwest
Ameeta Joshi	UHMBT
Andrew Higham	UHMBT
Andy Jones	Lancashire Care NHS Foundation Trust
Anthony Gardner	Cumbria CCG
Arun Thimmiah	Cumbria CCG
Asish Chatterjee	UHMBT
Carole McCann	Blackpool Fylde & Wyre Teaching Hospitals
Chris Snell	Lancaster Children and Young People's Trust Board
Chris Stokes	Cumbria CCG
Chrissie Hunt	Cumbria CCG
Christiane Shrimpton	UHMBT
Claire Kaye	Cumbria Partnership
Cliff Elley	Lancashire North CCG
Colin Brown	UHMBT
Daniel Hughes	Cumbria CCG
David Wilkinson	UHMBT
David Lewis	Cumbria Partnership
David Wrigley	CCG Exec
Dia Smith	
Dr Abdelrhman	UHMBT
Dr Highley	UHMBT
Dr Krishnaprasad	UHMBT
Eleanor Hodgson	Cumbria CCG
Elizabeth McDougall	UHMBT
Emily Griffiths	Cumbria Partnership
Fran Campion	UHMBT
Gary O'Neill	Lancashire North CCG
Gary Wilson	Cumbria County Council
Geoff Jolliffe	Cumbria CCG
George Dingle	Lancashire North CCG
George Nasmyth	UHMBT
Gill Murphy	UHMBT
Gill O'Connell	UHMBT
Gill Speight	Blackpool Fylde & Wyre Teaching Hospitals
Gill Wildon	Blackpool Fylde & Wyre Teaching Hospitals
Hazel Smith	Cumbria CCG
Helen Bailey	Cumbria CCG
Helen McConville	Lancashire North CCG
Helga Brown	UHMBT
Hilary Fordham	Lancashire North CCG
Hugh Reeve	Cumbria CCG
Ibtisam Jebur	Cumbria CCG
Jacqui Thompson	Lancashire North CCG
Janet Lavelle	UHMBT
Jeremy Marriott	Lancashire North CCG
Jo Morrow	Lancashire North CCG
Jo Newsham	Cumbria Partnership
Joann Morse	UHMBT
John Bannister	UHMBT
John Butterworth	UHMBT
John Howarth	Cumbria Partnership
John Keen	Cumbria CCG
John Miles	Lancashire North CCG
Julia Westaway	Lancashire North CCG
Julie Featham	Cumbria County Council
Julie Knowles	Cumbria County Council
Kairen Creighton	Lancashire Care NHS Foundation Trust
Karen Slade	Lancashire County Council
Kate Maynard	UHMBT
Kristyna Bohmova	UHMBT
Lee McGlynn	Lancashire North CCG
Linda Womack	UHMBT
Louise Corlett	Lancashire Care NHS Foundation Trust
Louise Freeman	Cumbria County Council
Marie Postlethwaite	Cumbria Partnership
Martin Clayton	NHS England
Martin Lovatt	Lancashire North CCG
Mary Moore	UHMBT
Mary Harrison	Cumbria Partnership
Mary Kiddy	Cumbria Partnership Trust
Mike Banks	Lancashire County Council
Mike Kingston	Lancashire North CCG
Nigel Grunshaw	UHMBT
Owen Galt	UHMBT
Paul Tynan	Lancashire North CCG
Paula Evans	UHMBT
Pauline Tschobotko	Blackpool Fylde & Wyre Teaching Hospitals
Rahul Keith	Lancashire North CCG
Richard Russell	Cumbria CCG
Rick Shaw	NWAS
Sarah Arun	Cumbria CCG
Sascha Wells	UHMBT
Sonia Mangan	Age UK South Lakeland
Steve Mcquillan	Cumbria CCG
Steven Naylor	
Sue Harding	UHMBT
Sue Lott	Lancashire County Council
Sue McGraw	St. John's Hospice
Tina Harris	UHMBT
William Lumb	Cumbria CCG

Care Design Group 3 Attendees – Morecambe Bay -

Name	Organisation
Aaron Cummins	UHMBT
Alex Gaw	Lancashire North CCG
Alex Proffitt	Healthwatch Cumbria
Alistair Mackenzie	Cumbria CCG
Amanda Boardman	Cumbria CCG
Ameeta Joshi	UHMBT
Anas Olabi	UHMBT
Andrew Bennett	Lancashire North CCG
Andrew Craven	Lancashire North CCG
Andrew Higham	UHMBT
Andy Knox	Lancashire North CCG
Anthony Gardner	Cumbria CCG
Asish Chatterjee	UHMBT
Bob Wilkinson	Mencap
Charles Welbourn	Cumbria CCG
Christiane Shrimpton	UHMBT
Clare Rice	Cumbria Partnership
Cliff Elley	Lancashire North CCG
Colin Brown	UHMBT
Colin Reynolds	South Lakeland Mind
Corrine Ralph	Cumbria CCG
Daniel Hughes	Cumbria CCG
David Wilkinson	UHMBT
David Wrigley	CCG Exec
Dawn Butterfield	Lancashire County Council
Dr Abdelrhman	UHMBT
Elaine Wilson	Bay Urgent Care
Eleanor Hodgson	Cumbria CCG
Elizabeth McDougall	UHMBT
Emily Griffiths	Cumbria Partnership
Gary Wilson	Cumbria County Council
Geoff Jolliffe	Cumbria CCG
George Nasmyth	UHMBT
Gill Murphy	UHMBT
Gill O'Connell	UHMBT
Gill Speight	Blackpool Fylde & Wyre Teaching Hospitals
Gillian Gregory	Lancashire North CCG
Hazel Smith	Cumbria CCG
Helen Fogg	FCMS
Hilary Fordham	Lancashire North CCG
Hugh Reeve	Cumbria CCG
Jacqui Thompson	Lancashire North CCG
Janet Lavelle	UHMBT
Jeremy Marriott	Lancashire North CCG
Jim Hacking	Cumbria CCG
Jim Hayburn	NHS England (Cumbria)
Jo Connolly	UHMBT
Jo Newsham	Cumbria Partnership
John Bannister	UHMBT
John Butterworth	UHMBT
John Howarth	Cumbria Partnership
John Miles	Lancashire North CCG
Jon Wimbourne	York Bridge Surgery (GP)
Judith Whittam	Cumbria County Council
Julie Featham	Cumbria County Council
Julie Knowles	Cumbria County Council
Juliet Walters	UHMBT
Kathy Blacker	NHS England
Kevin Parkinson	Lancashire North CCG
Leanne Copper	UHMBT
Linda Womack	UHMBT
Louise Corlett	Lancashire Care NHS Foundation Trust
Maddy Bass	St. John's Hospice
Martin Clayton	NHS England
Mary Kiddy	Cumbria Partnership Trust
Mike Kingston	Lancashire North CCG
Mike Prentice	NHS England (Lancashire)
Naomi Duggan	BCT
Patricia Chilton	HW Lancashire
Paul Grout	UHMBT
Paul Tynan	Lancashire North CCG
Paul Wood	BCT
Paula Evans	UHMBT
Paula Gibson	BCT
Pauline Tschobotko	Blackpool Fylde & Wyre Teaching Hospitals
Ray McGlone	UHMBT
Richard Russell	Cumbria CCG
Rick Shaw	NWAS
Rick Shaw	NWAS
Roham Rao	Lancashire North CCG
Sarah Senior	Cumbria Partnership
Sascha Wells	UHMBT
Shadaba Ahmed	UHMBT
Sheelagh O'Brien	Cumbria Societies for the Blind
Sonia Mangan	Age UK South Lakeland
Sophy Stewart	BCT
Stephen Toulmin	NWLMCS
Steven Cade	UHMBT
Sue Harding	UHMBT
Sue McGraw	St. John's Hospice
Sue Smith	UHMBT
Tim Reynard	UHMBT
Tina Harris	UHMBT
Tristram Reynolds	UHMBT
William Lumb	Cumbria CCG
Zafar Irfan	Coastal Medical Group

Clinical summit – Morecambe Bay 29th April 2014

Paul Smith	Age UK South Lakeland	Alistair Mackenzie	Cumbria CCG	Aaron Cummins	UHMBT
Halcyon Edwards	BCT	Amanda Boardman	Cumbria CCG	Ameeta Joshi	UHMBT
Naomi Duggan	BCT	Anthony Gardner	Cumbria CCG	Andrew Higham	UHMBT
Nicola Coles	BCT	Corrine Ralph	Cumbria CCG	Asish Chatterjee	UHMBT
Paul Wood	BCT	Craig Melrose	Cumbria CCG	Christiane Shrimpton	UHMBT
Paula Gibson	BCT	Eleanor Hodgson	Cumbria CCG	Colin Brown	UHMBT
Sophy Stewart	BCT	Hazel Smith	Cumbria CCG	David Wilkinson	UHMBT
Gill Speight	Blackpool Fylde & Wyre Teaching Hospitals	Jim Hacking	Cumbria CCG	David Burch	UHMBT
Gill Wildon	Blackpool Fylde & Wyre Teaching Hospitals	Judith Neaves	Cumbria CCG	Dr Abdelrhman	UHMBT
Liz Holt	Blackpool Fylde & Wyre Teaching Hospitals	Richard Russell	Cumbria CCG	Dr Highley	UHMBT
Nicola Parry	Blackpool Fylde & Wyre Teaching Hospitals	Steve Mcquillan	Cumbria CCG	Dr KrishnAprasad	UHMBT
David Wrigley	CCG Exec	Susan Blackemore	Cumbria CCG	Elizabeth McDougall	UHMBT
Becky Squires	Cumbria County Council	Wendy Gillen	Cumbria CCG	George Nasmyth	UHMBT
Gary Wilson	Cumbria County Council	Phil Jones	Cumbria CCG	Gill O'Connell	UHMBT
Jane Mathieson	Cumbria County Council	Dr Sudha Kapila	Cumbria CCG	Jackie Daniel	UHMBT
Judith Whittam	Cumbria County Council	Stephanie Jackson	Cumbria CCG	Janet Lavelle	UHMBT
Julie Featham	Cumbria County Council	John Adams	Cumbria CCG	John Bannister	UHMBT
Rebecca Maidment	Cumbria County Council	Andrea Bagai	Cumbria CCG	John Butterworth	UHMBT
Alan Swann	Cumbria Partnership	Miriam McNally	Cumbria CCG	Juliet Walters	UHMBT
Claire Molloy	Cumbria Partnership	Alison Johnston	Cumbria CCG	Kate Maynard	UHMBT
Clare Rice	Cumbria Partnership	William Lumb	Cumbria CCG	Kirk Panter	UHMBT
Emily Griffiths	Cumbria Partnership	Tracy Thornton	Cumbria CCG	Kristyna Bohmova	UHMBT
Esther Kirkby	Cumbria Partnership	Diane Ruell	Cumbria CCG	Leanne Copper	UHMBT
Jane Dickinson	Cumbria Partnership	Susan Stilling	Cumbria CCG	Linda Womack	UHMBT
Jo Newsham	Cumbria Partnership	Neil Margerison	Cumbria CCG	Mary Moore	UHMBT
John Howarth	Cumbria Partnership	Craig Melrose	Cumbria CCG	Owen Galt	UHMBT
Marie Postlethwaite	Cumbria Partnership	Hannah Mason	Cumbria CCG	Paul Grout	UHMBT
Nigel Maguire	Cumbria Partnership	Sheelagh O'Brien	Cumbria Societies for the Blind	Paula Evans	UHMBT
Salli Pilcher	Cumbria Partnership	Helen Fogg	FCMS	Sarah Cullen	UHMBT
George Stergiakis	Cumbria Partnership	Patricia Chilton	HW Lancashire	Sascha Wells	UHMBT
Ken Wood	Cumbria Partnership	Andy Jones	Lancashire Care NHS Foundation Trust	Sue Smith	UHMBT
Andrew Bennett	Lancashire North CCG	Jenny Gilpin	Lancashire Care NHS Foundation Trust	Tim Reynard	UHMBT
Cliff Elley	Lancashire North CCG	Dawn Butterfield	Lancashire County Council	Tina Harris	UHMBT
Gary O'Neill	Lancashire North CCG	Karen Slade	Lancashire County Council	Tristram Reynolds	UHMBT
Helen McConville	Lancashire North CCG	Sue Lott	Lancashire County Council	Jo Connolly	UHMBT
Hilary Fordham	Lancashire North CCG	Jackie Forshaw	NHS England	AliWarsi	UHMBT
Jo Morrow	Lancashire North CCG	Martin Clayton	NHS England	Karen Kyle	UHMBT

John Miles	Lancashire North CCG	Karen Bancroft	NHS England	Cath Clarke	
Julia Westaway	Lancashire North CCG	Dr Carole Ewing	NHS England	Julia Charnock	
Kevin Parkinson	Lancashire North CCG	Julie Cheetham	NHS England	Mike Prentice	
Mike Kingston	Lancashire North CCG	Barbara Smith	NHS England	Stephen Toulmin	
Paul Tynan	Lancashire North CCG	Jim Hayburn	NHSE	Rick Shaw	NWAS
Rahul Keith	Lancashire North CCG	Brian Niven	Mott MacDonald	Salman Desai	NWAS
Dr Duncan Hallam	Lancashire North CCG	Sarah Reeves	Mott MacDonald	Sandy Bradbrook	Public Reference Group
Julie Kennedy	Lancashire North CCG	Amanda Brooks	n-compass Northwest	Steve Charman	Public Reference Group
Dr Averil McClelland	Lancashire North CCG	Liz Mear	NW Health Alliance	Maddy Bass	St. John's Hospice
Jen Metcalfe	Lancashire North CCG			Sue McGraw	St. John's Hospice
Dr Jon Wimborne	Lancashire North CCG				
Dr Jonathan Williamson	Lancashire North CCG				

North Cumbria Care Design Group 1

Name	Organisation	Role	Name	Organisation	Role
Shelagh Hickson	British Red Cross		Amanda Evans	Cumbria County Council	Assistant Director of Adult Social Care
Dawn Kenyon	Carlisle Carers	Manager	Charlotte Macke	Cumbria County Council	Adult Social Care Eden Team Manager
Lynda Anderson	Carlisle Carers		Emma Robinson	Cumbria County Council	Occupational Therapist Locality Lead
Robert Cornwall	Carlisle City Council		Gordon Barwick	Cumbria County Council	Adult Social Care District Lead
Andrea Loudon	CCG	Clinical Pharmacy Lead	Helen Drozdz	Cumbria County Council	Adult Social Care Carlisle Team Manager
Andy Airey	CCG	East Network Deputy Director	Mark Hastings	Cumbria County Council	Adult Social Care County Manager
Anita Barker	CCG	West Network Deputy Director	Sarah Simmons	Cumbria County Council	Carlisle City Council
Anne-Marie Grady	CCG	West Network Senior Commissioning Manager	Sue Bowman	Cumbria County Council	Adult Social Care OT
Caroline Rea	CCG	Network Director - North Cumbria	Wendy Willis	Cumbria County Council	Adult Social Care District Lead
David Rogers	CCG	Senior Manager - Copeland GP Lead	Cilla Clarke	Eden Carers (Healthwatch)	Adult Social Care Team Manager
Eleanor Hodgson	CCG	Senior Manager - Director for Children & Families	Angela Murray	Healthwatch	Chief Executive Age UK Carlisle & Eden
Emma Bagshaw	CCG	East Network Senior Commissioning Manager	Anne Callagher	Healthwatch	
Rachel Chapman	CCG	Communications Services	Carole Jordan	Healthwatch	
Rosemary Granger	CCG	Programme Coordinator	Cilla Clarke	Healthwatch	Chief Officer Eden Carers
Craig Melrose	CHOC	Medical Director	Clare Edwards	Healthwatch	Carers Health Worker in Allerdale
Carol Graham	Citizens Advice Bureau	Copeland Manager	Janet Ferguson	Healthwatch	Chief Executive Eden Valley Hospice
Carol Woodman	Copeland Borough Council		Liz Clegg	Healthwatch	
Alan Swann	CPFT	Interim Medical Director, Consultant Psychiatrist for Older Adults	Mary Bradley	Healthwatch	Director Age UK West Cumbria
Ann Taylor	CPFT	Ward Manager	Michael Forsdyke	Healthwatch	
Claire Brock	CPFT	GP Penrith Hospital/ Part-time Clinical Director Eden Locality	Richard Lee	Healthwatch	
Elspeth Desert	CPFT	Clinical Psychologist Service Lead and Consultant in the North	Stanley Lightfoot	Healthwatch	

Emma Russell	CPFT	General Manager for Allerdale and Project Lead	Sue Whitehead	Healthwatch	
Jane Smith	CPFT	Associate Director, Development	Steve Cremin	NWAS	
Janet Folland	CPFT	Professional Lead for Occupational Therapy	Carol Davies	NWAS	Sector Manager
Jitka Vanderpol	CPFT	Consultant Neurologist	Ella Cullen	RCN	
John Crofts	CPFT	Governor	Chris Wood	West Cumbria Leukaemia & Lymphoma Research	
John Howarth	CPFT	Director of Integration	Bill Glendinning	NCUHT	Chief Pharmacist
Louise Overend	CPFT	Consultant Diabetes and Endocrinology	Deb Lee	NCUHT	Consultant Paediatrician
Luise Sanz	CPFT		Elizabeth Klein	NCUHT	Lead Nurse for Emergency Care
Richard Thwaites	CPFT	Consultant Clinical Psychologist, First Step	Fergus Young	NCUHT	Histopathologist
Ron Siddle	CPFT	Consultant Psychologist: Clinical Lead; Psychosis, Early Intervention Service - Amaze	Fiona Nixon	NCUHT	Consultant Orthodontics
Russell Norman	CPFT	General Manager Children's Services	Gill Long	NCUHT	Deputy Business Manager
Salli Pilcher	CPFT	Professional Head of Adult & Community Nursing & Patient Safety	Jim Methven	NCUHT	Medical Physics
Teresa Storr	CPFT	Locum Consultant, Palliative Care & Macmillan Nurses	Lynn Anderson	NCUHT	Acting Deputy Director of Nursing
Tim Evans	CPFT	Carlisle Locality General Manager	Michael Smith	NCUHT	General Manager - Emergency Care
Alan Edwards	GP		Mohamed Matar	NCUHT	Consultant Obstetrics & Gynaecology
Gail Newton	GP		Paul Plant	NCUHT	Respiratory CD
Michael Hanley	GP		Paul Whitehead	NCUHT	Consultant Paediatrician
Neil Margerison	GP		Ruth O'Dowd	NCUHT	Consultant Anaesthetics
Neil McGreevy	GP		Sara Jones	NCUHT	General Manager, Child Health
Peter White	GP		Tracey Mifflin	NCUHT	Professional Lead Physiotherapy
Simon Desert	GP		Val Wright	NCUHT	Operational Manager
Tom Ickes	GP		Yvonne Fairbairn	NCUHT	Interim General Manager, Surgical & Elective Unit

Appendix 5: Timeline to deliver Strategic Case – North and South Cumbria

There is a clear timeline for developing these options into an agreed solution for the BCT programme:

#	Milestone	Date Due
1	Options Definition Template sent to Options Development Group and Modelling Development Group for comment. Deadline for comments on Options Definition Template will be Tuesday 13th May.	Friday 9th May
2	Version 2 of Options Definition Template issued .	Friday 16th May
3	Options Evaluation session.	Tuesday 20th May
4	Options Evaluation Report produced and sent to stakeholders for review.	Friday 23rd May
5	CRG & Delivery Group to sign off Options Evaluation Report .	Wednesday 28th May
6	Agree narrative, costs and benefits for shortlisted options with MDG and ODG. This will be the final engagement session.	Friday 6th June
7	Version 1 of SC issued to SRO's for comment. Deadline for comments will be COP Tuesday 10th June.	Friday 6th June
8	Version 2 of SC issued to DG and CRG for comment by Tuesday 17th June.	Thursday 12th June
9	Version 3 of SC issued to DG and CRG for final comments by Friday 20th June.	Thursday 19th June
10	Version 1.0 of SC sent to Programme Board for sign-off.	Tuesday 24th June
11	Programme Board meeting for final SC sign off.	Thursday 26th June

This is the timeline for developing these options into an agreed solution for the north of Cumbria:

STRATEGIC PLAN PROGRAMME TIMELINE MAY – JUNE 2014

Date	Activity	Purpose	Confirmed
6th May	Care Design Group 1	To determine the planned model, and scale, for out of hospital services	Y
8th May	Programme Board	Maintain the governance of the programme, and agree key actions leading to June 20th	Y
12th May	PwC Key Deliverable 2	Update for National Partners' Programme Board on progress to date, and key emerging themes, risks, issues and areas of concern for implementation	
13th May	Planning Group	Review the Care Design Group and single version of the truth.	Y
14th May	NHS England Assurance	NHS England Area Team and Region to review the draft Cumbria Local Health Economy Plan using the Alliance session.	Y
15th May	NHS Cumbria CCG Clinical leads	To agree the commissioner requested services (stakes in the ground) assumptions	Y
15th May	Care Design Group 2	To review options for the configuration of hospital services, informed by the out of hospital model from CDG1.	Y

Date	Activity	Purpose	Confirmed
20th and 21st May	Clinical Principles Workshops	CLIC facilitate two sessions to update the broader clinical community on progress county wide and to agree key principles for how we work.	Y
21st May	Programme Board	Review progress	N
22nd May	Recruitment and Development Workshop	CLIC facilitate a session on how Cumbria can become a more attractive place to work with credible recruitment plans.	Y
23rd May	Primary Care Communities	To determine the core components of PCCs and the required enablers	Y
27th May	Planning Group	Develop shared planning assumptions, review progress and identify actions for the Programme Board.	Y
Last week in May	Planning Directors	Develop Governance and programme management arrangements for implementation	N
4th June	North Cumbria Maternity	PwC to facilitate a discussion with North Cumbria clinicians on maternity configuration options, based on Better Care Together format.	Y
First week in June	Planning Directors	To agree the key planning assumptions the CCG, NCUHT and CPFT will use for their respective plans, to ensure alignment.	N
5th June	Programme Board (extended session 1.30 – 5pm)	Review key options and debate 'front runner' option	Y
Date	**Activity**	**Purpose**	**Confirmed**
10th June	Planning Group	Review draft plan ahead of Alliance meeting, and prepare for clinical summit.	Y
9th/10th/11th June	Clinical Summit	Proposed summit to review the progress from public engagement, clinical engagement, and modelling, to allow a large number of clinicians and practitioners to inform the final plan.	N
9th/10th/11th June	Stakeholder summit Cumbria wide	Proposed summit to review the progress from public engagement, clinical engagement, and modelling, to allow a large number of key stakeholders to inform the final plan.	N
11th June	Cumbria Health and Care Alliance	Alliance collectively review the draft Cumbria Local Health Economy Plan.	Y
13th June	Maternity Networks	Greater Manchester, Lancashire and South Cumbria, and the Northern England, Clinical Networks for Maternity are jointly facilitating a maternity clinical discussion.	Y
17th June	Programme Board	Final north part of the plan sign off	Y

20th June	Submit Plans	NHS Cumbria CCG submit the Local Health Economy 5 year plan, Cumbria partnership NHS FT and North Cumbria University NHS Trust submit Trust Plans to Monitor and Trust Development Authority.	Y
30th June	PwC Key Deliverable 2	Brief, final report to national partners including a gap analysis on the final plans, flagging any risks or issues remaining and highlighting priority areas for follow up work.	Y