www.pwc.co.uk

Intensive Planning Support to Challenged LHEs

Report 3: 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

Cumbria

with Addendum

Monitor, NHS England, NHS Trust Development Authority

01 August 2014

Version 1.1

Commercial in Confidence

Contents

Glossary of terms and abbreviations

Abbreviation	Definition
CCG	Clinical Commissioning Group
CDG	Care Design group
CIC	Cumberland Infirmary Carlisle
CIPs	Cost Improvement Plans
CLIC	Cumbria Learning and Innovation Collaborative
CPFT	Cumbria Partnership FT
DoF	Directors of Finance
FT	Foundation trust
IT	Information Technology
JPMO	Joint PMO
LHE	Local Health Economy
MBFT	Morecambe Bay University Hospitals FT
MB	Morecambe Bay Health Economy
MoS	Menu of Services
NCUHT	North Cumbria University Trust
NHSE	NHS England
OOH	Out of Hospital
PMO	Programme Management Office
PwC	PricewaterhouseCoopers LLP
SVT	Single Version of the Truth
TDA	Trust Development Authority

1. Overview of project's delivery

The Cumbrian health economy has historically been managed as two distinct economies – the Morecambe Bay area in the south that includes both Cumbria and Lancashire North CCG, and the north of the county that includes North Cumbria University Hospital. Both economies have established change programmes – *Better Care Together* in the south and *Together for a Healthier Future* in the north. The south has been progressing its integrated care agenda since 2013 whereas the north only started in early 2014. This piece of work was focussed on accelerating the programme in the north and helping the CCG bring both programmes together to produce a single strategy for Cumbria. Summary of the work completed by PwC in support of Cumbria LHE:

Programme Management – PwC attended and presented at all Programme Board, Planning Group, DoF, and Clinical Reference Group meetings during the course of the engagement, ensuring we were an integral part of the programme team.

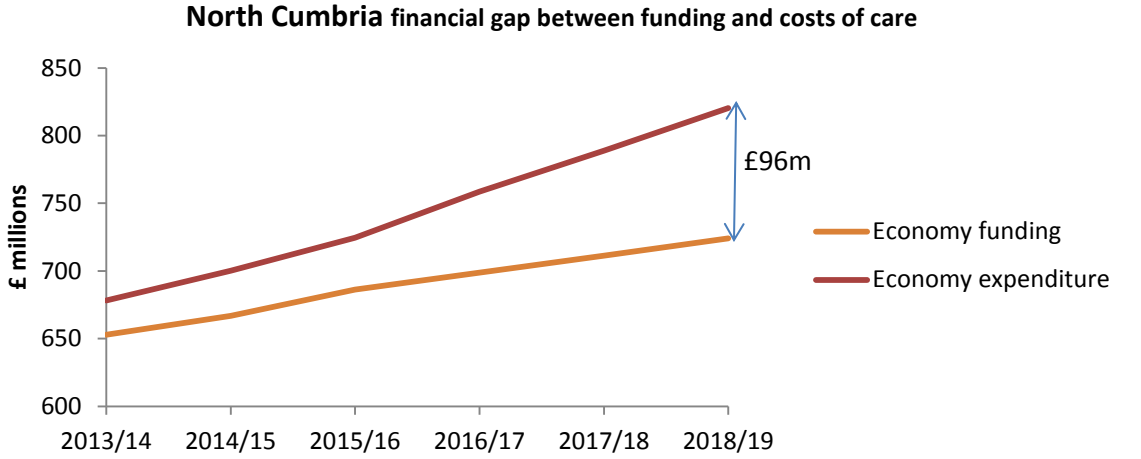
Key deliverables aligned to workstreams, objectives and Menu of Services (MoS):

Workstream	Objective	MoS	Deliverables
WS1: Diagnosis and supply	A financially sustainable future for both commissioners and providers	#1 #3	**Single Version of the Truth**. This was already in place in the south. SVT for north Cumbria produced to provide LHE with baseline from which to develop plans. Used existing strategies, data sources and national benchmarks to present a comprehensive information pack focussing on finance, quality and workforce sustainability. The SVT identified the extent of financial deficit, impact of quality and workforce issues. **Commissioner Requested Services**. Formally produced for south, less formally for the north (NCUHT not an FT). Comprehensive analysis of impact of consolidating services. A **financial analysis** of the impact of the proposed options – significantly more advanced in MB given the longer lead in time than the high level version in the north.
WS2: Solutions development	A sustainable set of high quality services for patients in each health economy Recommended future service configurations	#2 #4 #3	**Care Design Process**- Ran PwC's Care Design Process to generate potential options that would provide a solution to the issues faced. Ran 6 CDGs across Cumbria, and additional workshops for Maternity and Mental Health services. These sessions were very well attended by 300+ clinicians and key stakeholders so that the options were developed by front line staff. **Models of Care** established for Out of Hospital, In Hospital services, including Maternity, Mental Health and Community Services. We have modelled these scenarios to present a high level view of the potential impact they will have financially. In MB there has been agreement and sign-off to a preferred solution. In the north there is agreement to a strategic direction of travel.
WS3: Plan Development	Outline implementation proposals.	#6	The outcome of the SVT, Care Design Process and financial analysis have helped to inform the CCG in developing the **5 year strategy** that encompasses the work done in *Better Care Together* and the North Cumbria Programme Board.
WS4: Implementation plan	Critical friend input to implementation plan	#6	**Implementation and governance planning** - Presented options for implementation planning that was used at a Cumbria Alliance meeting to discuss and agree implementation vehicle and governance. In the south an implementation roadmap has been developed while in the north this will be completed in phase 2.

The result of this work is that plans have been submitted reflecting a common understanding from all organisations of the challenges faced by Cumbria LHE, a strategic outline of how these challenges can best be met through an innovative out of hospital model that enables hospital reconfiguration. The detailed design and subsequent modelling of this strategy will be completed in the coming 6 months.

2. Financial bridge

North Cumbria



North Cumbria	13/14	14/15	15/16	16/17	17/18	18/19
Total gap before provider efficiencies	**-25**	**-33**	**-38**	**-60**	**76**	**-96**
% the gap is of the total LHE budget	-4%	-5%	-6%	-9%	-11%	-13%
Total commissioner gap	**4**	**-1**	**-6**	**-11**	**-17**	**-23**
Commissioner gap as % of commissioner budget	1%	0%	-1%	-2%	-2%	-3%
Total provider gap	**-29**	**-32**	**-33**	**-49**	**-61**	**-73**
Provider gap as % of provider budget	-5%	-5%	-5%	-7%	-8%	-10%

Planned Provider efficiencies would reduce the gap to £17m. A 'downside' provider efficiency (75% of planned CIPs) would result in a gap of £36m. In addition to the CIPs Providers have plans to create £9m of efficiencies through service redesign. The Care Design Process has identified a new model of care and potential efficiencies. The Out of Hospital (OOH) model presents opportunities to reduce hospital activity that has been forecast, at a very high level, to offer c.£10m of efficiencies from delivery of the OOH model. The resulting gap of c.£17m is illustrated in the appendices.

Morecambe Bay

The demographic and structural challenges in MB are contributing to a current financial deficit position of £26.3m reported in 2013/14, anticipated to rise over time. The Morecambe Bay health system has been financially challenged for some years. Its financial fragility is driven by:

- The need to provide healthcare to a widely spread population requiring more hospital sites than health systems of comparative population size, with a consequent higher costs of provision.
- The impact of staff premiums, often up to 70% higher than the cost of NHS staff, and the requirement to address quality issues arising from regulatory reviews by the CQC and Monitor.
- The need for additional investment to address backlog maintenance in UHMB because capital investment has been suppressed in recent years as a way of addressing financial and cash pressures.

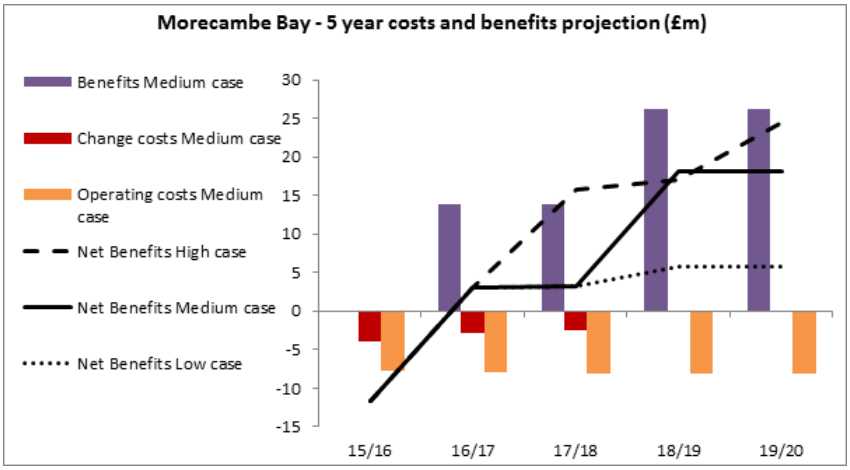
This analysis of the financial picture shows that:

- Solutions based upon an unfunded tariff modification (i.e. commissioners pay the providers more for activity) would not address the underlying and growing financial issues facing the local health system.
- The local health system needs to start changing the nature of care provision, moving away from inpatient acute hospital based care and refocus on out of hospital based alternatives as the right setting for care.
- Funded tariff modification (external funding) would be an appropriate way of managing structural financial pressures and implementation costs during the transitional period. MBFT is compiling a Tariff Modification for presentation to Monitor. Initially the case will be presented to the CCGs through the BCT Programme Board. The basis of the application is mainly concerned with the provision of services across three sites.

- In the longer term, the local health system will need to develop local flexibilities that take account of certain costs through local prices as part of an overall financial resource envelope that is affordable, or through funded tariff modification.

The BCT strategy has developed three cases that will contribute towards the above affordability gap by 2019/20. They are: Low Case £5.2m, Medium Case £18.1m and High Case £24.4m. These cases and the associated costs are set out in the graph below:

The five year cost benefit projection for option A, the preferred clinical model



Better Care Fund - In Cumbria the uncommitted health investment in social care (circa £13 million out of £36 million) is planned to be funded from the growth in CCG allocations in 2015/16 and has been included in Cumbria CCG's plans as such. As this is effectively "new" money in the local health economy and not predicated on assumptions around significant reductions in activity and income in the acute sector then it is not considered to be a further cost pressure in the health economy (other than an opportunity cost).

3. Key areas for focus and issues remaining

Delivering the change is as important as articulating the change, and as part of the work going on across Cumbria we have been through a rigorous process to develop a strategy and a clear roadmap that reflects key activity required over the next 5 years to implement the change. But Cumbria has been here before and always fallen down when it comes to implementation. This time however the LHE leadership team is aligned and relationships are good across the county with new leaders emerging that want to operate as one health economy, not individual organisations. There is good engagement with the **Local Authorities** who are members of the Programme Boards and we have witnessed their attendance and involvement in the development of the strategy. Furthermore the Programmes regularly attend formal meetings of the Health and Well Being Board and Health and Scrutiny Committee. Governance arrangements are good in both north and south (see appendices).

Detailed PMO arrangements for implementation are not yet agreed though good discussion has taken place to understand how these arrangements can avoid the pitfalls the LHE has experienced in previous strategy implementations. This challenge will continue to require transitional Programme Management Office (PMO) support in order to maintain the pace and momentum that has been built over the last few months, whilst managing key stakeholders & communications, and mitigating any risks that emerge.

The Cumbria Health Alliance has decided that two Programme Boards will continue going forward and that each will be supported by a formal PMO structure. In the south this will see the continuation of the PMO that has been in place since 2013. The north has a Programme Co-ordinator and Communications support but is yet to agree a more substantial support mechanism. This is a key task during phase 2.

The importance of Specialised Commissioning is recognised in the plans but there is little evidence of close working with NHSE in developing clear strategies going forward.

3.1 - North Cumbria – *Together for a Healthier Future*

Identification and delivery of quick wins and operational efficiencies. The OOH strategy will deliver whole system savings that will be quantified in phase 2, but will not start to take effect until at least FY16. To this end, it

is important that Cumbria outlines actions that will increase their ability to achieve their CIPS targets, and to take advantage of the quick wins that are identified.
Detailed design of models of care, including key enablers such as IT. Estates and Transport. This is the core of the next phase of work. The devil will be in the detail and the programme will need strong grip to draft detailed designs of the models of care that are bought into by clinicians, patients and local partners. The models of care need to be developed at pace but with a significant eye to the detail to ensure quality, sustainability and finance are all reaping the benefits.
Development of draft business case for each of the models of care, including sensitivity analysis. Further detailed work is required to define the benefits realisable through the strategy. This will inform operational plans, especially enabling visibility of when the various stages of change might occur. Cost is likely to follow a stepped change process, as activity levels decrease in one area and costs are transferred elsewhere. Additional modelling is required to predict the level of investment that is needed in order to enact the strategy, and when the financial benefits will flow.
Implementation planning and governance arrangements. This is critical as previous strategies in Cumbria have failed at implementation stage. It is commonly accepted that a major shift in attitude and culture is required and the LHE has commissioned The Cumbria Learning Improvement Collaborative (CLIC) to help facilitate this change. A continuous improvement culture is required in order to achieve both CIPs and to deliver the strategy.

Programme management support will be required to ensure pace is maintained and the errors of previous implementation efforts are not repeated.

The potential acquisition of NCUHT by Northumbria NHS FT must be considered alongside these issues, and will need to demonstrate how it will address the known quality and staff issues as well as achieving a higher level of performance and savings. Commentary on the suitability of the acquisition would be speculative as the Programme Board hasn't included the acquisition in any of its deliberations, nor has it been within our scope. Successful mergers in the NHS are few and far between, especially when looking to deliver value in the short to medium term. It is clear that NCUH need a stability partner and ideally any potential partner or acquirer will be supportive of the emerging clinical strategy.

3.2 – Morecambe Bay – *Better Care Together*

The *Better Care Together* strategy presents a robust and coherent set of service options for the future of health and social care in Morecambe Bay. The work has focussed on services rather than organisations and has had clinical and patient engagement throughout the high-level design stage. The focus is now switching into detailed design and implementation which includes:

- Building on existing schemes, where possible, that are part of the future of out of hospital service interventions
- Focusing on the implementation of a series of quick wins to pump prime the programme by end of 15/16.
- Detailed design of the key activity for each of the workstreams will be undertaken in detail between Q2 14/15 and Q3 14/15. At the end of this detailed design phase there will be a detailed business case, implementation plan and description of how each enabler will support the workstream and confirmation of quick wins
- Many of the OOH and in-hospital initiatives will be implemented using a phased approach in 3 'tranches'
- During the detailed design phase the different workstreams will establish the activity that will be implemented under each tranche and the process for taking each tranche forward. Taking this approach will allow the programme to implement in a focused manner at speed whilst having the opportunity to evaluate and act on the lessons learned from each tranche. Each tranche is split into:
    - Pathway re-design (approximately 6 months)
    - Implementation (approximately 6 months)
    - Benefits realisation (approximately one year to reach a point where full benefits will be delivered
- The extent to which elements of the proposed out of hospital model reflects the 'tranche' approach depends upon the amount of pre-existing work already in place. This is particularly the case with the integrated core teams where a number of localities are already in a position where they can mobilise their teams quickly
- The in-hospital initiatives will also follow the 'tranche' approach. The pace of many elements of the in-hospital changes will be driven by the speed at which benefits are released by the out of hospital model. In-hospital changes will need to be phased in this way to ensure the full impact of the potential benefits are realised by the health economy

4. Risk assessment for delivery and next steps

A risk assessment of the key risks for implementation and an assessment of the arrangements LHEs have in place to take forward their strategic plans.

Risk	Impact	Assessment of arrangement LHE have in place to take forward strategic plans
Consensus - The LHE is not able to obtain sign off to the preferred solution by all key stakeholders due to the contentious 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.	1 The plans will not be aligned. 2 There will not be an agreed solution to take to implementation. 3 Impacts the ability to implement the proposed change.	• Utilising all local networks to socialise the changes early to provide sufficient time for discussion and debate on the preferred solutions. • Continue to develop the solutions based on clear evidence and remind stakeholders of the burning platforms. • Agreement at Programme Board to communicate continually with a single voice to avoid divisions.
Finance - The emerging options do not provide sufficient financial benefit to close the forecast gap..	1 The resulting plans would not meet the needs of the local health economy, NHS England, TDA and Monitor. 2 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 - Strong focus on delivering the planned operational efficiencies
Capacity - There is insufficient capacity in the system to fully develop and deliver a plan as there are numerous other issues the LHE is managing – such as fall out from national inspections (special measures), acquisition of NCUHT etc	1 The plans are not as fully developed or bought into as they need to be as the right people haven't had sufficient input	- Strong leadership buy in to the importance of driving a clear strategy alongside running the business - Programme Board focus on driving the development of the plans - Good stakeholder management. - Recognition of operational issues when developing the plans and allowing for day to day business to be conducted.
Engagement - 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.	1 Delivery would be delayed, or even prevented.	- Stakeholder and public engagement has been strong across the county, which is set to continue. - Leaders will play their part in engaging the local government and local politicians - All engagement to be well documented as evidence. - Cross party engagement with politicians to explain the changes, benefits and evidence supporting the plans
Implementation - 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.	- 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 have worked with both programme boards to help develop the governance and delivery structure to support implementation as part of the plan development. - Continued strong leadership to drive through implementation and focus on the early wins to maintain the momentum

5. Lessons learned

	Worked well	Could be improved
Clinical engagement	- Extensive clinical engagement in both the North and Morecambe Bay with x Care design groups and over y clinicians attending these and leading the discussions and design of the future solutions	- Continuing this type of engagement and momentum into detailed design and implementation
LHE perspective	- Defined accountability and smaller governance groups is essential for rapid decision making - Analysis and modelling as early as possible in the process supports high quality care design - Early engagement of the public in the care design process supports the shaping of system options	- Provision of high quality data in a timely manner -
Intensive Planning support perspective	- Clarity of purpose for the work and detailed information to ensure the right issues were tackled - Good local support and interest from national partners -	- Communication between the JPMO in London and the local representatives of NHSE, TDA and Monitor could be improved. It often felt as though PwC were telling the local partners about issues that could have been communicated from London. - Reporting to JPMO timed to fit with Programme Boards and not with key milestones in the LHE's plan.

Addendum
01.08.2014

This addendum has been included in response to the additional information requested at the National Partner Programme Board on 18 July 2014. The Board requested that this report is *'resubmitted to better reflect the complexities of the system and the issues spoken about in the discussion at the supplier presentation day'.*

We have presented each of these issues below rather than trying to amend certain parts of the core report on pages 1 to 5 above as the information is supplemental to that already included in the report.

1. Specific challenges in Cumbria relating to Workforce

Workforce issues are a key driver of challenge across Cumbria, but it is accepted they are most acute in the north of Cumbria, directly impacting the safe delivery of services, particularly at West Cumberland Hospital (WCH). This has already seen the cessation of high risk surgery as there is insufficient anaesthetic cover to ensure safe practice.

At the core of the issue is that it has not been possible to recruit the required quality of medical workforce to ensure stability of rota and out of hours cover at WCH. This is not something that additional funding will solve as the Trust is simply not able to recruit medical staff at WCH due to a number of issues relating to its remoteness, brand and size:

- Lack of junior doctors, due to Deanery guidance being more onerous, and there being more demand than supply, means that consultants have to undertake junior doctor roles which many are not prepared to do, so recruitment and retention is difficult.
- This is a circular issue as the more locums that have to be utilised to fill gaps so the issues are exasperated – Locums are no longer allowed to manage juniors for example.
- Consultants can afford to be more choosey about where they work and north Cumbria is often seen at the end of the line in terms of appeal, certainly with regard to WCH.

Whilst it is the medical workforce that cause the most concern the reasons for non-recruitment also apply to nursing staff. There is no contractual demand for nurses to alternate between sites and most are simply unwilling to travel the 30 miles from Carlisle to Whitehaven.

Workforce plans are in place and are constantly being challenged and developed to find an approach that delivers the right solution. In the past 12 months the Trust has tried joint recruitment campaigns, working in partnership with Scottish Trusts and used Northumberland as a buddy organisation trying the methods that have worked in those regions, including joint branding. They have also run recruitment campaigns internationally. They have seen minimal improvement using these tactics. At the same time retention is becoming more difficult due to the same issues.

Our view is that no amount of joint branding or expert marketing can make WCH any less remote than it is today so these are structural problems that are unlikely to be unlocked in the short term.

2. Provision of Maternity services across Cumbria

The predominant issue that is vexing the LHE, both within the NHS and externally across the public and political landscape, is the future of maternity services, and possible alternative models of care. The CCG are keen to ensure a solution is found that works for both north and south Cumbria, with the added complexity that the Morecambe Bay solutions also require agreement from North Lancs CCG.

The issues relate directly to the workforce issue highlighted above. This is compounded by the volumes of births reducing, particularly at WCH, and standards rightly becoming more rigorous. The medical workforce is not available to provide the level of care that patients and the public should expect. Furthermore, Consultants, who are predominantly based in and around Carlisle

and therefore more than 30 minutes from WCH, are in the main unwilling to cover the night rota at WCH.

Early in 2014 it was agreed that the CCG should commission an external review of maternity services across Cumbria (and therefore to also include Lancashire North CCG). The Royal Colleges were lined up to undertake the review but ultimately declined to do so. The CCG, together with Gill Harris (the NHSE Nursing Director for the north of England) approached Professor Sir Bruce Keogh to identify an alternative suitable body/person to undertake the review. This search is ongoing but the CCG are still confident of completing the review in the autumn.

Our view is that while an external review will add an objective view of how services could meet safety measures it is unlikely that there will be a proposed solution that hasn't already been considered.

As part of the LHE work PwC carried out a Commissioner Requested Services (CRS) process on behalf of the CCGs which has shown that a substantial number of women living in an isolated town would have to travel 60-90 minutes for maternity care should services be reduced. This is not the same issue as with dispersed rural communities with small populations. Importantly, these women are disproportionately from lower socio-economic groups, therefore any move of maternity services away from these communities is going to potentially have a disproportionate effect on health inequalities and deprivation. It is not simply the matter of where to give birth but also the impact on families that will have to be taken into consideration. In line with the NHS Constitution, Clinical Senates, working on behalf of NHS England, need to take into consideration the broader population impacts, and not look narrowly at the usual ways of providing clinical care.

During our work in north Cumbria we facilitated a workshop that concluded there were three options that should be taken forward to the next level of detail. These are being worked up in detail by NCUHT, and the next phase of work will model the impact of them on the wider health economy, and make the dependencies with the options for other in-hospital services.

In south Cumbria the BCT strategy has concluded that maternity services with obstetric facilities will continue at both Furness DGH and Royal Lancaster Infirmary, with an MLU at Westmorland General Hospital.

3. The role of the CCGs in delivering solutions to the financial deficit

The CCG has been pivotal in ensuring the solutions are similar north and south so that their population does not end up with disparity in service between the geographies it covers. This has been particularly evident in developing and approving the Out of Hospital model in both the north and south of the county.

The CCGs have been and continue to be instrumental in driving and shaping discussions that are leading to the potential solutions. The programme team supported by the CCGs have developed the governance structure that brings together, on a regular basis, the key decision makers so that the solutions being developed are not only bought into but jointly developed by the whole system, including social care. The governance structure has also been particularly effective in driving clinical engagement and ensuring that all key areas of the strategy are clinically sound. This structure has been particularly effective in developing and approving the Out of Hospital, the In-Hospital options and achieving collective buy-in to the financial solution. The CCG has been pivotal in ensuring the proposed solutions effectively meet the needs of the populations they serve.

In the north the plans to tackle the financial deficit sit with the providers in the sense that it is they, and particularly NCUHT, that are the cause of the deficit, but the CCG has worked closely with them in developing their solutions. In the south the plans have been developed with the two CCGs and MBHT working in partnership.

4. Further detail on the unfunded v funded tariff models, and commissioner perspective

PwC has undertaken financial baseline reviews at Morecambe Bay FT, North Cumbria University Hospital NHS Trust and Cumbria Partnership FT in the past 6 months and concluded in all three reviews that there are 'structural' costs that are a result of the demographics, geography and historic construct of the three Trusts. Between £25m and £30m of the current deficit has been identified as structural, driven by issues such as: Number of, and distance between sites; Activity volumes; and PFI costs.

In the south the thinking is a little further developed, and as MBHT is an FT there is a more obvious route to a solution. The system identified that solutions based upon an unfunded tariff modification (i.e. commissioners pay the providers more for activity) would not address the underlying and growing financial issues facing the local health system. They feel that the local health system needs to start changing the nature of care provision, moving away from inpatient acute hospital based care and refocus on out of hospital based alternatives as the right setting for care to address the financial balance - as set out in the Better Care Together Strategy for Morecambe Bay. Funded tariff modification (external funding) would be an appropriate way of managing structural financial pressures and implementation costs during the transitional period. In the longer term however the local health system will need to develop local flexibilities that take account of certain costs through local prices as part of an overall financial resource envelope that is affordable, or through funded tariff modification.

This information may be used to request tariff modification in due course. The Commissioner is understanding of these issues but unless they are funded from outside the current allocation it will not help the LHE's overall position.

5. How the Quality challenges are being addressed

With both Trusts in Special Measures this is something that they tackle on a daily basis. Our work has been to ensure that whilst they progress their immediate challenges they are not ignoring the longer term issues that must be fixed to offer sustainable solutions.

BCT's Strategic Case and the emerging model of care in the north both have quality as the foundation of their thinking, a feature that has been evidently driven by strong clinical involvement in the development of both models.

Appendix

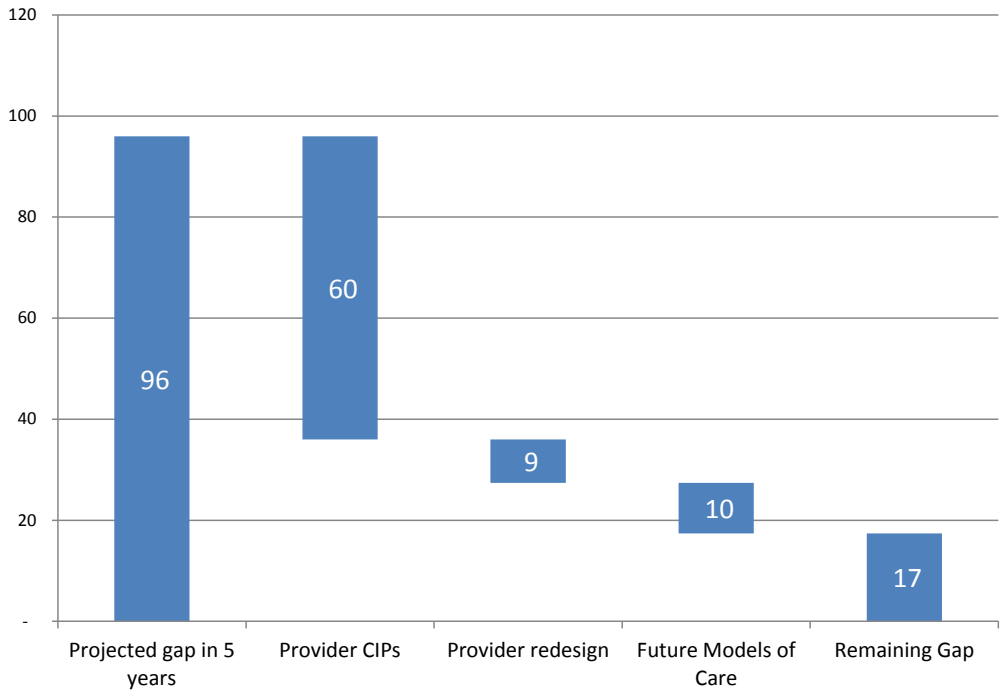
Section 2

Cumbria DoFs have not signed off the following financial analysis as this is not how the plans have been developed, but they do illustrate the reduction of the gap.

In North Cumbria (*Together for a Healthier Future*) there are three workstreams that will help to reduce the forecast gap in the health economy:

1. Provider CIPs. Both NCUH and CPFT have produced plans with ambitious CIPs. In the chart below we have presented the 'downside' scenario whereby each organisation delivers 75% of its planned CIPs as this is in line with historic levels of achievement.
2. Provider Service Redesign. CPFT have forecast c.£9m of service redesign opportunities over the next 5 years.
3. Future models of care – at this stage we have estimated that full implementation of the Out of Hospital model and associated In Hospital changes could offer c.£10m of efficiencies.

The potential impact that each of these workstreams could make on meeting the financial challenge:

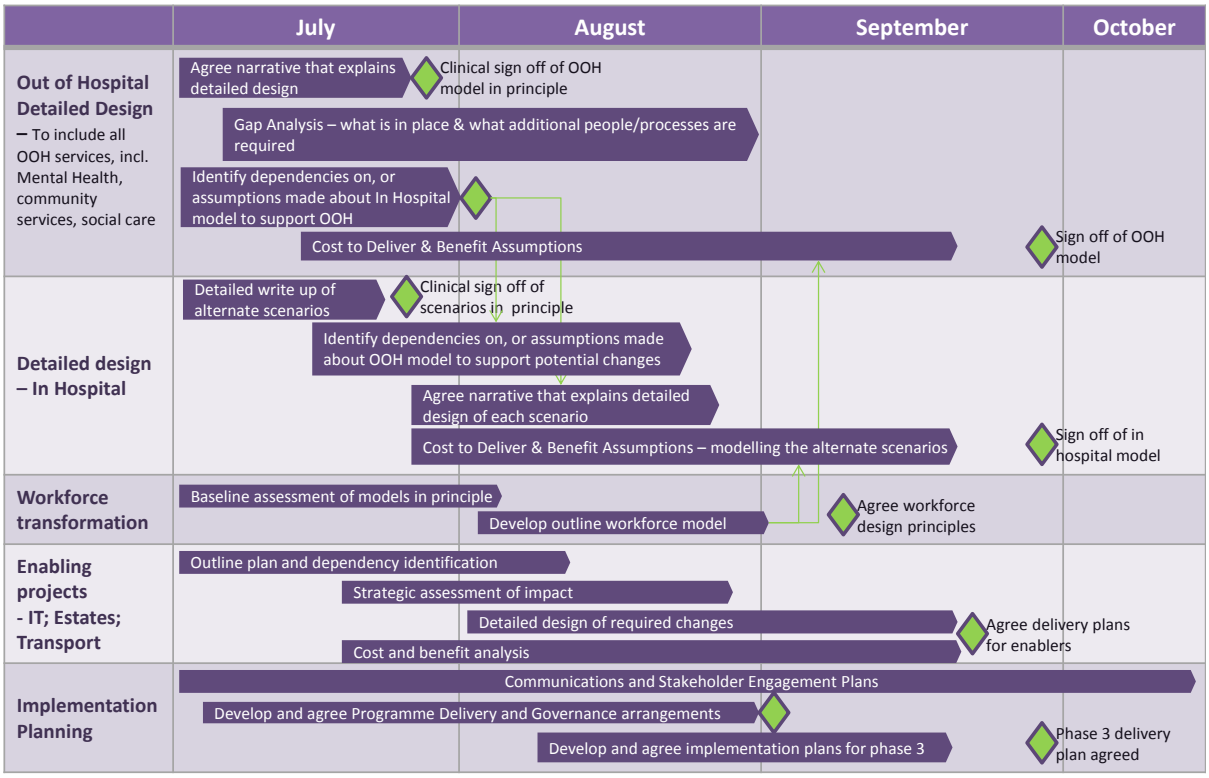


The *Better Care Together* programme has not run its financial forecasts in a way that enables a similar comparison to be made. The current deficit is c.£26m which is entirely made up of the Morecambe Bay University Hospitals FT deficit. The focus of the BCT work has been to identify whole system changes to benefit patient care within a sustainable financial envelope - the results of which are included in Report #3.

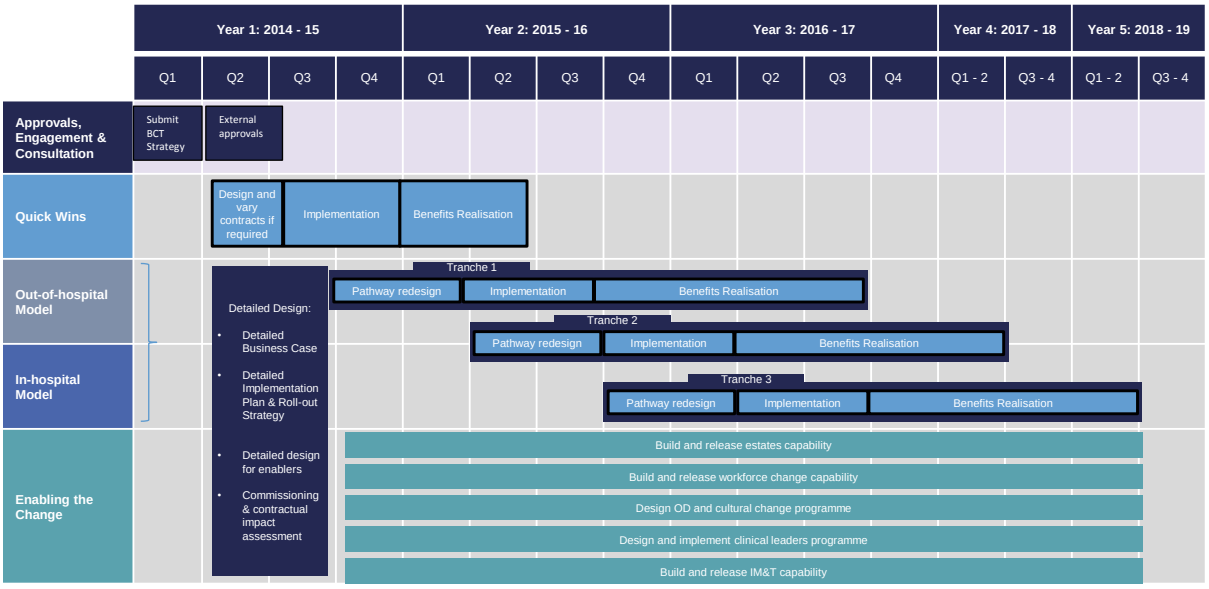
Section 3

Together for a Healthier Future has developed the following plan to provide clarity on what the key tasks are in the phase of work. A high level view of this was included in the North Cumbria 5 year plan.

Delivery plan for 'Phase 2' – detailed design and business case preparation



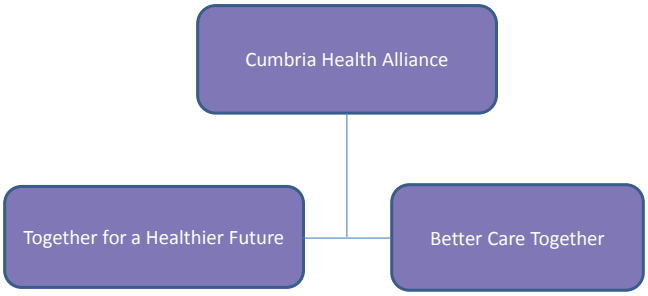
Better Care Together has developed an extended timeline to illustrate the next phases of work:



A more detailed timeline for each Workstream (Quick wins, OOH, In Hospital and Enabling the Change) has also been produced.

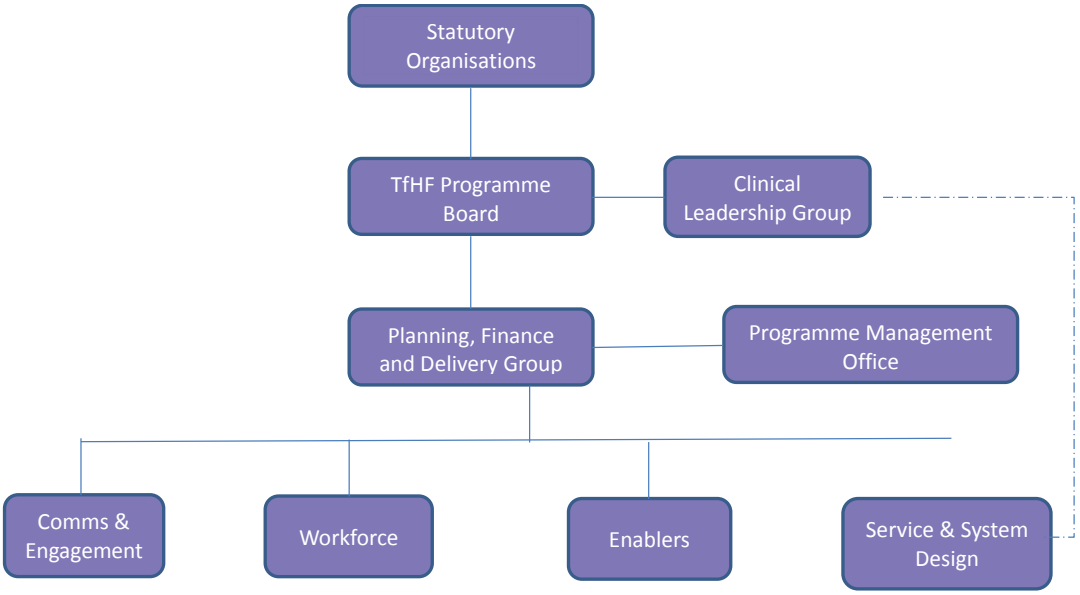
Programme Governance

The Cumbria Health Alliance is the body (non-xxx) that sets the direction for the Cumbria LHE, while the detailed delivery plans are agreed and governed by the respective Programme Boards.



Both programmes have established governance structures that have served Phase 1 well and will be carried forward into the next phases of work:

North Cumbria – *Together for a Healthier Future*



South Cumbria – *Better Care Together*