The whole Strategic Plan is subject to review by NHS England, and by both NHS England and Monitor in relation to elements drawn from the Better Care Together Plan. The Strategic Plan is therefore an interim document, with a final document anticipated in the early Autumn.
Foreword

Welcome to this five year plan for the Cumbria Local Health Economy which sets out how health and care organisations across the county will make sure that our population have the best possible chance to live healthy lives but that if they do become ill or have an accident that they consistently receive the high quality services they deserve.

NHS Cumbria Clinical Commissioning Group (CCG) has led on the development of this plan, in line with a national requirement to do so, but has worked collaboratively with all partner NHS bodies and Cumbria County Council. We are also pleased that we have been joined in our discussions by Healthwatch Cumbria.

The development of this plan perhaps carries more significance in Cumbria than in other areas because of the difficulties we have faced in recent years and more so over the past 12 months when we have seen national intervention over quality of care issues. This has been compounded by serious recruitment difficulties and severe financial problems.

However, we have reached a turning point and have recognised that across the health economy that if we sincerely wish to make sure that the care our patients receive is what we would wish for ourselves or our families, we need a step change in our approach to collaborative working.

To drive forward the necessary improvements we have established the Cumbria Health and Care Alliance and as system leaders we are strongly committed to ensuring that we do the right thing for our patients and service users. This means making sure that they can access the right healthcare in the right place when they need it and that any plans we develop are capable of helping us to address the financial problems that we have suffered from for so long.

There are already two substantial programmes of work in the north and south of the county, branded together for a healthier future and better care together respectively which are ploughing ahead to plan for a better future for health and care services.

At the forefront of our thinking is radically increasing the scale and integration of services provided outside hospitals. This means a much greater focus on providing more care and support in local communities to help people to stay well but when they do become unwell making sure that as much of their care as possible can be provided close to where they live. It also means that services will be much more joined up without organisational barriers.

Another important element of our plan is to make sure that when people do need hospital care, for example, in an emergency, that they can be assured of the best and safest possible services, based on nationally recognised outcomes, so that they have the best chance of a good recovery.

This will mean making decisions, with our health and care professionals and with patients, the public and our key stakeholders on which services should be consolidated on which hospital sites. Most of all we want to improve the health of our local population by collectively using all of the resources available to the NHS and our key partners in local authorities and the third sector to tackle some of the enduring public health challenges we face. It is only by doing this that we can
promote wellbeing and encourage people to live healthier lives on a much bigger than we do now that we can begin to reduce some of the inequalities that exist within and across our communities.

We accept that people may be cynical and say that they have seen strategic plans launched in Cumbria in the past but that not much has changed, as many of the problems are still there. The difference with this five year plan is that with the existence of the Alliance, we have the weight of the local health economy behind it. These organisations are determined that improvements will be made and we describe in the plan the mechanisms we will use, supported by a new clinical and managerial culture.

We have reached a point where we can only and must go forward – our patients deserve no less. If we do not, the responsible regulatory and commissioning organisations outside Cumbria will intervene and we will no longer be in control of our own destiny. We recognise that change is never easy and we would like give a reassurance that we will be mindful at all times of our statutory obligations in relation to patient, public and stakeholder engagement and to those relating to formal public consultation.

We hope that this plan gives confidence about the commitment and determination that exists at the highest levels and throughout our organisations to bring about the transformation in services and care that is needed.

Hugh Reeve
Clinical Chair
NHS Cumbria Clinical Commissioning Group

Nigel Maguire
Chief Officer
NHS Cumbria Clinical Commissioning Group
Interim: Subject to review from NHS England

Executive Summary

1 Status of this Document

This document sets out the collective five year plan for the Cumbria Local Health Economy. It is both the draft plan for NHS Cumbria Clinical Commissioning Group (CCG), and the collective plan for all the partner NHS organisations working together, including:

- Cumbria Partnership NHS Foundation Trust
- NHS Cumbria Clinical Commissioning Group
- North Cumbria University Hospitals NHS Trust
- North West Ambulance Service NHS Trust
- University Hospitals of Morecambe Bay NHS Foundation Trust.

Although obviously not an NHS organisation, Cumbria County Council is a key partner in the delivery of this plan, in terms of the Local Authorities place based leadership role and its responsibilities for Public Health and Social Care.

2 Our Vision and Principles

We are here to make a real difference to people’s lives. Firstly this is about making a difference by improving the health and wellbeing of individuals and their families. In particular it is about taking serious action to reduce the inequalities in health that exist between different communities across Cumbria. We want to add years to peoples’ lives, and quality life to those years.

Making a difference to people’s lives also includes improving the day to day experience of patients and those working to deliver better healthcare. Working for the health service in Cumbria should be a privilege and a source of pride. We want this to be true for all our colleagues, as we recognise that quite simply people who are happy in their jobs provide better care.

Our key underpinning principles are:

- Doing the right thing for our patients, service users and populations
- Putting ourselves in your shoes – is this the care we would want for ourselves or our families?
- Access to the right healthcare, in the right place, right when you need it
- The Cumbrian health pound is finite and can only be spent once.
3 Our Objectives

To achieve our vision, we have set ourselves some important objectives. Collectively, as a system we are fully committed to:

**Radically increase the scale and integration of out of hospital services, based around Primary Care Communities:**

Primary Care Communities are developing around groups of practice lists in natural communities, and will serve populations of between 15,000 and 40,000 depending on local circumstance. At an overarching level, the key transformation for Primary Care Communities will be to move away from episodic, unconnected care, to a seamless system based on joint work around the patient and their family.

**Achieving sustainable, high quality provision, by delivering a programme of Hospital Services Consolidation:**

However successful our population health programmes and Primary Care Communities become, there are times when most of us will need to go to hospital. This should be reserved for those times when we need specialist help, requiring the staff skills, technology, and support services which can only be delivered in hospitals.

At the moment, there are real challenges in ensuring that our hospitals can continue to deliver the expected levels of care, and some major changes may be needed. The international evidence shows that small hospitals can deliver excellent quality of care, particularly if they work as part of broader clinical networks with larger, more specialist hospitals.

Overall, we will need smaller, cheaper, but still better hospitals in the future.

One important feature will be to fully address transport, across emergency ambulance provision, patient transport for planned interventions, and transfers between hospitals using new solutions, particularly to enable Cumbrian patients to access the optimal intervention delivered in tertiary centres outside our county.

**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:**

There is much more to a modern model of integration than Primary Care Communities. There will need to be a real connection between Primary Care Communities and clinical resources which have traditionally worked only within hospitals. We will need to develop networks so that clinicians with specialist skills, traditionally based in hospitals, can provide support to clinicians working outside of the hospital. The document, ‘Future hospital – Caring for medical patients’ published by the Royal College of Physicians in September 2013 proposed the creation of medical divisions. This is one element of the specialist support for our Primary Care Communities. A large part of a medical division would be based in the community and would be made up of clinicians, nurses and therapists for all organisations – ‘teams without walls’. The ‘walls’ are both physical (the 4 walls of the hospital) and organisational. This will bring specialist skills into the community.
to contribute to the management of increasing acuity and dependency outside of a hospital setting. The basic model is shown below.

**THE CUMBRIA HEALTH AND CARE SYSTEM**

![Diagram of the Cumbria Health and Care System]

Figure 1 : The Cumbria Health and Care System

Improve population health outcomes, based on a major impact on reducing social isolation, smoking and alcohol misuse, and increasing activity and healthy eating:

We will work together with partners across Cumbria to deliver the Cumbria Wellbeing Strategy, and to refocus our system to promoting population outcomes as a health system, rather than just...
a healthcare system. This will include removing the constraints which prevent the third sector from taking a greater role, and seeking to achieve a new partnership between statutory and non-statutory services, built on the unique contributions both sectors can make.

4 The Challenge for Cumbria

Delivering our aims and objectives will be difficult. We will need to achieve radical change on a scale previously unseen. In part, this is because of the major challenges the NHS, and the interconnected social care services, are already facing in Cumbria.

Collectively, we need to acknowledge the scale of the problem:

The system causes more harm than is acceptable

A wide range of core standards, including NHS Constitution Commitments, are not reliably delivered in Cumbria. This inevitably compromises patient outcomes.

There has been significant regulatory intervention from the Care Quality Commission (CQC) regarding the quality of a wide range of services. At the time of writing both North Cumbria University Hospitals NHS Trust and University Hospitals of Morecambe Bay NHS FT are in special measures, the highest level of escalation in the NHS.

Our system currently spends more money than it is allocated

Collectively, we need to get the best possible value from our resources, and deliver a credible programme of cost reduction that removes our current over spend (in the order of £40M in 2013/14) and meets the efficiency challenges of the future (in the order of £30M in the next five years), in a period of austerity for the NHS.

There has been a loss of public confidence

Inevitably, the continuous media reporting of the challenges in Cumbria has led to significant public anxiety. Additionally, communities are worried that valued local services will be lost, and that the NHS system will make bad choices just to balance the books.

We can't always attract the right staff

Across Cumbria it continues to be very difficult to attract the right clinical staff, particularly in some specialist areas.

Our previous plans weren’t successful enough

Many of these problems have been present in Cumbria, to different degrees, for a long time. Despite some notable successes, we need to accept that we have not collectively planned successfully to deliver a sustainable system, which delivers the right quality and right outcomes within the available resources.
5 What will be Different This Time

Collectively, the senior clinical and managerial figures in the Cumbria system have recognised that there has been a collective failure to fully confront and resolve these challenges in the past. These leaders have committed to working together, in the best interests of the patients, the population, and the system, rather than the interests of individual organisations. This gives us the best possible chance of jointly solving the challenges we face, in the spirit of shared accountability.

This will not be enough. We will need to engender a new clinical and managerial culture. This will need to be based on a credible continuous improvement culture, supported by evidence based tools to support front line practitioners and clinicians to drive service improvement, all of the time, everywhere, forever. For the future, ‘just about good enough’ will no longer be anywhere near good enough.

This will require a major investment in how we value all of our colleagues, striving to deliver the best care in our system.

We also need to be realistic. If we are not able to meet our challenges locally, the responsible regulatory and commissioning organisations outside Cumbria will intervene, and will impose solutions outside our control. We need to show demonstrable improvement quickly to keep control of our destiny.

6 Our Commitment

Collectively, the organisations across Cumbria have made some important joint commitments, so that we can meet the challenges we face:

- We will be much more accountable, and ensure that we consistently and reliably deliver the standards of care that are already enjoyed across most of the country, and should be ours of right
- We will stop spending other people’s money, and will return our local NHS system to sustainable financial balance
- We will embed continuous service improvement methods across our system, empowering front line clinicians and practitioners to drive their own improvement in the interests of patients and communities
- We will work together much more flexibly, including where necessary changing which organisation delivers services, where it is delivered, and how it is paid for
- We will always put the interests of patients and the overall system first, ahead of our own organisations interests and professional interests.
7 Getting Back on Track: Long Term Transformation

In the short term we need to take action to stabilise our services, to get back on track, in order to achieve:

- A reduction in the harm caused to people
- Momentum through credible steps towards financial balance
- Developing an open narrative for the public, which reduces anxiety, instils confidence, and encourages participation.

This will involve taking difficult decisions, and will require resilience, creativity, flexibility and a good deal of collaborative working.

In the medium term we will transform the local health and care system. This will be based on delivering our objectives, i.e:

- Developing Primary Care Communities
- Achieving hospital services consolidation
- Delivering an excellent modern Model of Integration
- Improving Mental Health and Learning Disabilities Services
- Building a high quality Children’s Health and Care System
- Becoming population health focused.

8 What This Will Mean for Our Population

The population health challenge is enormous. We will work with partners to deliver the key priorities set out in the Joint Strategic Needs Assessment (JSNA):

- Improving care to respond to the challenges of an ageing population
- Improving the health of children and young people and the quality and integration of care services
- Improving mental wellbeing and reducing alcohol misuse
- Reducing health inequalities and premature mortality from cancer and cardiovascular disease.

This will include up scaling population health approaches, to seriously address some of the key determinants of health and causal factors in people avoidably using healthcare services, including social isolation, smoking, alcohol misuse, excess weight and inactivity.

9 What This Will Mean for People Who Use Our Services

To deliver our vision we will need to develop a new level of partnership between the local population and the local health and care system. This will include:

- Providing much better information to help people to make good, informed decisions about when and how to access services
• Radically re-orientate our system to provide specialist support for self-management. People want to retain control of their own health and healthcare, we need to reorganise the system to help them to do it.

10 What This Will Mean for Our Staff

Our staff are our greatest strength. Individually and collectively they strive to provide the best quality of care they can for their patients. To support the workforce, we will:

• Enable continuous service improvement, all of the time, everywhere, forever, through the development of the Cumbria Learning and Improvement Collaborative (CLIC)
• Ensure that we have safe, but productive, staffing levels
• Ensure that care is provided in the right place, by the right clinician, based on good team working and multi-disciplinary approaches
• Provide rewarding careers
• We won’t simply ask hard working staff to just do more, rather we will work together to maximise the time staff spend on work which really adds value to patients, and reduce the activities that don’t.

11 What This Will Mean for Organisations

Organisations in Cumbria will need to change. This will mean much less organisational sovereignty, and a focus on working together for the common good.

To be sustainable, the current configuration of NHS trusts, social care, and commissioning organisations may need to change. Any changes will be designed around promoting integration in the best interests of patients.

12 What This Will Mean for Everyone

Overall, we want to achieve a much high quality system, which delivers really good and much fairer outcomes, within the financial resources we have available. This is summed up by the seven ‘No’s’ developed by the North East Transformation System, as listed below:

• No barriers to health and wellbeing
• No avoidable death, injury or illness
• No avoidable suffering of pain
• No helplessness
• No unnecessary waiting or delays
• No waste
• No inequality.
Section 1 Introduction and Context

1 The Purpose of this Plan

In December 2013 each of NHS England, Monitor, the NHS Trust Development Authority, and the Local Government Association set out joint operational and strategic planning guidance.

This required all NHS trusts, NHS Foundation Trusts and NHS Clinical Commissioning Groups (CCGs) to develop the following:

- A two year operational plan for submission on April 4th 2014
- A draft five year strategic plan for submission on April 4th 2014
- A final five year strategic plan for submission on June 20th 2014.

The guidance required NHS Trusts and CCGs to jointly produce the plans, working as part of a Local Health Economy (LHE).

This document is therefore both the draft plan for:

- NHS Cumbria Clinical Commissioning Group (CCG) as the lead commissioner of healthcare for Cumbria
- The plan for the whole healthcare system.

The plan should be considered alongside the complementary:

- Two year operational plan for NHS Cumbria CCG
- Two year operational and five year strategic plans produced by the local NHS Trusts.

The plan is intended to provide a clear:

- Direction of travel for healthcare in Cumbria
- Clear statement of our collective ambition to
- Set of intentions to enable services to become clinically and financially sustainable
- Outline of engagement, including public and clinical engagement
- Description of how the local organisations work together in governance terms
- Indication of the main interventions we will take forward to deliver our ambitions
- An initial indication of options for some services.

This is not intended as a consultation document, rather it provides a strategic direction of travel. We fully recognise our statutory obligations in relation to public consultation and we are committed to working with the overview and scrutiny committee to ensure these are carried out in line with requirements.
2 Introducing the Supporting Documents

We have worked to deliver two major planning programmes to provide much more detail on the planned service models. The products from those programmes should be read alongside this overarching plan, and provide much more detail. The programmes are:

Better Care Together: Over the past year NHS Cumbria CCG has worked with Lancashire North CCG, NHS England, and University Hospitals of Morecambe Bay NHS FT to develop a strategic plan for the south Cumbria and north Lancashire area. Latterly this process has broadened out to include participation from all NHS Trusts and providers of Social Care in the area.

This work has resulted in the strategic plan provided at the end of this document.

Together for a Healthier Future: More recently, we formed the north Cumbria programme in mid-February, to similarly develop a long term strategic plan for the system. The governance arrangements have been comparable to Better Care Together, but in some ways simplified as there is only one CCG, one NHS England Area Team, one Acute Trust, one Community Services and Mental Health Trust and one upper tier Local Authority involved.

This work is less developed in north Cumbria, and has so far been based on developing a shared narrative for the challenges we face and the service models and service improvement we will need to overcome those challenges.

A second phase of development during July – September 2014 will be undertaken to include a much fuller appraisal of the scenarios and proposals, including activity, workforce and financial modelling.

Engagement as part of the process: Both programmes have included extensive clinical, patient, public and stakeholder engagement, as described in both documents.

3 The Partner Organisations

3.1 The Partner Organisations

In Cumbria, the Local Health Economy (LHE) is comprised (for planning purposes) of:

- Cumbria Partnership NHS FT
- NHS Cumbria Clinical Commissioning Group
- North Cumbria University Hospitals NHS Trust
- University Hospitals of Morecambe Bay NHS FT

As there are major interdependencies between healthcare and social care, Cumbria County Council is a major partner within the LHE, although it is not technically part of the LHE in relation to the national guidance.
3.2 Our Partnership: The Cumbria Health and Care Alliance

Collectively the partners of the Local Health Economy firmly believe that to address our current and future challenges, the whole system will need to work much more collaboratively. This will include a new partnership with the public, patients, and partner organisations.

In 2013 NHS Cumbria CCG brought together the leaders of the Cumbria health and social care organisations, under the banner of the Cumbria Health and Care Alliance, to work collectively with shared commitments.

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

The Alliance development has been led by the CCG Clinical Chair and Chief Officer, with extensive support from the Director of Clinical Innovation, with the full participation of the Chief Executive and Medical Director from each of the NHS Trusts, and the Chief Executive and lead Directors from Cumbria County Council.

3.3 The Partnership for Population Health: Cumbria Health and Wellbeing Board

The Board will play an increasingly important role, not only in providing challenge and assurance of our plan, but in providing leadership and coordinating joint work.

It will be especially important for us to work closely with the Board in relation to:

- Moving to a population health based system
- Enabling the integration of health, social care and the third sector in the best interests of our population and service users.

3.4 Formal Democratic Scrutiny: Health Scrutiny Committee

NHS Cumbria CCG has worked closely with the committee leading up to the submission of the five year plan, and will continue to work with the committee during the subsequent implementation.

It is possible that a number of public consultations maybe needed. NHS Cumbria CCG is committed to ensuring that no major, permanent changes in services occur without the full participation of the public. The CCG will seek to work with the committee to ensure that the NHS and social care partners fulfil this commitment, and will continue to seek guidance from the committee.

4 How We Produced This Plan

In the autumn of 2013 the leaders of the Cumbria health and social care system came together to have a full, frank reflection on the challenges we collectively face. Those leaders, which included the Chief Executive and Medical Director of the local NHS Trusts, the Clinical Chair and Chief
Officer of NHS Cumbria CCG, and the Chief Executive of Cumbria County Council, agreed the joint following work:

- A **single version of the truth**, describing consistently the quality, financial and workforce challenges we collectively need to overcome
- A clear set of **stabilisation** actions, to fix the here and now
- A clear set of **transformation** actions, to meet our high aspirations for the future.

Those leaders agreed to set up the Cumbria Health and Care Alliance, as an important forum for us all to work together. Through the Alliance, we have jointly taken forward our planning work, leading to the production of; first our individual organisations two year operational plans, and now our draft five year strategic plans. This has been supported by:

- The Better Care Together process in south Cumbria and north Lancashire
- Analogous work in north Cumbria, first through the North Cumbria Clinical and Strategic Leaders Group, and latterly through the Together for a Healthier Future Programme Board
- Cross Cumbria specific work streams, for example Children’s Services
- Specific service reviews, for example the review of community hospitals and minor injury units, adult mental health services and the planed review of maternity services
- Taking forward key enabling programmes, for example establishing the Cumbria Learning and Improvement Collaborative and joined up clinical informatics
- Specific planning work, for example the development of the Better Care Fund Plan.

Both the appended Together for a Healthier Future and Better Care Together Strategic Plans describe fully how the plans were developed, including clinical, public, patient and stakeholder engagement.

## 5  The Structure of the Local Health Economy

In total, Cumbria is served by 81 GP Practices (and one practice in Bentham which is a member of NHS Cumbria CCG) providing general practice to list sizes from 700 to nearly 25,000. Out of hours primary care is provided by Cumbria Health on Call. Cumbria is primarily served by the following NHS Trusts:

- **Cumbria Partnership NHS FT:** Provides community services (e.g. District Nursing), some specialist physical health services (e.g. Neurology and Diabetes) and community and inpatient mental health and learning disability services. The Trust works across Cumbria, and provides a limited number of specific services to the north Lancashire area.
- **North Cumbria University Hospitals NHS Trust:** Provides a range of secondary care services, and some tertiary services, from Cumberland Infirmary Carlisle and West Cumberland General Hospital in Whitehaven. The Trust primarily serves the Allerdale, Copeland, Carlisle and Eden localities of Cumbria, as well as providing a small volume of patient activity to Scottish residents.
- **University Hospitals of Morecambe Bay NHS FT:** Provides a range of secondary care services, and some tertiary services, from Furness General Hospital in Barrow, and Royal Lancaster Infirmary, and a more limited range of services from Westmorland General
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Hospital in Kendal. The Trust primarily serves the Furness and South Lakes localities of Cumbria, as well as the population of NHS Lancashire North CCG.

- **North West Ambulance Service**: Provides patient transport and emergency ambulances to the population of Cumbria, as well as the wider geographical area of Lancashire, Cheshire, Merseyside and Greater Manchester.

Additionally, patients from Cumbria access a wide range of NHS services outside the county, particularly for elective and complex procedures, including some interventions which are not otherwise available in Cumbria. The chart below shows the broad deployment of NHS Cumbria CCG resources financial terms.

![Figure 2: Deployment of NHS Cumbria CCG resources financial terms](image)

6 **Geography**

Cumbria is England’s second largest county, covering over 2,600 square miles. With a population of only half a million people, Cumbria is also England’s second least densely populated county. The challenge of providing quality services to isolated clusters of population is unique in the north of England.

Cumbria is geographically isolated, rather than rural. The majority of the population live in towns and large villages. These centres of population are far away from each other, and even further from the nearest cities. The west coast is especially isolated. Barrow, with a population in excess of 70,000 is some 47 miles from the nearest large town of Lancaster, and 100 miles from the regional capitals of Manchester and Leeds (entirely by A roads in the latter case). Whitehaven and Workington, with respective populations of 25,000 each, are some 39 miles and 30 miles from Cumbria’s largest urban centre of Carlisle with a population of 75,000, which itself is another 60 miles away from the regional capital of Newcastle.

In part because of our geographical context, and also reflecting our natural communities and District Council boundaries, Cumbria works on a locality model for large parts of healthcare commissioning and delivery.
The localities are a key building block to enable locally responsive services, which recognise the diversity of Cumbria and that one solution does not fit all our communities. Importantly for NHS Cumbria CCG, the localities form the main mechanism for engaging with its member GP practices, for primary care development, and for commissioning community services. The commissioning localities are largely co-terminus with the provider locality for both Cumbria Partnership NHS FT and for Cumbria County Council.

Figure 3: Map of NHS Cumbria CCG Commissioning Localities
Section 2  The Case for Change

1  Our Demographic and Geographic Context

The age distribution of the population of Cumbria is expected to change significantly over the next five years. While the overall population of north Cumbria is forecast to grow by at 0.9%, the number of people aged over 85 is expected to grow by 19%. This is a bigger shift than the national forecast, the total population growth across all ages is 4.3%, and in the over-85 population 18.1%, as shown in figure 4 below.

Figure 4: Local and national cumulative forecast population growth

Overall, older people have both more frequent and more complex care needs. As such, an ageing population has a disproportionate effect on the overall demand for health and social care services. For example:

- Currently 28% of people in north Cumbria are aged 60 and over, but 42% of all secondary care activity is provided to this age group
- Another example is dementia, which affects 1.3% of the national population at age 65, but 12.2% of people by age 82.

This means that demand for care services will increase more rapidly than general population growth, as a result of the ageing population.

Cumbria accounts for half the land mass of the whole north west region, spread across 2,600 square miles. The distance between the two main towns of Carlisle and Barrow is the same as from Manchester to Birmingham. Overall we have very low population density. Eden valley has the lowest population density of any Local Authority in England, just 24 people per square km,
Interim: Subject to review from NHS England

compared to Islington with 13,875 people per square km. Our west coast hosts geographically isolated and economically deprived small towns and villages. This presents major challenges for service delivery. We have major differences in health outcomes across the county - people in Barrow spend twice as long in their life suffering ill health than people in South Lakes or the Eden Valley. One of the drivers in variations in outcomes is excess weight, from the Public Health England report in 2014 we have the most obese Local Authority area in England (Copeland) and high levels of type 2 diabetes in both adults.

2 Key Findings from Engagement Activity

As part of the Better Care Together and Together for a Healthier Future programmes we have undertaken extensive public engagement. For a full description of the engagement, please refer to those documents. The key messages from both programmes were very consistent, and are shown below.

Better Care Together Summary

- **Travel** – patients should only travel where necessary. Services should be local, although people were willing to travel for the best care available.
- **Access** – often seen as problematic and should be improved. GP access and out of hours care at evenings and weekends seen as insufficient and should be improved.
- **Integration** – services are not sufficiently joined up, whether within health for example acute and mental health services or between health and social care. Care pathways are not joined up and boundaries between different services are hard to understand and navigate. Good discharge management is a particular area that should be improved.
- **Out of Hospital care** – seen as providing effective alternatives to current care, with many people being very satisfied with community alternatives to acute care.
- **Prevention** – personal responsibility for maintaining health seen as important. Young people in particular said they understood and took on such responsibility.
- **Acceptability of change** – many people understood and accepted the need for change, however it was important that change delivers real benefits that are quickly apparent.
- **Risk** – concerns raised around a number of risks, particularly, increases in risk arising from changes to services, travelling longer distances when people are unwell, whether enough staff will be available particularly at weekends and risks from budget reductions.
- **Customer care and communication** – mixed experience with a number of people concerned about lack of caring approach form some clinical staff and the need for more effective communication by administrative staff.

Together for a Healthier Future Summary

- **Travel**: Travel was a big issue with many comments about the distance people often have to travel for services and how the timings of appointments means they have difficulty in getting there by public transport. There was recognition that it is sometimes necessary if patients need specialist care and in the focus groups in particular there were indications that quality was more important than distance.
- **Access to services**: There were many comments about perceived difficulties in access to GP services and long waits for hospital treatment, as well as operations being cancelled and a
feeling that the administrative arrangements were not always as efficient as they should be.

- **Integration:** There were many comments about the need for more joining up across services, particularly for older people and those with complex health needs. This included strong messages about the need to work more closely with the third sector.

- **Prevention:** The importance of prevention was stressed at the road shows and at the third sector events.

- **Better communication:** Communication across services and with patients needs to be better, with experiences of breakdowns in communication, particularly between GPs and hospitals.

- **Loss of local services from Whitehaven:** There were also comments about services being taken out of Whitehaven and being moved to Carlisle.

- **Patient experience:** While there were many positive comments about local NHS staff, some felt that it was no longer a vocation but just a job and that the personal touch was increasingly missing.

### 3 Outcomes and Inequalities

#### 3.1 Outcomes

As clinical leaders, improving outcomes for our communities is what drives us. We must lead our local health economies to use the challenges we face, financial and otherwise, as a platform to make real and transformational change which will make significant improvement to the quality of care provided to our patients and the outcomes we achieve. All CCGs, together with their NHS England Area Teams are being asked to jointly set levels of ambition against seven overarching outcomes. The seven outcomes are deliberately broad so as to drive improvement for all our local population. These are rooted in the NHS Outcomes Framework.

For measures where NHS Cumbria CCG currently performs below national benchmarks, the CCG has set more challenging levels of ambition, recognising both the increased need and potential for change. All these levels of ambition are underpinned by the initiatives set out in this strategic plan and, while challenging, are realistic ambitions for improving outcomes for our population, as shown in the chart below.

The chart shows:

- The ambition area
- The metric, being the measure we will use to judge if we are successful in meeting the ambition area
- The baseline from 2012/13
- The trajectory for 2018/19
- The comparative position for our 2012/13 baseline position shown as a red, amber, green based on quintiles as explained in the legend.
## Ambition area

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<th>2018/19</th>
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<td>Potential years of life lost from conditions considered amenable to healthcare</td>
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</tr>
<tr>
<td>2. Improving the health related quality of life of people with one or more long-term condition</td>
<td>Health related quality of life for people with long-term conditions (measured using the EQ5D tool in the GP Patient Survey).</td>
<td>71.1</td>
<td>76.7</td>
<td>7.9%</td>
</tr>
<tr>
<td>3. Reducing the amount of time people spend avoidably in hospital</td>
<td>Composite Measure on emergency Admissions</td>
<td>2204</td>
<td>2009</td>
<td>8.7%</td>
</tr>
<tr>
<td>4. Increasing older people living independently at home following discharge from hospital.</td>
<td>Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services</td>
<td>84.3</td>
<td>88.0*</td>
<td>4.4%</td>
</tr>
<tr>
<td>5. Increasing the positive experience of hospital care.</td>
<td>Patient Experience of Inpatient Care (proportion of poor responses)</td>
<td>118.5**</td>
<td>137.0</td>
<td>-15.6%</td>
</tr>
<tr>
<td>6. Increasing the positive experience of care outside hospital, in general practice and in the community.</td>
<td>The proportion of people reporting poor experience of General Practice and Out-of-Hours Services</td>
<td>4.30</td>
<td>4.28</td>
<td>0.5%</td>
</tr>
<tr>
<td>7. Progress towards eliminating avoidable deaths in our hospitals caused by problems in care.</td>
<td>Hospital Deaths Indicator in Development</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

### Legend: National Quartiles

- **Bottom**
- **2nd Bottom**
- **Middle**
- **2nd Top**
- **Top**

The Case for Change
3.2 Population Health and Inequalities

The health of people in Cumbria is varied compared with the England average. Overall, deprivation is lower than average, however there are some high levels of deprivation, with areas of the county falling in the most deprived 10% nationally. Deprivation is particularly severe in the urban areas of Barrow and west Cumbria. 15.4% of children in the county live in poverty below the national average of 21.3%, however in one ward in Copeland the percentage of children living in poverty rises to 49.2%. Although deprivation is most prevalent in Cumbria’s urban areas there are also hidden pockets of deprivation in some of the county’s most rural communities.

Cumbria’s overall performance in a range of health and wellbeing indicators disguises significant inequalities in health outcomes. There is a 19.5 year gap between the wards with the highest and lowest life expectancies in the county, with life expectancy in some areas 8.4 years below the national average. Health outcomes in north Cumbria are poorest in Copeland and Carlisle whereas Eden and South Lakes have high levels of health and wellbeing. With the exception of Eden, all districts have problems around alcohol misuse. Poor mental health is also an issue for the county with incidences of neuroses, self-harm and suicide higher than those nationally.

The chart below shows the correlation between deprivation and mortality, and demonstrates the need for us to work much more strongly across the health and care system but also with all our partners to address serious inequalities.

![Figure 6: Correlation between deprivation and mortality in Cumbria](image)
4 Performance and Quality: Delivering Standards Reliably

4.1 Quality Challenges

During the two year period of 2012/13 – 2013/14, there have been a number of substantial quality challenges in Cumbria, which have resulted in regulatory intervention.

North Cumbria University Hospitals NHS Trust was included in the Mortality Review led by Sir Bruce Keogh, NHS England Medical Director. The review identified a significant number of impediments to the delivery of quality services. In the period following the review the Trust have taken forward many improvements and are now within the expected range for Hospital Related Mortality. The review led to the Trust being placed in special measures.

University Hospitals of Morecambe Bay NHS FT were included in the wave 1 of the new Chief Inspector of Hospitals reviews. Following the review, and the subsequent risk summit, the Trust were placed in special measures.

This means that at the time of writing, both the major Acute Trusts serving Cumbria are in special measures, the highest level of escalation in the NHS.

Additionally, there has been further intervention from the Care Quality Commission and/or NHS England regarding:

- A wide range of interventions across nursing homes in Cumbria
- A series of Quality Surveillance Groups, leading to several Risk Summits, relating to specific NHS trusts and or services across Cumbria.

Finally, at the time of writing the Inquiry in Public primarily relating to maternity services at Furness General Hospital is still in hearing.

A key recurring issue across many of these quality challenges, is the difficulty of recruiting clinicians and practitioners with the necessary skills, and of enabling those clinicians to continuously improve services within a professionally supportive clinical culture.

4.2 NHS Constitution Standards

Our system does not reliably deliver the standards associated with the NHS Constitution. The performance of NHS Cumbria CCG and that of our local acute trusts is consistently below the national operational standards on a number of measures from the Expected Rights and Pledges within the NHS Constitution.

NHS Cumbria CCG has failed to achieve the 18 week referral to treatment time throughout 2013/14 and continues to fail in 2014/15 at May 2014. This is primarily due to North Cumbria University Hospitals NHS Trust (NCUHT) which has failed this standard for over a year. NCUHT is also inconsistent in achievement of the incomplete pathways. University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBT) has improved greatly in achieving RTT standards in 2013/14 but is still on occasion not achieving the admitted standard. In 2014/15 they have identified that a
backlog has built up due to insufficient capacity and they plan to fail the RTT admitted standard during June/July 2014 in order to clear the backlog and get back on track. This has been agreed with commissioners but with requests for assurance that a backlog will not then recur. Cumbria Partnership NHS Foundation Trust (CPFT) regularly underperform on the 18 week non-admitted standard in services commissioned by the CCG. This is in the specialties of neurology and community paediatrics.

In addition NCUHT and CPFT are now not achieving the **diagnostic 6 week wait standard** by a significant amount (15.9% and 18.6% respectively at May 2014), and UHMBT have failed it by a small degree (between 1.1-2%) on occasion in recent months. NCUHT and UHMBT are also failing to achieve the standard for **cancelled operations not rebooked within 28 days**. Together these present a risk to the CCG in terms of the challenge to achieve and consistently maintain the elective pathway standards for the patients of Cumbria into the future, with by far the largest risk currently being NCUHT.

**Cancer waiting times:** The CCG has failed the maximum 62-day wait from referral from a GP to first definitive treatment for all cancers standard for 12 out of the last 13 months and NCUHT has failed this for 11 out of the last 13 months. In January 2014 NCUHT also failed the maximum 31 day targets for surgical, drug and radiotherapy treatment, the first time it has failed all three at the same time, and in April 2014 the 14 day from referral to first OPA standard was not achieved, a standard that NCUHT have achieved for the past 6 months. UHMBT had been achieving the cancer standards for much of 2013/14 but have failed to achieve the 62 day standard in recent months. Again this presents a risk to delivery of optimal cancer care for the Cumbrian community.

**Urgent Care Services:** For a large part of 2013/14 NCUHT has not achieved the four hour waiting time standard for A&E. In February and March 2014 performance improved dramatically with the 95% standard being achieved almost every day, as a result of primarily internal changes to the Trust that have improved patient flow. However, performance since then has been extremely variable and the current Quarter 1 performance at 8/06/2014 is 93.2%. UHMBT have deteriorated in their performance. Having achieved the 95% four hour standard in quarters 2 and 3 of the year, quarter 4 has deteriorated dramatically and they did not achieve the standard. At 8/06/2014 their Quarter 1 performance is 92.2%. In addition they have only achieved the maximum 30 minute ambulance handover for one month in the last 12. Urgent care services therefore continue to be challenged across all of Cumbria and effective, substantial and deliverable urgent care plans will need to be implemented in the next two years to ensure a sustainable system is in place into the future.

**Health Care Acquired Infections:** Although NCUHT perform well against C. Difficile trajectories UHMBT had failed their 2013/14 trajectory by January 2014 and the CCG has also overall failed its trajectory. In addition there have been two MRSA cases for the CCG in 2013/14 as well as one at NCUHT and one in UHMBT. Further work is therefore needed to reduce and prevent health care acquired infection in Cumbria.
4.3 Variations in Reliably Delivered Services

We know that there are significant variations in the delivery of services right across the system. For example:

**Primary Care**: Although General Practice across north Cumbria has a high level of Quality Outcome Framework (QOF) attainment, there is very wide variation in the levels of disease registers (case finding) compared to forecast disease prevalence, and in the consistent delivery of interventions. Similarly, there are widely varying utilisation rates of hospital services, though both elective referral and unscheduled care, which are not a correlation of overall morbidity.

**Hospital Care**: We know that hospital mortality as measured through both HSMR and SHMI consistently show higher rates of mortality at West Cumberland Hospital than at Cumberland Infirmary Carlisle, although overall mortality as recorded through these measures has significantly improved in the last year.

**Mental Health Services**: There is a significant variation in access to IAPT services, and services for severe and enduring mental health, across north Cumbria, and significant variation in the interventions service users receive for comparable needs.

4.4 Delivering Care in the Right Place, at the Right Time

We commissioned the Oak Group to carry out an audit at each of University Hospitals of Morecambe Bay NHS FT, North Cumbria University Hospitals NHS Trust (NCUH) in February-April 2014 and the community hospitals delivered by Cumbria Partnership NHS Foundation Trust (CPFT). This audit was undertaken in order to facilitate improvement of care quality and reduction in delivery costs by identifying patients in the acute setting whose care could be delivered in an alternative setting (non-qualified admissions or bed days). The audit showed that care could be provided in alternative environments for:

- 28% of medical admissions and 61% of continuing days at UHMBFT
- 23% of medical admissions and 62% of continuing days at NCUHT
- A large part of the unqualified provision at both Acute Trusts relates to sub-acute needs, which could potentially be met in community hospitals)
- 18% of admissions and 47% of continuing bed days in community hospitals.

This position is typical across England, and any major change is reliant on developing more effective out of hospital options and an increased use of sub-acute wards.

5 Workforce

Overall, our staff tell us that things need to change. While staff in some specific services show very high levels of professional satisfaction, this is not the norm. Overall, our staff have consistently provided feedback, including through the national staff survey, that shows lower levels of satisfaction and lower levels of confidence in the service delivered than any national benchmark.
Our staff have repeatedly identified ways in which they could be better supported and enabled to drive service improvements. Although there are signs that we are becoming much better at responding to those issues, there is still clearly lots of room for improvement.

Delivering sustainable services is dependent on recruiting, retaining, and developing our workforce. Currently, we have a major over reliance on temporary staff, including on locum consultants, middle grade and junior doctors. This over reliance is potentially a risk to the clinical and financial sustainability of services, and is a clear risk to continuity of service and quality.

A much fuller description of the workforce challenges is provided in each of the Better Care Together and Together for a Healthier Future Documents.

6 Financial Sustainability

NHS Cumbria CCG has delivered a planned surplus of £5 million in 2013/14, and plans to maintain this level of surplus over the next 5 years (i.e. it will spend its annual funding allocation in full).

For 2014/15 NHS Cumbria CCG will receive a revenue allocation of £677 million that is 8.5% (circa £57 million) above target funding. Following guidance issued by NHS England, the CCG’s financial plan is based upon the minimal allocation uplift over the planning period. Although the CCG allocation formula identifies Cumbria’s population need to be greater than that for the predecessor Cumbria PCT, NHS Cumbria CCG’s financial allocation is significantly over target owing to a combination of the baseline position inherited from the PCT along with a small fall in Cumbria’s overall population at a time when the rest of England’s population has increased. However, it is noteworthy that the CCG allocation formula does not make allowance for the cost of delivering healthcare where significant elements of the population are located in geographically remote areas or the impact of rurality.

In Cumbria the NHS system currently spends much more than it is allocated and this deficit presents in the provider sector. In effect, the Cumbria acute trusts, and therefore Cumbria collectively, are reliant upon resources from outside Cumbria to remain solvent, as noted below. Also, given the CCG’s current distance from target allocation it would appear unlikely that a change in the allocation formula would provide significant additional resource into the Cumbria health economy to potentially off-set the problem.

- University Hospitals of Morecambe Bay NHS Foundation Trust has a financial risk rating of 1. The Trust has a recurring financial deficit of c£25 million, against an annual income in the region of £260 million.
- North Cumbria University Hospitals NHS Trust has received in excess of £100 million transitional funds over the last five years to “balance the books”. The Trust is forecasting a deficit of £26 million in 2013/14, against an annual income in the region of £228 million.

Work has been undertaken in both acute trusts to establish the underlying reasons for the level of deficit, including the extent to which it inherently costs more money to deliver services across small district general hospitals which are geographically isolated from each other. It noteworthy that both trusts are currently (in common with other healthcare providers in Cumbria) placing significant reliance on premium cost staffing (e.g. locums).
Cumbria Partnership NHS Foundation Trust, following a period of financial health, is now facing difficulty in identifying a deliverable cost improvement programme for 2014/15 and beyond.

Our approach to rebalancing the system therefore will need to be planned and delivered at a credible pace and scale, ultimately delivering a radical, rather than piecemeal, redirection of resources.

The scale of our financial challenge is more fully described in each of the Better Care Together and Together for a Healthier Future documents.
Section 3  Our Vision for Cumbria

1  The Vision

The following principles were adopted by NHS Cumbria CCG and endorsed by all the partner organisations of the Cumbria Health and Care Alliance:

**NHS Cumbria Clinical Commissioning Group Vision:**

We are here to make a real difference to people’s lives. Firstly this is about making a difference by improving the health and wellbeing of individuals and their families. In particular it is about taking serious action to reduce the inequalities in health that exist between different communities across Cumbria. We want to add years to peoples’ lives, and quality life to those years. Making a difference to people’s lives also includes improving the day to day experience of patients and those working to deliver better healthcare. Working for the health service in Cumbria should be a privilege and a source of pride. We want this to be true for all our colleagues, as we recognise that quite simply people who are happy in their jobs provide better care. Our key underpinning principles are:

- Doing the right thing for our patients, service users and populations
- Putting ourselves in your shoes – is this the care we would want for ourselves or our families?
- Access to the right healthcare, in the right place, right when you need it
- The Cumbrian health pound is finite and can only be spent once.

Building on those principles, we recognise that health and social care services in Cumbria need to change for the better. There are four reasons for this:

- We know that not all services are as safe as they should be - and furthermore, the people of Cumbria are not all sharing in equal access to the best possible outcomes for their health or their care
- The day-to-day experience of people using services is not as good as it should be – and we don’t listen enough to what people are telling us about their experiences
- The ever increasing cost of services as they are currently delivered – even if they were good enough and fair to everyone – is not sustainable and the local NHS and the County Council will be bankrupt if things carry on as they are
- The staff – doctors, nurses, carers, managers, everyone – who work for the NHS and for social care in Cumbria are often frustrated, unhappy, over-stretched and demoralised and there is a crisis in trying to recruit new people to come and work here.

We believe we can change things for the better and we believe we must do it together with all the people who live, work and use services in Cumbria. We think all of the following will be required:

- Individuals and families taking more responsibility for their own health and wellbeing – supported by expertise from many places, which is coordinated by...
Interim: Subject to review from NHS England

• ... Local communities having an integrated and constantly developing approach to all the assets based in their community (including voluntary, professional, commercial and faith based) – supported by expertise from ...
• ... Local health and care integrated teams, working with shared budgets, to serve communities of between 15 and 50 thousand people – supported by ...
• ... Two teams of acute services (north and south) working across the community and in all our hospitals to meet needs that cannot be managed by the local teams – supported by ...
• ... Specialist services, many in Cumbria and some – where necessary – as far afield as Newcastle and Manchester.

To make this work we will need:

• Much more of a 7 day approach to how services work and are accessed
• More skills to eliminate waste, improve everyday processes and manage changes (without drama and heartache)
• Better communication skills, both one-to-one and for communities, between the professionals and the people who use our services
• Better information and clinical informatics systems
• Better alignment of planning and budgets so no perverse incentives block our plans or our progress.

Ultimately, we want everyone using our services to be delighted at the quality of care that they receive, and all of our workforce to be proud of the quality of care they are able to give, with an equal partnership between service users, including their carers, and clinical and practitioner staffs. Additionally, we cannot be successful by continuing to overspend.

As part of our commitment to improving quality and outcomes, we have also agreed to adopt the Improving Fairness, Quality and Outcomes: The Seven No’s framework developed by the North East Transformation System:

• No barriers to health and wellbeing
• No avoidable death, injury or illness
• No avoidable suffering of pain
• No helplessness
• No unnecessary waiting or delays
• No waste
• No inequality.

2 Aims and Objectives

Our collective overarching aims for the next five years are to:

Ensure a Sustainable NHS for Future Generations: By this we mean ensuring a system which is clinically sustainable in terms of the service model, standards, and safe, appropriate levels of staff, and which is also affordable.
Improve Outcomes: By this we mean improving the outcomes for individual patients and their families, and population level outcomes.

Reduce Health Inequalities: By this we mean narrowing the gap between the populations who enjoy the best outcomes, and those populations who endure the poorest outcomes. A good example is to reduce the difference in life expectancy between communities.

Our collective objectives for the next five years are to:

Radically increase the scale and integration of out of hospital services, based around Primary Care Communities: Primary Care Communities are developing around groups of practice lists in natural communities, and will serve populations of between 15,000 and 40,000 depending on local circumstance. Primary Care Communities will be to move away from episodic, unconnected care, to a seamless system based around the patients and their families.

Achieving sustainable, high quality provision, by delivering a programme of Hospital Services Consolidation: However successful our population health programmes, and Primary Care Communities, become, there are times when most of us will need to go to hospital. This should be reserved for those times when we need specialist help, requiring the staff skills, technology, and support services which can only be delivered in hospitals.

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: Building on the integration through Primary Care Communities, we will break down traditional boundaries between the workforce in the community and in hospitals. One example is how we will connect the care for older people in and out of hospital under the leadership of Elderly Care Consultants working in both settings.

Improve population health outcomes, based on a major impact on reducing social isolation, smoking and alcohol misuse, and increasing activity and healthy eating: We will work together with partners across Cumbria to deliver the Cumbria Wellbeing Strategy, and to re-focus our system to promoting population outcomes as a health system, rather than just a healthcare system.

3 Principles for Success

The following principles for success were agreed by a broad range of clinicians and practitioners. We will achieve better outcomes for the people of Cumbria by building upon the foundations of:

- Putting prevention first
- Being person centred in everything we do
- Rigorously using national and local evidence for our services.
We require pioneering leadership and we intend to:

- Show more respect and better behaviours, both as individuals and organisations, creating a positive and transparent culture for success
- Build the right workforce that learns and trains together, and then works together in collaborative, well-communicating teams
- Create sustainability by building common platforms and continuously improving everything we do.
Section 4  Our Initiatives

1  Continuous Collaboration: Cumbria Health and Care Alliance

The Cumbria Health and Care Alliance is focused on a continued collaboration across the system, based on the optimal models for meeting patient’s needs, and seeking to reduce the constraints caused by organisational sovereignty. In seeking to increase our collaboration, it was necessary to adopt some collective principles backed up by a common set of behaviours.

We have agreed the following as important characteristics for our behaviour, and the need for those behaviours to be actively modelled by the clinical and managerial leaders in our system:

- Have a relentless focus on quality
- Seek to integrate and work together
- Actively performance manage, hold ourselves and each other to account
- Be clear what we are trying to achieve, with a small number of important priorities
- Work hard on alignment of vision, with day to day actions in accordance with a shared narrative
- Always involve clinicians, and hold them to account
- Be mindful of tactical opportunities grounded in reality, not just intellect and emotion
- Ensure we make things happen while creating strategy, importance of momentum
- Collectively, have more ambition
- Put patients and the whole system first, and the health of our organisations follow
- Develop solutions which are politically possible, managerially credible, can attract or already enjoy public support, and command clinical and professional respect.

2  Continuous Service Improvement: Cumbria Learning and Improvement Collaborative (CLIC)

2.1 CLIC

We know that delivering the right configuration of services is important. However, we also know that supporting frontline clinicians, practitioners and managers to continuously improve the services they deliver will have an even greater impact. If we are to be successful, we will need to engender a genuine and continuous cultural and behavioural change across the system, enabled by leadership and by giving all our staff the right improvement tools and techniques.

To achieve this, the Cumbria Health and Care Alliance committed to forming the Cumbria Learning and Improvement Collaborative, CLIC. This is intended to develop into the key shared vehicle for continuously driving service improvement, in all services across Cumbria, forever. We are still working on the final CLIC work plan, but in simple terms CLIC is:

- An umbrella that brings together the collective effort of the CCG, its member practices, the Cumbria Partnership NHS FT, two acute trusts and Cumbria County Council (Adult Social Care, Public Health and Children’s Services) on education, training, development,
improvement work – indeed any organised effort to meet the needs of individuals and teams, helping them to achieve their objectives in a better way.

- A kind of snow-plough to help you get where you are going, clearing away barriers of any kind by sharing experiences, skills and innovations and supporting (and improving) all our organisations in doing what needs to be done to achieve the right outcome.
- A club (a partnership) so we all learn together, where no one partner is assumed to have a monopoly on need or solutions and where all talent is being used in a patient and population centred way, not a ‘sovereign organisation’ way.
- An infant. Full of potential but definitely not fully formed. There is as yet no fixed plan or position – indeed no fancy ideas, jargon, models or must do’s at all – just a commitment to find a way (together) to stop just talking about excellence and start the journey towards it, one step at a time. You cannot be right or wrong about what ‘it’ is, as we (together) haven’t yet developed it.

2.2 The Workforce Solution

Through the workforce session facilitated by CLIC we developed an outline five year plan for improving recruitment, retention and development with detailed actions for the next three to six months. The plans, and indeed all the content from the session, can be found at:


3 Joint Commissioning

Cumbria County Council and NHS Cumbria CCG are developing ambitious plans to take forward joint commissioning on a much greater scale. This recognises the significant interdependencies between health and social care, and the potential to deliver more efficient, integrated services through joint commissioning.

The creation of the Better Care Fund has provided a powerful catalyst for accelerating those plans. In 2015/16 the Better Care Fund for Cumbria will be £40M, and will require new and improved governance and joint commissioning arrangements. However, we aspire to pool much greater sums in 2015/16 to grow the Better Care Fund. Those include:

Mental Health, Learning Disabilities and Substance Misuse:

- Establish a revised learning disability pooled fund focused on the most complex packages
- Establish a new mental health pooled fund for April 2015, working closely with Cumbria Partnership NHS FT as the lead provider
- Establish a mental health and learning disabilities joint commissioning team across health and social care, to be in place by October 2014.
Continuing Health Care, Nursing and Residential Homes:

- Aim to establish a joint team to undertake contract management, including performance and quality, by April 2015
- Actively explore establishing a joint service framework for procurement in 2014.

Integration to Improve Outcomes for Older People with Frailty:

- This is the key focus of our Better Care Fund plan for 2014/15 – 15/16, as submitted by the Chair of the Health and Wellbeing Board on April 4th 2014
- Further integrate health and social care provision as part of Primary Care Communities.

4 Clinical Informatics

There is strong local agreement across Cumbria health and social care organisations, through the Cumbria Health and Care Alliance, for the continued support to deliver, utilise and maximise opportunities to continue to develop shared clinical informatics system.

This particularly includes:

- Community of Interest Network (COIN) infrastructure and its future state i.e Public Service network (PSN)
- Medical Interoperability Gateway (MIG) development i.e. ability to share detailed GP Cumbria Care record into relevant provider organisations e.g. A&E, Out of Hours, Primary Care Assessment centres and Outpatients
- E-referral and resource management software, (Strata) providing an “air traffic control system” for patient transitions across Cumbria
- Maintain and enhance a single Active Directory for Cumbria, however that may be configured, to facilitate communication and training and access to systems wherever people are based in Cumbria.

These constitute elements of the Common Platform, we are also collectively working to:

- Prioritise development of electronic records over the next two years, which are currently paper based / reliant on faxed information and agree timescales for implementation between the respective Chief Clinical Information officers
- Set out a two year plan to introduce tele–consultations in line with service delivery and improvement plans
- Agree to rationalise and standardise the range of referral forms that are transmitted between any combination of primary, community, mental health and acute services, with the aim of having single Cumbria wide electronic referrals over an agreed timescale.

These developments will provide major gains for the whole system, including:

- Reducing waste through the removal of inefficient paper based systems and through fail safe systems which will prevent the loss of information such as referrals
• Improving clinical decision making, by ensuring that clinicians and practitioners have access to appropriate clinical information, with patient consent
• Improving patient experience, by reducing how often patients have to re-tell their own story, and by maximising the time clinicians and practitioners can add value to the consultation.

5 Primary Care and Community Services

5.1 Communities and Support for Self-Management

We know that the real bedrock of health and wellbeing is to be found in individuals, families and social connections, and our communities. We will need to find new ways to harness this capacity to enable much more effective health promotion, prevention and self-care, and to move towards a more proactive system preventing rather than managing crisis. Key to this will be developing new relationships between services users and our whole system, including:

• Providing support for self-management on a much larger scale, building on our positive experience from roll out of diabetes patient education programmes, particularly DESMOND for type 2 diabetes
• Use of a whole range of health, social care and community assets
• Better use of what is already available in the community
• Greater involvement of the third and voluntary sector, faith communities and so forth including volunteers
• Use of the Neighbourhood Care Independence Programme
• A stronger emphasis on the fact everything needs to put the person at the centre
• Use of assistive technologies including equipment, tele-health and tele-care.

5.2 General Practice

General practice forms the bedrock of our primary care community approach. GP practices locally however are struggling to cope with increasing demand, face recruitment pressures and falling incomes. The Centre for Workforce Intelligence (2013) reported a 75% increase in the number of GP consultations in England from 1995-2009. They concluded ‘There is insufficient capacity in primary care to meet current and future needs’.

Yet we are about to make major additional demands on the primary and community care system:

• To work collaboratively with each other, with community services, social care and specialists working in the community
• To move from care of the individual to care of a population
• To support a huge shift of care from our acute hospitals into our community based intermediate care tier, sicker patients remaining at home, more support to nursing and residential homes etc.
• To support a huge shift to proactive and up-stream care especially for the frail elderly
• To move from a mainly medical model to a social model of health and wellbeing within communities
• To become experts in admission avoidance
Interim: Subject to review from NHS England

- To lead a major change in the way we manage long term conditions based on care planning and support for self-management
- To provide additional skills in areas such as primary mental health, child health, end of life care and geriatric medicine to support more people safely in the community with the need for fewer admissions and fewer elective referrals.

A core part of our five year plan is therefore how we support general practice to work within primary care communities. The roll out of primary care communities will require a large programme of learning and skills development for primary care both for the ‘day job’ and in improvement science. A learning community is currently being developed with the support of the Cumbria Learning and Improvement Collaborative (CLIC) to support the first wave of 10 primary care communities being rolled out in 2014/15. The large provider trusts with their infrastructure and critical mass have a key role to play in partnering and supporting primary care in what increasingly will become an ‘Alliance’ approach to health and care delivery across Cumbria.

This approach to primary care development will be delivered in line with the key recommendations in the Transforming Primary Care document published by the Department of Health in April 2014.

We often refer to primary care when we really mean general practice. However, the role of community pharmacists will also need to continue to develop as part of the model. We know that community pharmacy is not currently used to its full potential, we also know that large numbers of hospital admissions are primarily caused by sub optimal prescribing and medication errors.

5.3 The Model for Primary Care and Community Services

We continue to work to develop community services that are responsive to the needs of the Cumbria population. The focus is to create a proactive, joined up out of hospital care system that improves quality and drives efficiency. The model is aligned with national NHS strategy and with the Royal College of Physician’s promotion of the principle of joint working across institutional boundaries that would enable healthcare professionals to deliver integrated, personalised care. The basic model is shown below:
The service model will be delivered in slightly different ways across different parts of Cumbria, reflecting the local context.

Also, our language, in terms of the names we have given to particular functions, is different, particularly between south Cumbria which has worked with our colleagues in Lancashire North CCG and north Cumbria. Overall though, the model in terms of the basic functions and more importantly the outcomes it will deliver is consistent across Cumbria.

The following is an outline description of each of the building blocks for the Out of Hospital model.

For a fuller description of the model in each of south and north Cumbria please review the Better Care Together and Together for a Healthier Future strategic plans.

<table>
<thead>
<tr>
<th>Element 1 –Primary Care Community Teams</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Definition of Primary Care Communities (PCCs)</strong></td>
</tr>
<tr>
<td>Primary Care Communities are a group of care professionals and third sector staff drawn from a range of organisations and professions who collaborate to addresses the physical, mental and social needs of patients and their carers. They work in partnership with other agencies to also improve the general wellbeing of the population for which the team is responsible.</td>
</tr>
<tr>
<td>They are based on GP practice registered populations of between 15,000 and 40,000 that mostly cover more than one GP practice. Teams are configured around natural communities and built upon the workforce in the constituent practices and wider community assets. They are comprised of medical staff, nursing, health care assistant, mental health care, social care, voluntary care, administrative staff and managers working together across organisational boundaries.</td>
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<tr>
<td>Primary Care Community Teams will in particular develop flexible approaches to delivering care making the best use of all the expertise available to them in the following areas:</td>
</tr>
<tr>
<td>• Frail elderly care</td>
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<tr>
<td>• Long term condition management</td>
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<tr>
<td>• Services for the housebound</td>
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<tr>
<td>• Urgent/on the day care</td>
</tr>
<tr>
<td>• Seven day a week services/care</td>
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<tr>
<td>• Supporting people to maintain their independence ideally in their own home</td>
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<tr>
<td>• Health inequalities; improvements in case finding, disease registers and reduction in unwarranted variations in care.</td>
</tr>
<tr>
<td><strong>The Building Blocks of our Primary Care Communities are:</strong></td>
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<tr>
<td><strong>A Multi-Disciplinary Team:</strong> There would be ‘one team’ with a common purpose that included the GPs, responsible for the health of their defined population. There would be a proactive, coherent multidisciplinary approach to care for older people and for those with long term conditions within the PCC focusing on a shift to supported self-care and care planning. District nurses and practice nurses will work together more productively, maximising the skills across</td>
</tr>
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</table>
the whole workforce. In some areas the PCC model will help fast track discussions that are already underway around integration of rehabilitation and reablement services.

**Population Based Approach:** The population in each PCC would be risk stratified to identify the risk of non-elective admission, frequent users of services and risk of admission to residential care. The PCC would be the building block for asset based approaches and there would be a tele-health network would connect each PCC to specialists.

**Shared Systems and Data:** The PCC would share information, have a common (or at a minimum interoperable) IT system and real time patient data.

**Leadership and Delegation:** Each PCC would have a leadership team with representation from primary, community, social care, the CCG and third sector and manage at least part of their health and care budget, and would be linked to a programme of education and development – learning how to continuously improve quality, working with other PCCs to share ideas and good practice. Each locality, supporting local PCCs will work very closely with local district/ borough councils to address the health needs of their local populations, maximising the benefit to their populations from joint working and collaboration.

**Primary Care Communities will deliver the following benefits:**

**Primary Care**
- A reduction in unwarranted variation in elective referrals
- An improvement in case finding and disease registers
- Standardised long term condition management including cancers
- Standardised management of the frail elderly, including in residential and nursing homes
- Standardised end of life care
- The delivery of urgent care 8am – 8pm Monday to Fridays and at weekends
- Improved access to, and outcomes from, psychological therapies (IAPT).

**Hospital Admissions**
- A reduction in avoidable unscheduled admissions
- A reduction in hospital re-admissions
- A reduction in elective procedures of low clinical value
- An increase in people who die in their place of preference
- A reduction in length of stay for medical patients, and in delayed transfers of care.

**Element 2 - Urgent care co-ordination centre**

The urgent care co-ordination centre will ensure that patients get to the right place in the system at the earliest opportunity. It will work with the primary care community team and track patient journeys using real time system information.

For professionals it will provide a single point of access to a range of health and social services for patients with an urgent health and/or social care need whilst at home and can provide an alternative to admitting to urgent care services. It will agree the appropriate clinical response for a patient in accordance with care plans, including discharge plans for patients with complex care needs. The centre will be able to deploy additional community services, for either adults or
Interim: Subject to review from NHS England

children. It will also arrange appointments at ambulatory clinics as well as hospital admission.

For professionals, including those in hospitals, the centre will provide a single point of access to a range of health and social care services to help them address the needs of their patient with an urgent need whilst at home. The service will be for patients of all ages with a call option to divert to a children’s response where needed. For the patient in hospital the centre will coordinate discharge planning and referring and accessing community and post hospital care across the health and social care system. The urgent care co-ordination centre at Cumberland Infirmary Carlisle (CIC) has started to perform this function.

The role of the co-ordination centre will be to agree the appropriate clinical response for a patient, given the need, the care plan and the knowledge of available local services. The service will have access to care plans for those patients who have been identified as likely to require support to enable continuity of care.

The team will operate using local knowledge and “real time” system capacity data across the health and social care system and ensure that the best package of care or support is delivered to a patient in the most appropriate location, and at the most appropriate time. The centre will be able to deploy community services that support primary care community teams, for either adults or children. For those who need it, the centre can also arrange appointments at ambulatory clinics as well as hospital admission.

A critical enabler is to have a shared IT platform/system in place which displays real time capacity across the system, i.e. in general practice community services, local authority services as well as in the hospital. STRATA is a system being piloted and learning from this early pilot will help identify how best to design the future tools or build on STRATA. If STRATA proves to be effective it can be extended beyond unscheduled care to streamlining referrals, managing appointments, bed management, etc.

The hub or care co-ordination centre will also be able to provide advice to professionals as an alternative to admitting to a care service and will have a vast knowledge base on which to make decisions. This is a critical function of the team and requires skilled staff to be available seven days a week.

The care co-ordination centre at CIC is already beginning to deliver some of these functions successfully, and gives us good local experience to learn from and build on.

Element 3 - Integrated rapid response and community services

A number of services will be developed, either by PCCs or where appropriate on a larger footprint to specifically target the needs of patients in the community. Examples include:

**Hospital at Home/ integrated rapid response teams:** A multidisciplinary team designed to avoid hospital admission where appropriate and enable hospital discharge before the patient has fully recovered with the necessary out of hospital support. The team makes a rapid assessment of the patient’s medical, nursing and care needs. The team then delivers a package of health and social care (“hospital at home”) until the patient no longer requires intensive
support and their care continues to be provided through the primary care community team for ongoing recovery and rehabilitation.

There would be a multidisciplinary rapid response function including nurses, occupational therapists, physiotherapists, social workers and home care practitioners (currently called STINT or rehabilitation teams), community hospitals (where appropriate) and pharmacists. People presenting with health and/or social care needs will have access to reablement, rehab services and voluntary sector partners to maximise independence in the first instance. This will include a rapid response function to prevent avoidable admissions and will therefore be available throughout the seven day week. This approach will include access to equipment, assistive technology, adaptations and prevention services. There would be a ‘Virtual Ward’ including prevention, focusing on those identified as high risk for admission, and reactive for patients who are more acutely ill, for example, those needing IV antibiotics at home. For those with long term needs a care coordinator approach will be in place to ensure people know who to contact if there are changes in their circumstances and to embed a proactive, personalised approach to care and support for themselves and their carers/family.

**North West Ambulance Service (NWAS) Pathfinder Programme:** We are working with NWAS to deliver the pathfinder programme during the day in addition to the already established out of hours programme. This service gives NWAS paramedics the ability to direct patient care needs to local primary and community services if these are better able to meet the patient’s needs, rather than taking all patients directly to an A&E service.

**Element 4 - Community specialist services**

Specialists would operate across the out of hospital model, providing specialist support for patients, in localities where possible but with good access to hospital based services. They would have an overarching responsibility for the delivery of care and health outcomes for the population in their locality that has diseases covered by their specialities.

In delivering this responsibility specialists would have dedicated time to advise GPs or patients outside a traditional clinic environment. Specialists would have a key role in the education and support of other professionals. Clinical nurse specialists, GPs with a special interest, other community health professionals and social care professionals would have a greater role in the direct delivery of patient care and patient education.

The role of the specialist will evolve and whilst it will still include direct clinical care it will also have a key role in skilling up primary care teams, helping coordinate care across pathways and set standards, pathway leadership and a significant increase in direct same day advice and support to colleagues in the primary care community.

A large number of medical specialities from different organisations could join this medical division for example, acute medicine, geriatrics, rheumatology, neurology, diabetes, endocrinology, respiratory medicine etc. All specialities will still in reach to provide acute care within the hospitals but they will become community based specialities.

Use of technology is a key enabler to this element of the model and opportunities can be learnt
from remote healthcare systems and how they use non face to face interaction to diagnose, offer advice and support and maintain follow up care without the patient travelling to hospital. For example, the model includes a clinical support service for nursing homes, providing from the bedside advice on appropriate care, removing the need for residents to be taken to other care facilities unless that best meets their needs.

**Element 5 - Referral support system**

This element is a number of activities and approaches that together provide a more effective and efficient system for the pre-operative or pre-acute intervention phase of a patient’s care pathway. Many of the functions below are already in place. We now need to deliver these more consistently across North Cumbria in a more focused way.

The referral support system will encompass:

- Access to specialist advice and guidance
- Improved access to diagnostic investigations for community based health professionals
- The development of care pathways across specialities including the use of shared decision aids
- Making these pathways clearly available for viewing by all those involved in patient care
- Referral templates
- Peer review of referrals for specialist opinion
- An advice and guidance tool
- Co-consultation in for example outpatient community settings between specialist and members of the primary care community team.

The system will help reduce the need for specialist follow up, including discharge from specialist follow up, but facilitating quick access to specialist review when appropriate. The service will also aim to up-skill community based health professionals’ referral skills.

**6 Community Hospitals and Minor Injury Units**

There are nine traditional community hospitals in Cumbria at Alston, Brampton, Cockermouth, Keswick, Maryport, Millom, Penrith, Wigton and Workington. Additionally, there are four step up step down units created in 2010 on the Cumberland Infirmary Carlisle, West Cumberland Hospital, Westmoreland General Hospital and Furness General Hospital sites.

We are committed to a positive future for all of the community hospitals. They provide a vital role in ensuring local access to services and enabling needs to be met in the most appropriate care environment. At an overarching level, the community units should provide 2 clear functions:

- They should be used for step down (after a very short stay in the acute) and step up care, as an integral part of the whole elderly care bed base run by a team of GPs from local practices and elderly care physicians
Interim: Subject to review from NHS England

- They should provide enhanced admission avoidance hubs, acting as ‘Frailty units’ - one stop assessment centres for the frail elderly (replacing outpatient clinics), focussing on comprehensive geriatric assessment, reablement and rehab, prevention (co-opting third sector and community resource) and admission avoidance such as falls assessments.

Our approach to maximising the contribution of community hospitals will be guided by the following principles:

- The community hospital and SUSD beds should be combined with the elderly care beds in North Cumbria University Hospitals NHS Trust to form a joint bed base for older people.
- This should be run within a new ‘medical divisions’, with medical leadership from GPs and elderly care physicians working as one team.
- The norm for Acute Trust admissions should be short stays for older people with rapid transfer out to home (‘home first’) or one of the community facilities (which may include sub-acute wards in the Acute Trust setting) within the medical division for further assessment and treatment. This is in keeping with the findings from the Oak Group audit.
- There should be day case/ambulatory units within each locality where transfusions and other IV therapies can be reliably delivered. The portfolio of these ambulatory treatment centres should be developed in partnership with North Cumbria University Hospitals NHS Trust to deliver whatever treatments currently delivered in the acute trusts that can safely and feasibly be done in the community.
- Each of the minor injury units will either become a part of the Primary Care Community, offering local extended access to community services, or will be aligned to the Type 1 Accident and Emergency Units as part of the joint medical division working to shared governance and standards.

7 Hospital Consolidation

As listed in our objectives, a key focus for the delivery of our plans in to ensure high quality, sustainable, hospital services for the future. Delivering this challenge is difficult task. It will require creativity, invention, and courage from the clinical community and local population.

Our overall aim is to ensure:

- Access to the highest quality urgent and emergency care (connected to Primary Care Communities and A Modern Model of Integrated Care)
- A step-change in the productivity of elective care
- Specialised services concentrated in centres of excellence (working with our commissioning partners in NHS England).
To meet these aims, our local hospital services will need to:

- Be able to reliably deliver the NHS Constitution Standards
- Maintain quality orientated services, which adhere to recognised standards or are based on clinically agreed variations to those standards in patients best interests
- Be sustainable through the support of a skilled, qualified and continuously improving workforce
- Be delivered in the appropriate estate and infrastructure.
- Be delivered efficiently within the resources, which will inevitably mean at lower cost than today.

Through both the Better Care Together and Together for a Healthier Future programmes we have considered a range of scenarios to meet these aims. These scenarios are summarised below. We fully recognise our statutory obligations in relation to public consultation and we are committed to working with the overview and scrutiny committee to ensure these are carried out in line with requirements.

**7.1 South Cumbria**

For a fuller description of our plans for hospital consolidation in south Cumbria and as relevant north Lancashire, please refer to the Better Care Together strategic plans.

The Better Care Together programme had an extensive process for determining hospital options. This started with 132 options which were reduced to a shortlist of six following application of agreed qualifying criteria and ‘stakes in the ground’ (supported by the Monitor Commissioner Requested Services process).

The six options are outlined in the figure 8. All contain the out of hospital model, and A&E and consultant led maternity services at both RLI and FGH. The differentiation centres on where elective day case surgery takes place.
### Table: Hospital options in south Cumbria

<table>
<thead>
<tr>
<th>#</th>
<th>Out of Hospital Model</th>
<th>Urgent care</th>
<th>Women’s and children’s</th>
<th>Planned care in-patient</th>
<th>Day surgery – GA / LA list</th>
</tr>
</thead>
</table>
| A | 5 elements of the Out of Hospital model deployed in each locality | - FGH Type 1 A&E & dependent services (current service)  
- RLI Type 1 A&E & dependent services (current service)  
- WGH Minor Injuries Unit (current service) | - Maternity services with obstetric facilities at FGH  
- Maternity services with obstetric facilities at RLI  
- MLU at WGH | Consolidate onto RLI and FGH | Consolidate onto RLI and FGH |
| B | As above, in option A | As above, in option A | As above, in option A | As above, in option A | Day surgery delivered on all sites (WGH, FGH, RLI) |
| C | As above, in option A | As above, in option A | As above, in option A | As above, in option A | Consolidate all day surgery onto RLI |
| D | As above, in option A | As above, in option A | As above, in option A | As above, in option A | Consolidate onto WGH |
| E | As above, in option A | As above, in option A | As above, in option A | As above, in option A | Consolidate onto RLI / WGH |
| F | As above, in option A | As above, in option A | As above, in option A | As above, in option A | Consolidate onto FGH / WGH |

**Figure 8: Hospital options in south Cumbria**

We will continue to refine the preferred option through the Better Care Together process, and through further engagement and formal consultation where appropriate.

### 7.2 North Cumbria

**For a fuller description of our plans for hospital consolidation in north Cumbria, please refer to Together for a Healthier Future the North Cumbria Strategic Plan 2014 – 19.**

We have not developed options for the required change. Rather, we have developed scenarios across a continuum of change, which will be continually reviewed. We will move along the continuum as senior clinicians judge necessary to secure quality, clinical and financial sustainability. All changes will need to be supported by strong evidence and will take into consideration the views of patients, the public and our key stakeholders. We fully recognise our statutory obligations in relation to public consultation and we are committed to working with the overview and scrutiny committee to ensure these are carried out in line with requirements.
### Level of Consolidation

<table>
<thead>
<tr>
<th>Low</th>
<th>Medium</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continuous improvement to meet current and new standards</td>
<td>Reconfiguration of most unsustainable / highest risk services</td>
<td>Planned reconfiguration of whole service model to provide consolidated clinical capacity to adhere to standards and drive quality and efficiency</td>
</tr>
<tr>
<td>Continuous review of workforce models and safe staffing</td>
<td>Reconfiguration of elective services informed by public and patient engagement</td>
<td>Increased use of emergency transport</td>
</tr>
<tr>
<td>Continuous review of clinical risk and outcomes</td>
<td>Continuous review of all other services</td>
<td></td>
</tr>
</tbody>
</table>

**Figure 9: Continuum of consolidation**

In relation to medium to high consolidation, the following may be necessary:

**Elective Care**

- To significantly increase the total number of elective in-patient episodes at West Cumberland Hospital. This will support the delivery of the 18 week referral to treatment standard, reduce cancelled operations, and improve outcomes.
- To develop Cumberland Infirmary Carlisle to deliver higher risk elective procedures, but with a reduction in the total number of in-patient elective procedures at the site. This will ensure the right clinical capacity and capability to improve outcomes for more complex / higher risk patients and procedures.
- Outpatient appointments and procedures, day cases and diagnostics will continue at both sites to ensure access.

**Unscheduled care**

- The population of west Cumbria will continue to need to be able to access accident and emergency services at West Cumberland Hospital, and to access the continued provision of lower risk medical interventions and admissions
- In order to reliably meet the needs of patients across north Cumbria, over time, higher risk / complexity patients will need to be admitted to Cumberland Infirmary Carlisle, in some cases following stabilisation at West Cumberland Hospital
- This would mean the consolidation of some urgent care and acute medicine at the Cumberland Infirmary Carlisle site.

#### 7.3 Maternity Services

Both the Better Care Together and Together for a Healthier Future programmes have considered a range of scenarios for the sustainable provision of maternity services. Additionally, we have held joint clinical workshops with the two Strategic Clinical Networks serving north and south Cumbria.
and the clinicians working in our maternity services at both North Cumbria University Hospitals NHS Trust and University Hospitals of Morecambe Bay NHS FT to develop and share solutions.

We are currently working with NHS England to agree an independent review of the future configuration of maternity services, where possible supported by the relevant Royal Colleges. This will significantly inform how we take maternity services forward in the medium to long term.

8 Mental Health

8.1 Mental Health Strategy

Partner organisations across Cumbria are working to produce a comprehensive Adult Mental Health Strategy for October 2014, which will provide a fuller direction of travel for those services. An independent review of adult mental health services jointly commissioned by the CCG and local authority and delivered by Cumbria Partnership NHS FT working jointly with Cumbria County Council carried out by the Centre for Mental Health has further identified the service areas we need to improve. Two key commitments in the emerging strategy are:

We will develop:

- A comprehensive primary care treatment service as part of the development of Primary Healthcare Communities
- Integrated delivery between health and social care.

We will improve:

- Patient and Public engagement and experience
- The performance of our local recovery & rehabilitation services
- The performance of our NSF target services, particularly in access times
- The relationships with other services and agencies
- The consistency of service standards
- Our approach to improving the physical health of people with mental illnesses
- The relationship between resources and needs.

8.2 Access

We have a very high access rates to Improving Access to Psychological Therapies (IAPT) for patients with anxiety disorders, although waiting times can be far too long. Over time some of the First Step service will need to become fully embedded as a part of the Primary Care Community.

We know that access to services with severe and enduring mental health problems is less good. We will deliver a much improved access model, including clear exit planning for patients to return to primary care, and clear and easy re-entry to secondary care services. Similarly, we will need to make major improvements in the flow between home treatment and in-patient services.
We will develop a single point of access into specialist mental health services, providing:

- Assessment and Formulation
- Engagement
- Crisis Resolution at home and in inpatient settings
- Signposting
- Home treatment
- Brief interventions.

8.3 Psychiatric Liaison

There is substantial evidence that providing effective psychiatric liaison at scale delivers major benefits to quality and financial sustainability. Effective liaison enables Acute Trusts to meet the physical health needs of patients with mental health co-morbidities, including cognitive impairment in older people, much more effectively. Liaison also significantly reduces the utilisation of physical health urgent care services, particularly accident and emergency, by people with substance misuse, self-harm, and personality disorder, by enabling their needs to be met in a much more planned way.

We will further develop plans to significantly increase the provision of liaison services working in and out of the Cumberland Infirmary Carlisle and West Cumberland Hospital sites in north Cumbria, and Furness General Hospital and Royal Lancaster Infirmary for south Cumbrian patients. This will include resolving arising issues in providing a ‘cross border’ service for patients from Cumbria accessing services at Royal Lancaster Infirmary, to ensure consistent patient pathways are delivered reliably and efficiently.

8.4 Community Mental Health Services – Psychosis and Non-Psychosis Teams

Community mental health service (P&NP) teams will provide therapeutic interventions and Care Co-ordination services including:

- Dedicated Cognitive Behavioural Therapy (CBT), pharmacotherapy and care co-ordination response focused on supporting the recovery of people experiencing severe mood and anxiety complaints
- Dedicated Psycho Social Interventions, pharmacotherapy and care co-ordination response focused on supporting the recovery of people experiencing distressing psychotic complaints
- Rehabilitation/recovery functions, including employment, day care and leisure services aimed at supporting people to experience purpose, inclusion and meaning
- Dedicated dementia and frailty service for older adults
- Crisis resolution and home treatment services.

Additional dedicated expertise for specific presentations to support P&NP Teams will include:

- Personality Disorders
- Dual diagnosis (drug and alcohol)
- Eating Disorders
• First episode psychosis (early intervention)
• People with Learning Disabilities who have mental health problems
• Neurological Mental Health
• Autism and ADHD (see Learning Disabilities & Autism Strategy for further information).

8.5 Recovery and Inclusion Resources

Integral to the delivery of services will be the pooling together of recovery and social inclusion resources to support effective care co-ordination and promote mental and physical wellbeing.

At present significant resources are tied up in traditional rehabilitation services that are predominantly inpatient based. In order to deliver a comprehensive recovery service that emphasises rehabilitation in community settings it is planned that existing resources tied up in rehabilitation wards will be directed into more appropriate community based resources linked to individual service user needs.

It is fundamental to the principle of a person-centred approach to ensure the service user is seen as a person and not an illness. To facilitate this, the P&NP teams need to ensure they can support users to access a range of community-based services that will support them to remain engaged in activities of daily living and find meaning, purpose and connection in their lives. It will be the task of the care co-ordinator to support the service user in engagement with mainstream services, i.e. employment, housing, education and leisure. The recovery/inclusion resources will act as a ‘pick and mix’ menu of resources that can be drawn upon by the care co-ordinator and/or service user to ensure they remain engaged and socially included.

8.6 In-patient Services

Mental Health services should be organised on ‘least restrictive’ principles, whereby service users received treatment and care in an environment as close to the persons own home and the community as possible. Currently, we think that there are major opportunities to improve home treatment, thereby reducing the number of avoidable unscheduled admissions and also reducing the time patients spend in hospital.

As we improve the effectiveness of our primary care, access and recovery focused mental health services we will also consider the optimal way to configure in-patient services. Initially, we consider that a consolidation of in-patient care across less sites to be a principle that can be applied successfully in both the north and south of Cumbria. We will explore this further with service users, carers and service providers, including of the re-investment back into alternative local services that will be necessary to realise the benefits for patients and their families.

In north Cumbria this would potentially mean consolidating acute mental health inpatient services at the Carleton Clinic site in Carlisle. In south Cumbria this would potentially mean consolidating acute mental health inpatient services at the Dane Garth site in Barrow. Such changes would be subject to much fuller engagement with patients, public and stakeholders, and would require formal consultation.
8.7 Transition

Transition from children’s to adult services has for many years not been done as well as it should. It was highlighted in “Closing the Gap” and we plan to work with Children’s commissioners and CPFT to develop and programme of work to implement national directives and best practice. It has been agreed that as part of the “Earn back” for 2013/14 that CPFT will undertake this work.

9 Children’s Services

9.1 Developing a strategy for children and young people

Working in partnership, we are developing a Child Health Strategy 2014 -2019: Building Health with Children and Young People. The vision underpinning the strategy is that the children and families of Cumbria should expect support to be healthy through:

- Fair access to a range of support and services to prevent ill health, provide early intervention and when required have ready access to safe, sustainable high quality health services that are designed around their needs to achieve the best possible outcomes
- Integrated services delivered as close to home as possible, provided by a team of healthcare professionals working together in partnership with children, their families and other agencies.

9.2 Key objectives

The key objectives of the strategy are:

- To support children and young people to be healthy and safe by working with partners to strengthen prevention and early help
- To standardise quality and provide better health outcomes providing more focused and integrated services, including children with long term conditions and complex needs
- To develop and implement services to reduce unnecessary hospital attendance and admission
- To develop the whole system pathway to promote emotional resilience and good mental health
- To develop whole system patient feedback across services for children and young people
- To produce a workforce development plan that addresses the needs of the whole workforce
- To develop ways to effectively monitor and support continuous improvement.

Working in partnership with the wide range of agencies involved in the health, care and safety of children and young people, we are developing a model that will deliver the strategy outlined above.

The model will address the needs of all children including those who are acutely ill and the ongoing needs of children and young people with more complex needs and/or who are particularly vulnerable.
The services will be provided by integrated medical and nursing teams working across community and secondary care. The emphasis will be on supporting children and families in the home environment, with a renewed focus on assessment rather than admission. A smaller number of children will be admitted to hospital.

The basic service model is shown below:

![Figure 10: Children's Services model](image)

### 9.3 Prevention and early help

The importance of prevention and early help is a key priority and we are working together as commissioners and providers to support and deliver the prevention agenda and healthy child programme. We will continue to strengthen the partnership with Cumbria County Council children’s services to promote early help and the use of Common Assessment Framework (CAF) approach.

Safeguarding practice across the health economy will continue to improve within the Local Safeguarding Children’s Board (LSCB) partnership by embedding good practice and developing a culture of learning and continuous improvement.

### 9.4 Primary Care

Primary care will be central to meeting the needs of all children and young people and there is a need to have appropriate skills in place to enable this to happen. An advice and guidance service, established pathways of care, common assessment tool and outreach consultant presence will support primary care.
9.5 Unscheduled care

Children will access the same unscheduled care services as adults, including GPs, GP out-of-hours services, minor injuries and A&E. The specific requirements of the model in relation to children are detailed in *Standards for care of Children and Young People in emergency care settings* and cover the following areas: service design, environment, management of the sick or injured child, staffing and training, safeguarding in emergency care settings, mental health and alcohol substance misuse and major incidents involving children and young people.

When children are acutely ill and require services beyond primary care, GPs will contact a single point of access, where the decision will be made to ensure they receive their treatment in the right place first time. Access will be to an integrated children’s nursing team and/or short stay paediatric assessment (SSPA) service for children who require observation and treatment. The SSPA unit operating times will be defined through more detailed analysis of the patient flows. Those children needing care for longer than the short stay unit is in operation should be transferred to an inpatient unit depending on acuity of illness. Assessment and treatment of children and young people with mental health problems will be integral to the model.

9.6 Children with complex needs

Child Health Integration Centres will be based in the localities and will be fully linked to primary care, secondary care and the full health team. The centres will provide a focus for health professionals and partners to work together to ensure the right skills are in the right environment to provide high quality integrated services for children with a wide range of needs. This will include children with more complex needs such as children with disabilities and long term conditions, Children who are looked after and children with mental health problems. The centres will use single assessment, evidence based pathways and will develop the lead professional role to enhance quality services. Complex needs will be planned in partnership.

9.7 Integrated children’s nursing

The integrated children’s nursing function will develop so that it can both support children with long term needs as well as working with children who are acutely ill to avoid hospital admission or facilitate early discharge.

9.8 Child and adolescent mental health services

Work is underway to develop and implement a comprehensive multi agency framework for emotional health and wellbeing for children and young people. Within the overall model we will work with partners to reduce unnecessary hospital admissions for deliberate and non-deliberate self-harm. The transformation of tier three CAMHS will continue improving the quality of service, response to urgent and non-urgent need and supporting the whole system including supporting and training others.

9.9 Transition
There is also a need to develop services appropriate to the needs of young people as distinct from younger children and also to improve the transitions from adolescent to adult services. This is a theme that will run through the development of the model.

10 Population Health

We will work in partnership, though the leadership and accountability of the Health and Wellbeing Board, to move towards a health promoting system refocused on population health. This will include a focus on delivering the Cumbria Health and Wellbeing Strategy, which set out the importance of each of the following:

- Build a health and social care system based on good intelligence
- Use all available resources
- Involve our communities and the voluntary sector
- Recognise inequalities in all work programmes
- Ensure children get the best start in life
- Prioritise lifestyle improvement, particularly around obesity
- Integrated services and partnership working
- Promote mental and emotional wellbeing
- Good mental health is more than just the absence of mental illness.
- Mental health and physical health problems often coexist
- Improve services and contain mental health related costs
- Increasing numbers of people will live to a greater age with a number of long term conditions
- Support communities to remain independent
- Many more will suffer from dementia
- Build capacity through partnership working.

Importantly, our of Primary Care Communities will have much greater responsibility for their population, including working with partners such as District Councils, the third sector and others to address the wider determinants of health.

11 Patient Experience and Safety

11.1 Learning When Things Go Wrong

NHS Cumbria CCG has established robust systems for driving service quality from a commissioning perspective, led by the CCG Medical Director and Lead Nurse for Quality and Safety. We have developed strong dashboards, working collaboratively with local NHS Trusts and NHS England, and though our Governing Body Quality and Outcome Assurance Committee have strong governance for triangulating information and identifying underlying and interconnected trends. Working with each Trust, we are actively encouraging increased reporting of adverse events, particularly serious incidents, and are promoting a culture of continuous learning enabled by an improved approved to root cause analysis and meta-analysis.
11.2 Patient Experience

We have established a cross system group leading the work on improved capture and use of patient recorded experience and outcomes, including the family and friends test. This is reviewed by the NHS Cumbria CCG lay Governing Body lead for patient engagement, and along with very hard work at the front line in provider Trusts has driven a significant improvement in participation rates and the net promoter score in the family and friends test.

We have established a programme to introduce the iWantGreatCare patient experience system across a number of providers, including working with our GP Practices to use the system. iWantGreatCare is not the only system available, the important thing is that across all our providers we are capable of producing timely, well organised and presented data on patient experience.

11.3 Safeguarding

Our collective approach to safeguarding children is outlined in section 8.5.1. Additionally, we have strengthened our collective arrangements for adult safeguarding, as coordinated by Cumbria County Council and the NHS Cumbria CCG Quality and Safeguarding team. We will continue to embed safeguarding as a core part of all our staff roles.

12 Working with NHS England

12.1 General Practice

NHS Cumbria CCG will continue to have place a great focus on supporting the development of Primary Care as the key building block to successfully delivering our out of hospital model.

The CCG has provisionally expressed interest in formalising the role the CCG will play with NHS England. The outcome of that expression of interest will not be known until later in 2014.

12.2 Specialised Commissioning

Specialised commissioning services are subject to a national review by NHS England and are outside the scope of both the Better Care Together and Together for a Healthier Future strategies. There may be changes arising from the review which will impact on those strategies. We will continue to work with NHS England to ensure that the Cumbria population has appropriate access to high quality specialist services.

A key consideration is the delivery of cancer services. Radiotherapy is currently delivered only in Preston or Carlisle and many patients in south and west Cumbria (especially in the Furness area) are unable to access the service within the 45 minute standard set by NHS England on the advice of the National Radiotherapy Advisory Group. Access within 45 minutes is known to impact on access and uptake.
The former Cumbria PCT was in positive discussions with North Lancashire PCT, UHMBT and Lancashire Care Trust to develop a business case to deliver radiotherapy at Westmorland General Hospital in Kendal. This decision is now on hold with NHS England pending a national review. The Better Care Together partners support the campaign to provide radiotherapy at Kendal and would strongly urge NHS England to prioritise the resources necessary to establish a sustainable centre at Westmorland General which will ensure all our residents can access high quality care within national standards and which can be a beacon of excellence for cancer care in the wider sub region.

In north Cumbria we will work with NHS England to secure radiotherapy services at Carlisle, including the investment in new Linear Accelerator. We will also work with NHS England to secure the long term, high quality, local provision of clinical oncology in north Cumbria through a well governed clinical network with a specialist Trust delivering services in our local hospitals. Our collective ambition is to achieve a clinically sustainable services, which adhering to recognised standards and delivering excellent outcomes.

It is likely that further developments involving specialist providers delivering more services in our local hospitals may also be beneficial across a number of specialisms.
Section 5   Finance, Activity and Outcome Trajectories

1   Outline Financial Strategy

We will be constantly refining this financial strategy to enable the delivery of the Better Care Together and for a Healthier Future programmes. This outline financial plan has essentially been developed on an ‘as is’ basis, and will be iterated to fully support our transformational changes over time.

1.1   Principles

Over the period 2014/15 – 2018/19 our financial strategy is based on:

- Ensuring the whole system moves towards and then sustains financial balance over a credible time period
- Achieving an optimal deployment of resources to enable the most effective and efficient models of clinical care
- Provides the financial resources to enables the delivery of sustainable services for the population
- Facilitates a planned reduction in the reliance on distress funding by local NHS Trusts.

To achieve this will require the delivery of the service models described in this strategy, and in the more detailed plan for north Cumbria, Together for a Healthier Future, and the Morecambe Bay geographical area, Better Care Together. This will include an increased investment in the out of hospital model, and a reduced reliance on the hospital sector although it should be acknowledged further detailed assessment is require to develop more detailed costings below the “headline” figures. In addition, the CCG considers that potentially alternative contracting models to those currently used in the NHS may be appropriate to manage system risk more effectively and incentivise both commissioners and providers to ensure financial sustainability is maintained.

Where beneficial to the whole system, we will explore the potential benefits of local pricing modification within the context of affordability and the available resource envelope in Cumbria.

1.2   NHS Cumbria Clinical Commissioning Group Allocation

The financial strategy is predicated on the national planning assumptions for CCG allocations and commissioning responsibilities. Any significant changes to either of those assumptions will clearly impact on the financial strategy. It is noteworthy that the current allocation formula does not reflect the impact of rurality and remoteness, and hence the impact on access and cost of service provision that is a very significant for Cumbria.

1.3   Acute Trusts

In 2014/15 the investment in both North Cumbria University Hospitals NHS Trust and University Hospitals of Morecambe Bay NHS FT includes significant non-recurring resources, for example to support the Trusts in delivering the 18 week referral to treatment standards and it is assumed
therefore that these requirements will be reduced in 2015/16 (i.e. Investment and activity levels, overall, will be similar to 2013/14).

From 2016/17 onwards, the planned investment is based around an increase in activity, driven by demographic pressures, which is greater than the planned tariff deflator reduction. This means that the Trusts will have marginally increasing income, within which to meet increased demand and inflationary pressures (i.e. based upon the current model of services). A similar approach has also been used in assessing activity and costs outside Cumbria. This will be reviewed each year, particularly in light of the significant changes to activity that we aspire to deliver through our developing clinical models.

1.4 Cumbria Partnership NHS FT

The investment in the Trust will be on a ‘flat cash’ basis, meaning that the commissioner will provide an additional investment to address increased demand from demographic growth equal to the planned tariff deflator. This is part of our commitment to increase the investment in community services, and to ensure parity of esteem for mental health and learning disability services, in each financial year the investment in the Trust will be held constant. This is prior to any further potential deployment of investment resources to address the impact of the strategic change and transformation of “out of hospital services” through our developing clinical models.

1.5 Continuing Health Care and Packages of Care

The total cost of continuing healthcare and packages of care is forecast to increase by c13% by 2018/19 from the planned 2015/16 level. This reflects the trend for cost growth currently experienced less the efficiency savings we can deliver for example through more effective procurement. It is assumed that the impact of legacy CHC provisions from PCT’s are fully covered through the arrangements made in 2014/15 by NHS England.

1.6 Prescribing

The forecast prescribing cost is based upon net underlying growth experienced for Cumbria over the preceding years, and the marked increase in prescribing costs shown in the most recent indicators, but also reflecting the fact the Cumbria is already identified as a relative efficient level of prescribing spend. This includes a 1.7% growth in 2015/16 from the 2014/15 baseline, and growth in all subsequent years rising to 2.5% in 2018/19 from the forecast 2017/18 investment reflecting both demographic pressures and that the scope for efficiency is diminished over time.

1.7 New Investments

NHS Cumbria CCG plans to make a £4M investment in predominantly community based services in 2014/15. Those investments will continue on a recurring basis, subject to evaluation, though the Better Care Fund in 2015/16. The CCG plans to make additional investments in 2016/17 of £0.6M, rising up to £4M by 2018/19. This resource, alongside the opportunities through the Better Care Fund of at least £4M recurring, provides our some planned investment in the service models required by this strategy along with funds to manage other known pressures such as re-establishing NHS111 as an effective service. The CCG will additionally seek further cost improvement opportunities in both its commissioning of services and against its running cost.
allowance, to generate additional resources to offset any unforeseen cost pressures, and to mitigate the risks of the broader financial assumptions outlined above.

2 Outline Activity Plan

The table below shows our overarching activity planning assumptions for all providers at aggregate level across 2014/15 – 2018/19

<table>
<thead>
<tr>
<th>ALL PROVIDERS</th>
<th>14/15</th>
<th>15/16</th>
<th>16/17</th>
<th>17/18</th>
<th>18/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective Admissions - Ordinary Admissions</td>
<td>2.14%</td>
<td>-1.82%</td>
<td>-1.85%</td>
<td>-1.90%</td>
<td>-1.94%</td>
</tr>
<tr>
<td>Total Elective Admissions - Day Cases (FFCEs)</td>
<td>2.82%</td>
<td>0.63%</td>
<td>0.63%</td>
<td>0.62%</td>
<td>0.62%</td>
</tr>
<tr>
<td>Total Elective FFCEs</td>
<td>2.67%</td>
<td>0.10%</td>
<td>0.10%</td>
<td>0.09%</td>
<td>0.09%</td>
</tr>
<tr>
<td>GP Written Referrals (G&amp;A)</td>
<td>-0.76%</td>
<td>0.56%</td>
<td>0.42%</td>
<td>0.54%</td>
<td>0.64%</td>
</tr>
<tr>
<td>Other referrals (G&amp;A)</td>
<td>-0.52%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>Total Referrals</td>
<td>-0.69%</td>
<td>0.40%</td>
<td>0.30%</td>
<td>0.39%</td>
<td>0.46%</td>
</tr>
<tr>
<td>Non-elective FFCEs</td>
<td>-1.24%</td>
<td>-0.84%</td>
<td>-1.42%</td>
<td>-1.75%</td>
<td>-1.90%</td>
</tr>
<tr>
<td>All First Outpatient Attendances</td>
<td>-0.24%</td>
<td>0.38%</td>
<td>0.29%</td>
<td>0.37%</td>
<td>0.44%</td>
</tr>
<tr>
<td>First Outpatient Attendances - following GP Referral</td>
<td>-0.10%</td>
<td>0.57%</td>
<td>0.43%</td>
<td>0.55%</td>
<td>0.65%</td>
</tr>
<tr>
<td>All Subsequent Outpatient Attendances (G&amp;A)</td>
<td>-1.65%</td>
<td>-0.18%</td>
<td>-0.14%</td>
<td>-0.18%</td>
<td>-0.21%</td>
</tr>
<tr>
<td>A&amp;E Attendances - All types</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
</tbody>
</table>

Figure 11: Activity planning assumptions

2.1 Trajectory Assumptions

The activity Trajectories for 2014/15 – 2018/19 have been based on a number of assumptions. Most importantly, the assumptions do not take account of the activity changes that will result from the implementation of the Better Care Together and Together for a Healthier Future strategic plans. Rather, they have been prepared on an ‘as is’ basis, and include service changes already at the implementation stage. As such, the assumptions will need to be revisited and will be subject to ongoing iteration.

The current assumptions include:

- The impact of Demographic Growth on demand
- Activity required to achieve sustainable 18wk RTT positions
- Growth in Referrals; coding and counting changes
- The impact of planned some Service Developments and Avoidable Admissions reductions, but not our overall transformational actions
- The ongoing increase in day case rates
- The Reduction in outpatient follow-up appointments.
2.2 2013/14 Baselines & 2014/15 Trajectories

2013/14 baselines have been based on month 8 forecast outturn MAR figures. In 14/15 an adjustment has been made to account for a data quality issue at NCUH, specifically, in 13/14, NCUH has included specialist activity within NHS Cumbria CCG figures, the Trust intend to correct this from 14/15 onwards and therefore the 14/15 activity reflects a significant reduction in activity to reflect this. Even taking this into account, there is still a significant difference in the volume of Elective Day case admissions in the MAR figures compared to the contract values (MAR is about 3500 admissions higher than the contract baseline), this is likely to be a coding issue between Day Case and outpatients that has been corrected within the contract figures, however, this is still to be investigated by the Trust and CCG.

Detailed assumptions were applied in the 14/15 contracts and the 14/15 activity plans align directly with the forecast change in activity in the contract plans. It should be noted that MAR baselines are not directly comparable to contract baselines due to differences in definitions.

2.3 2015/16 – 2018/19 Trajectories

For 2015/16 onwards, slightly broader assumptions were applied as below.

**CPFT & Out of county providers** – Activity remains static over the 4 years as service developments in other parts of the system cancel out the impact of demographic growth.

**NCUHT & UHMBT** – the following assumptions have been applied from 15/16 onwards:

- The impact of **demographic growth** – estimated by a local activity model – although this has not been applied to non-GP referrals.
- **Service developments** in Elective reducing the impact of demographic growth
- A shift from Elective Ordinary to **Day Case** activity
- A **reduction in Outpatient Follow up** attendances to keep the total number of outpatient attendances static.
- Reductions in the rate of **Avoidable admissions** in line with plans based on the implementation of the Any Town Interventions. It is expected that these interventions will reduce Avoidable emergency admissions by 12% over the 5 years.
- Stabilisation and reduction in all **other non-elective admissions** through the implementation of the Any Town interventions and other transformation programme interventions over the next 5 years. It is expected that these interventions will reduce all other emergency admissions by 1% plus the impact of demographic growth at each provider.

It is also expected that there will be a shift from Day Case Activity to Outpatients (as Outpatients with Procedure). However, this shift has not yet been quantified but is likely to be significant over the five years.
3 NHS Outcomes Framework

Our current performance in relation to the NHS Outcomes Framework is shown in Section 3, The Case for Change earlier in this document.

Measuring and publishing information on health outcomes helps drive improvements to the quality of care people receive. The White Paper: Liberating the NHS outlined the Coalition Government’s intention to shift the NHS from a focus on process targets to a focus on measuring health outcomes. Indicators in the NHS Outcomes Framework are grouped around five domains, which set out the high-level national outcomes that the NHS should be aiming to improve. The domains focus on improving health and reducing health inequalities, namely by:

- Preventing people from dying prematurely (Domain 1)
- Enhancing quality of life for people with long-term conditions (Domain 2)
- Helping people to recover from episodes of ill health or following injury (Domain 3)
- Ensuring that people have a positive experience of care (Domain 4)
- Treating and caring for people in a safe environment and protecting them from avoidable harm (Domain 5).

The NHS Outcomes Framework, alongside the Adult Social Care and Public Health outcomes frameworks, sits at the heart of the health and care system.

NHS Cumbria CCG has worse outcomes that national benchmarks in several of the key outcome framework indicators, including premature mortality from Cardiovascular Disease (CVD), respiratory disease and Cancer, unplanned hospital admissions for ambulatory care sensitive (ACS) conditions, for asthma, diabetes and epilepsy in under 19s and for acute conditions that should not usually require a hospital admission. Therefore the levels of ambition for improvement in these outcomes over the next five years is higher than for those where Cumbrian patient are currently achieving better outcomes than national benchmarks.
Section 6  Our Delivery Arrangements

1 Governance for Implementation

We know that good implementation is much more important than a good plan. We have previously fallen short in successfully delivering our plans. To ensure that we are successful this time, we will work together in a well governed, structured way to collectively agree service changes and to collectively manage the system risks and maximise the system benefits, including:

- Continuing the Cumbria Health and Care Alliance providing Chief Executive and Medical Director overarching leadership to support an integrated system across all of the county
- Continuing the Together for a Healthier Future Programme Board as the main driver of senior cross organisational leadership to ensure delivery
- Continuing the Better Care Together Programme Board as the main driver of senior cross organisational leadership to ensure delivery
- Ensuring there is an ongoing programme of patient, public and stakeholder engagement so that their views inform any proposed changes and future developments.

2 Roles and Responsibilities

The Cumbria Health and Care Alliance will provide the overarching point of strategic leadership for the whole Cumbria system, holding the ring on how we take forward our plans and solving problems together as they emerge. The Alliance will also ensure that consistent principles are applied in both the Better Care Together and Together for a Healthier Future programmes.

The two Programme Boards will form the formal governance for the delivery of the Better Care Together and Together for a Healthier Future programmes, ensuring that the programmes are delivered effectively and that appropriate actions are taken if implementation begins to fall behind plan.

Within each of the programmes, there are clear responsibilities as we move beyond detailed planning. This will mean two distinct elements to each programme, commissioning the new system of care, and providing the new system of care. We will develop robust arrangements to respond to both these elements, and critically to ensure that they continue to be connected as we all work collaboratively to ensure we deliver our collective ambitions for the population.

3 Further Work

This strategic plan provides an overarching statement of our direction at a particular point in time. We will undertake much more detailed work, particularly during July – September 2014, to further develop our service models.

We also recognise that as we move towards more defined proposals, we will fully respond to our duties to undertake appropriate engagement and where appropriate public consultation.