West North & East Cumbria

Sustainability and Transformation Plan

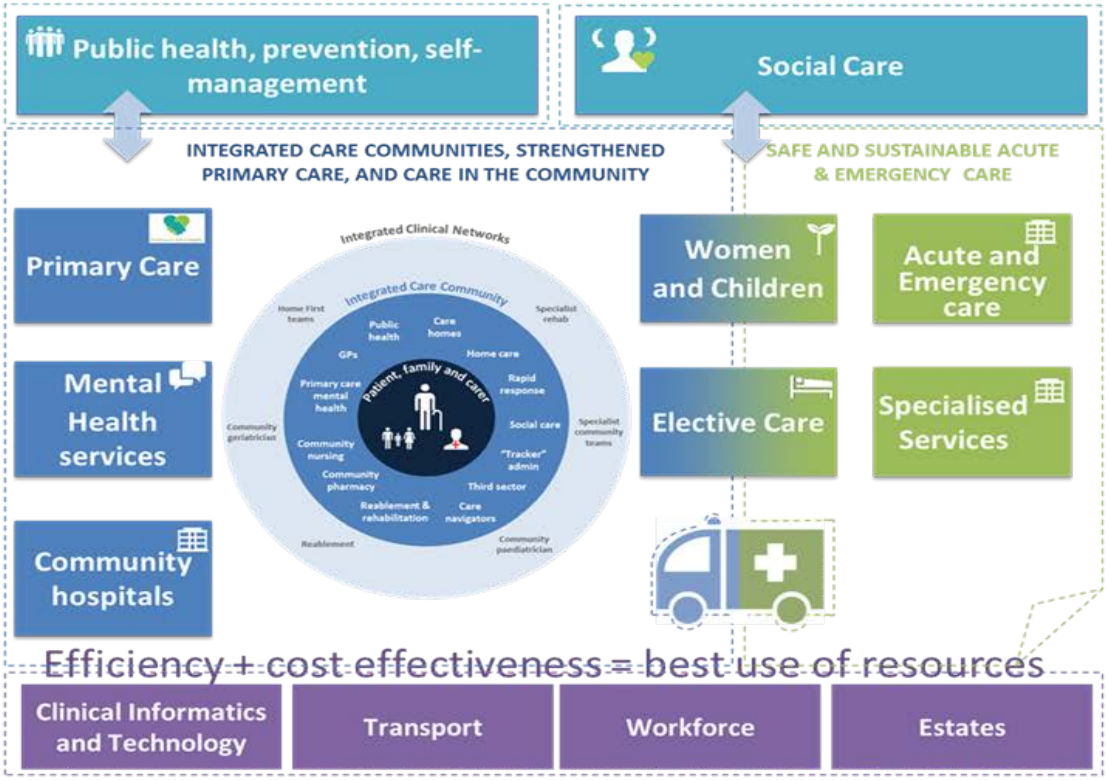
2016-2021

Organisations within footprints:

- Cumbria Clinical Commissioning Group (CCG) – whole county
- Cumbria County Council – whole county
- Cumbria Partnership NHS Foundation Trust – whole county
- North Cumbria University Hospitals NHS Trust – North Cumbria
- North West Ambulance Service – whole county and beyond
- Primary Care Organisations – Localised
- Tertiary and Network Providers (Newcastle Upon Tyne Hospitals NHS Foundation Trust, Northumbria Healthcare NHS Foundation Trust, Dumfries & Galloway Health Board)
- Healthwatch Cumbria,
- Health Education England
- NHS England (specialised commissioning),
- Community & Voluntary Sector partners

WNE Cumbria Sustainability & Transformation Plan (STP)

Integrated health and wellbeing system and clinical service strategy



A cohesive system working with communities to deliver aligned intentions

Communication, Engagement & Participation

System Governance & Accountable Care

System Enablers

Healthy & Well COMMUNITY

STP High Impact Themes	Benefits for citizens and patients
1	Prevent illness and empower people to be independent
2,3,4	Strengthen and invest in local primary care, social care and community care
5	Deliver the A&E and ambulance standards and make urgent and emergency care more accessible. Tangible improvements to cancer services Improve the quality of all hospital services including maternity
6	Tangible improvements to mental health services

Integrated Health and Care Services
+
Aligned Incentives & Behaviours
+
Mobilised Community, Place and Individual Resources
=
New Population Health System

STP Outcomes

1. Improved Population Health and Wellbeing
2. Improved Quality of Services
3. Financially Sustainable Services
4. A Continuously Improving System

Table of Contents

1. FOREWORD FROM STEPHEN EAMES, SUSTAINABILITY & TRANSFORMATION PLAN LEAD, WEST NORTH & EAST CUMBRIA

In developing this plan we have come together as cohesive partners to set out our vision and plans for the people of West North & East (WNE) Cumbria to enjoy improved health and wellbeing underpinned by health and care services that are sustainable and effective. In doing this we have set out how we will most effectively use the resources available over the next five years to reduce our financial challenge. We know that this will require a transformation of services and more effective relationships between all parts of our health and care system and our local communities. The transformation we are planning is far reaching and will be achieved through cohesive and tenacious implementation across all partners.

In developing this plan we have taken the opportunity to go further and deeper in our analysis and understanding of the key gaps we need to address in health and wellbeing, care and quality and in our finances.

Our success will require strong partnerships with the people of WNE Cumbria as we seek to empower and share responsibility for health and wellbeing with individuals, communities and local services. We plan to enable people to be as independent and with as much choice and control as possible. Demonstrating parity of esteem across all groups in our society we are prioritising good mental health for all in our plans. Whilst we have more work to do to refine our plans we have undertaken widespread engagement with communities, staff and health and care organisations and commenced public consultation in September, this has commenced a fresh conversation with people on the scale of our ambitions, some key changes that are required and our need to both rapidly adopt best practice and be at the forefront of innovation in the delivery of integrated health and social care for rural and dispersed communities.

> *The Sustainability and Transformation Plan (STP) has been developed to address three key priorities; Population Health & Wellbeing, Service Quality and Sustainability. We have based this STP on a new local health and wellbeing system led by the local authority and a new and more comprehensive clinical service strategy led by the NHS. All partners are working actively to deliver the Health and Wellbeing strategy for Cumbria. In line with statutory duties Cumbria CCG are formally consulting the public about proposed NHS service changes in WNE Cumbria. Cumbria County Council are scrutinising the proposals contained within the public consultation in accordance with their statutory duty to do so and the Council will also be formally responding to the consultation.* ***The development of this STP plan and submission as required within nationally set timescales in no way prejudges or predetermines the outcomes of the consultation that is currently underway or the local authority's position (now and in due course) on the consultation and the service changes that are proposed.***

As such, we are keen to emphasise that the proposals in our STP will be refined and improved through future engagement, consultation, scrutiny and partnership based agreements with Cumbria County Council and local authorities as we move forward. The plans set out in this document are all subject to these well embedded governance processes and we intend for our STP to be fully tested and refined through these as we move forward.

Fig 1: West, North & East Cumbria STP footprint

2. OUR VISION

We have a vision of the future;

- Everyone in WNE Cumbria having improved health and wellbeing and there will be reduced health and wellbeing inequalities across our communities.
- Recognised service excellence for people living in rural, remote & dispersed communities with outstanding provision of integrated services.
- A range of safe and sustainable local services linked into vibrant wider regional networks.
- An economically viable health and social care community with a track record of delivery.

Our vision is based on radically improved care models and relationships with the people of WNE Cumbria that empower, enable and support them to play an important part in their own health and wellbeing and the success of local health and care services. The county's health and social wellbeing system will provide a foundation for our approach and our health and care services will be proactive and responsive; right care, right place, right time. By 2021 we aim to have achieved an improvement in health and wellbeing, safe and cost effective care, treatment and support. Most fundamentally we will have created a new partnership with service users and wider communities in which we promote independence and self-care as part of delivering more care in home based settings. Our model of integrated care will support our workforce to grow and develop in their roles and careers – and to stay in WNE Cumbria. It will also attract new staff to help meet recruitment and retention challenges.

Source: Cumbria Health & Wellbeing Strategy 2016- 2019

Our STP, builds on the Cumbria Health & Wellbeing Strategy 2016- 2019[1] (H&WBS), it brings together organisations across health and social care to work on a shared agenda to transform care in WNE Cumbria over the next five years, in line with the *NHS Five Year Forward View*. By 2021, through delivering on our high impact changes we can expect to see a radically different care system which improves the quality of people's lives by promoting independence and a new partnership between people and care professionals. There are two principles, outlined in H&WBS and below, on which our plans are based which we will seek to make the biggest differences:

1.) New Population Health System

We are planning for the whole of the WNE Cumbria population. This shift in relation to systems rather than organisations is crucial because of the complex range of influences on people's health and wellbeing. While integrating services is important we know this must be part of a broader focus on promoting health and reducing health inequalities across whole populations. In WNE Cumbria, our ambition is to build a population health system which consists of integrated health and care provision; communities mobilised at scale for health and wellbeing, operating within a new set of system incentives and behaviours, shown in the diagram left.

This new system will have a greater focus on helping people take responsibility for their own health; on prevention; on the social conditions that affect health and wellbeing; on people who are at high risk of needing social and/or health care; and more integrated working between all parts of the health and wellbeing system.

[1] http://www.cumbria.gov.uk/publichealth/

New models of delivering health and social care are being developed that will create the right incentives for the whole system to focus on keeping individuals, families and communities healthy, and to develop and grow capacity in community based services, while maintaining services for those with complex needs. These new models of care will lead to the establishment of commissioning based on capitated budgets – to enable a shift from outputs to outcomes – and the increased integration of health and care including accelerated pooling of health and care budgets. Behaviours need to change around every bit of the system - primary care, social care, care homes, hospital care, community care, public health, third sector, support services and system leadership. We identify high potential benefit from a move to new models of place based system governance and are actively exploring this for the future.

2.) Mobilising individuals communities and places

Changing the way health and care organisations work and investing in early intervention and prevention is not, by itself, enough As part of a radical service re-design, activity needs to move towards services that support people to develop the skills to help themselves – for example, life skills, confidence and self-esteem, and the ability to take control of their own lives. This requires enabling a fundamental cultural shift away from public services being seen as delivery agents to a passive population, to the creation of a system where everyone 'does their bit' and where everyone plays their part in looking after their own health and being good neighbours to people who are struggling.

This will require development within the wider locality based public realm and civic society and a new way of working based on four complementary concepts:

- Asset-based –builds on existing assets.
- Place-based – works in the neighbourhood as the space in which networks come together and shared interests are negotiated and acted on.
- Relationship-based – creates the conditions for reciprocity, mutuality and solidarity.
- Citizen-led, community-driven – empowers individuals and communities to take control of their lives

Increasing assets within communities and enabling individuals or communities to access these increase their individual and collective resilience. It turn, increased resilience brings direct benefits to mortality, health behaviour, quality of life, as well as education and employment. By increasing resilience and self-help we can reduce demands on the formal health and care system.

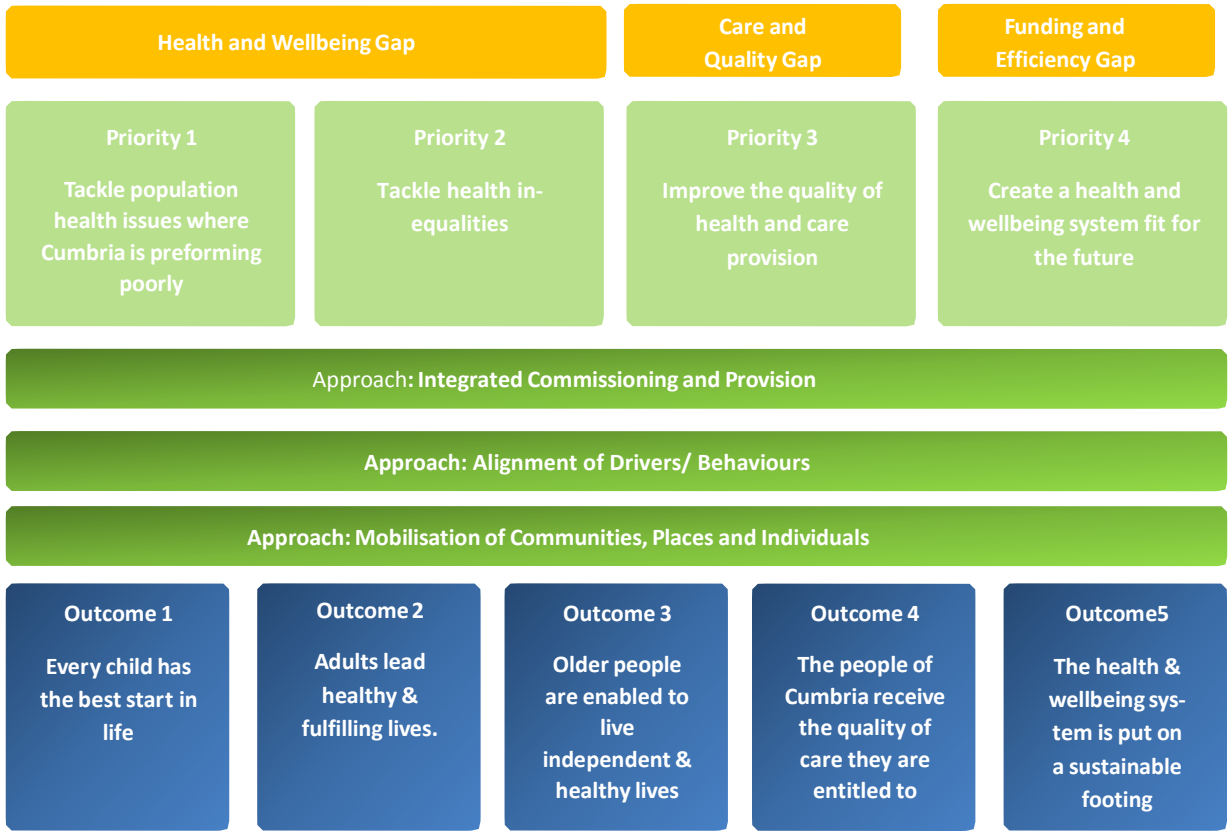
Fig 2: Four complementary concepts for mobilisation

Source: Cumbria Health & Wellbeing Strategy 2016- 2019

Overall our STP is ambitious - as we know our gaps are already unacceptable and services unsustainable. In order to meet the challenges, and building on the existing programmes, four priority areas of activity have been identified. We will:

- Tackle population health issues where WNE Cumbria is performing poorly
- Tackle health inequalities
- Improve the quality of health and care provision.
- Create a health and wellbeing system fit for the future.

Our STP is therefore based on realising the agreed health and wellbeing strategy and addressing clear priorities through a programme of integration and joined up implementation across the relevant organisations. Our STP governance ensures and reflects the breadth of leadership required to form and deliver our ambitious plans and realise the vision of the future.



Source: Cumbria Health & Wellbeing Strategy 2016-19

3. WNE CUMBRIA; THE PEOPLE AND PLACE

People

Our STP is focused on our entire population from birth to the end of life. The total population of WNE Cumbria is approx. 327000 (resident population) and geographically, is defined as the districts of:

- **Allerdale.** 96,471 residents.
- **Copeland.** 69,832 residents of which approx. 8,400 are in Lancashire & South Cumbria STP area.
- **Carlisle.** 108,022 residents.
- **Eden.** 52,630 residents.

WNE Cumbria represents c.65% of the wider Cumbria population.

There is an ageing and more deprived population than the national picture. These differences can be expected to grow in the future based on current projections. The fast growth of the over-65s population brings particular challenges to the sustainability of the health and care system with the average spend per head on this group significantly higher than any other age group. Without action this will add considerable pressure into the system, particularly around care for those with long-term conditions (LTC) and dementia. There are differences in the rates of occurrence of disease between different groups which lead to substantial inequalities in health in our population. Further details on our populations, including the impact of the growing numbers of younger people, are available in our Joint Strategic Needs Assessment.[2]

Given the increasing and changing needs of our population's health and social care, we recognise that the current system is unsustainable without transformational change. Our health and social care economy is facing a very clear set of challenges. Our most pressing challenges are:

- An ageing population, with more people needing more care.
- An increasing proportion of life spent in ill-health.
- Patterns of poor health and unhealthy lifestyles linked to deprivation, particularly around Carlisle and the west coast towns.
- Ongoing and increasing demand for acute hospital admissions as a default response to urgent care needs, resulting in a saturated bed system.
- A rising demand for mental health support particularly linked to significant health inequalities.
- People's rising expectations around the quality and location of care.
- Financial deficits across local healthcare providers and commissioners and local social care facing significant decreases in funding available.
- Significant future saving requirements for local authority social care and public health services over the next five years.

There are some opportunities arising through developments in the local area that are potentially relevant to the solutions to our challenges. These include major infrastructure investments in the nuclear industry, supported by housing developments and potentially transport improvements.

Place

WNE Cumbria is one of the most rural counties in England, averaging a population density of 74 people per sq.km (Eden having lowest at 25 people per sq. km). Despite its rural nature a third of WNEs Cumbria's population c100,000 people, live in and around the city of Carlisle a World Health Organisation healthy city since 2009. The other major conurbations are the adjacent towns of Workington and Whitehaven, with populations of roughly 25,000 people, and are located on Cumbria's west coast. Despite their population size these towns are geographically isolated (removed from essential services and transport links) being 39 and 30 miles respectively from Cumbria's largest urban centre Carlisle and 100 miles from Newcastle (the nearest Metropolitan City) and it's specialised NHS services.

[2] http://www.cumbriaobservatory.org.uk/health/JSNA/2015/homepage.asp

WNE Cumbria's isolated and scarcely populated geography means higher travel times and additional difficulties in providing care, (the population density is 80% lower than the national average and travel times to a GP are twice the England average). Additionally, our population is swelled by millions of people who visit the Lake District National Park each year.

In many other areas this number of people would be served by just one hospital. Our big geographical footprint, sparse population and geographically isolated communities means we have to stretch the available resources to operate across two main hospital sites, the Cumberland Infirmary in Carlisle and the West Cumberland Hospital in Whitehaven. Importantly sometimes we need to duplicate services to ensure equity of access particular for those people who live in some of WNE Cumbria's more deprived and socially isolated communities e.g. if services were only provided at Cumberland infirmary, 45% of people in WNE Cumbria would need to travel over 60 minutes to access services and 20% over 90 minutes.

Our relative isolation and small team sizes also mean we often have difficulty recruiting to secondary care roles, with NCUHT at present heavily reliant on locum cover at premium cost and meaning that our services are very fragile and do not always achieve continuity of care for people or have the right leadership to support improvement. This conflict between balancing the need for localism with the economies of scale needed to provide safe care and good patient outcomes within our means is an ever present challenge and one that only a whole system approach can address. These practical and further reputational issues have an impact throughout our health and care system: there is a need to work together to successfully achieve this balance with a clear vision, plan and credible implementation. In order to positively change we have identified in our STP a mix of innovative, radical, contentious, evidence based proposals including some difficult decisions we believe are essential for the future.

Key principles

There are a number of principles that our STP is using as a basis for large-scale transformation and a move to more sustainable services for the people of WNE Cumbria. These principles apply equally to people of all ages and those with mental and physical care needs. These include:

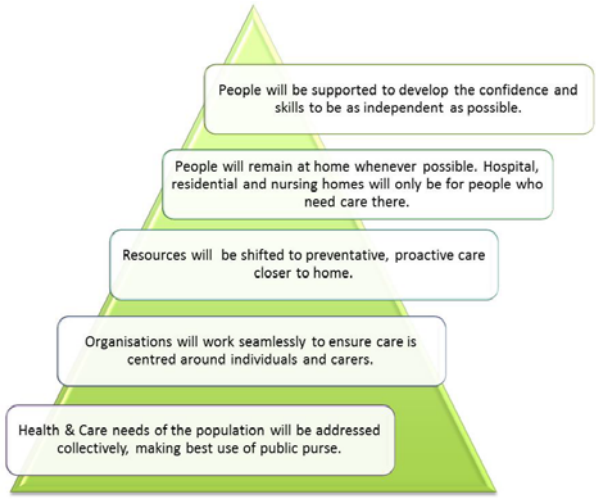


Figure 3: Our key principles

The foundations of lifelong health for our population involve tackling risks to health such as obesity, smoking, substance misuse, and poor sexual and mental health. These are commonly established in childhood and adolescence therefore it is essential that preventive activities supporting children and families are prioritised.

4. THE DEVELOPMENT OF OUR PLAN

WNE Cumbria has developed its STP based on;

- Cumbria's Health and Wellbeing Strategy
- WNE Cumbria Success Regime
- Links with specialist regional services and clinical network partner organisations.

We have developed our STP with a view to the long term, whilst being rooted in the immediate improvements we are committed to deliver. We have therefore utilised both the democratic mandate and value of the pre-existing Cumbria Health and Wellbeing Strategy and the intense and supportive WNE Cumbria NHS Success Regime process, all subject to well established Overview and Scrutiny processes.

Through these we have been able to draw on a wide breadth of social care, public health and health service based insights including;

- The public and patients
- Communities and community based organisations
- Professionals in public health, clinical care and social care
- Leaders and Board/Governing Bodies across relevant statutory sector organisations.
- Expert external advice, research and evidence based practice

Our STP has been developed through these pre-existing governance mechanisms wherever possible and is based on strong ambitions to establish effective and cohesive local system leadership governance into the future to oversee implementation and in due course to look beyond the STP to the longer term. Annex A shows the STP governance used to develop our STP and we describe below the forward governance arrangements we have agreed.

With this in mind the STP has been developed concurrently with the consideration of potential system development towards Accountable Care models. All organisations have commenced discussions and intend to follow a shared process to take forward an options appraisal to consider the case for new organisational arrangements. These discussions will ensure form follows function so that we identify the best way to ensure our organisations support the integrated delivery and commissioning agenda within our statutory powers and current legislative/regulatory frameworks. We expect a forward road map for this work to be agreed collectively in advance of March 17.

Locally we have established the following to enable our STP to be constructed;

- STP lead CEO (from local CEO cohort)
- STP Coordinating Director (from local Director cohort)
- STP CEO leadership Group (Local NHS CEO's + County Council CEO, DASS, DPH, Success Regime)
- STP Coordination Group (NHS Orgs + Social Care + Public Health)

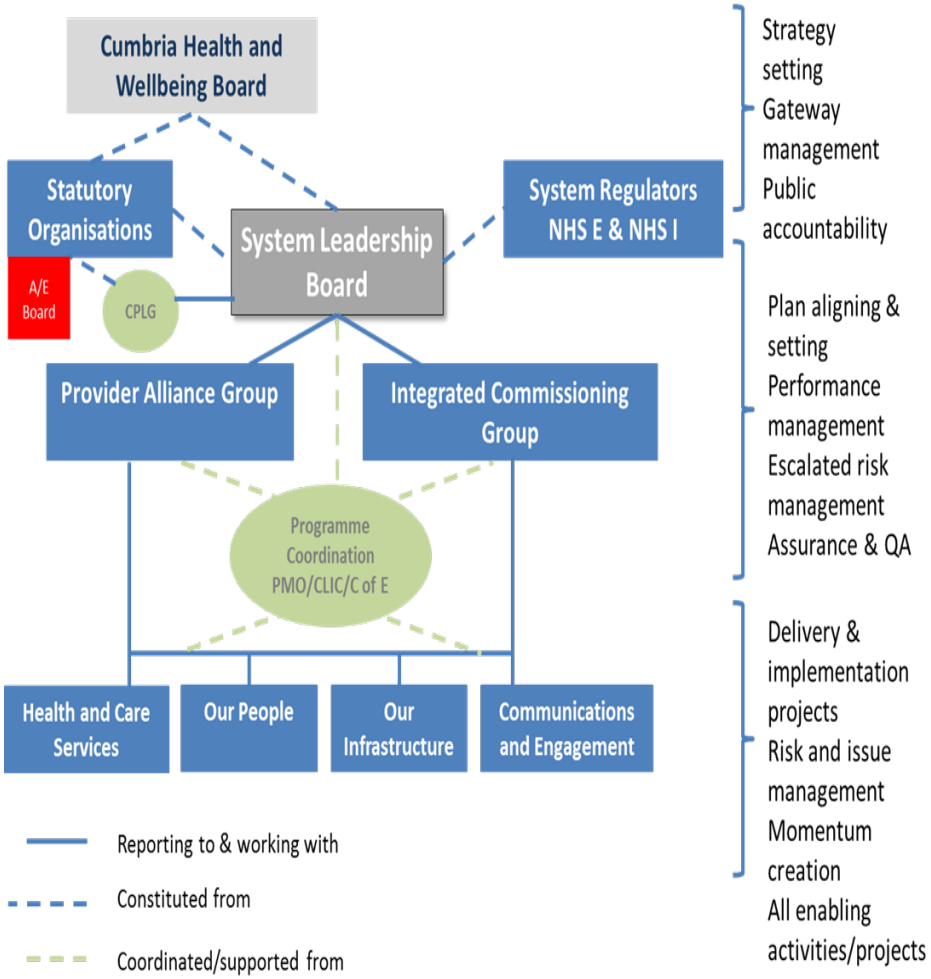
To govern our STP from planning to delivery phase we have agreed to work within a system governance and leadership structure. This structure is being implemented from 1st October 2016;

To make this governance structure live we have established Chair and vice Chair arrangements for our Systems Leadership Board that utilise the Success Regime and STP leadership. We see this as transitional so that STP leadership takes over from SR leadership in due course.

We have identified Sponsoring CEOs for our key work areas within this structure and have in place and planned for the future a clear programme delivery leadership approach utilising PMO support and Senior Responsible Officer arrangements.

We have agreed this approach to ensure all local leadership capacity is cohesive and aligned to deliver the ambitions in our STP.

Fig 4: Agreed STP Governance Arrangements



5. OUR ANALYSIS OF THE GAPS AND ASPIRATIONS

The *NHS Five Year Forward View* set out three 'gaps' – health and wellbeing, care and quality, and finance and efficiency. This section sets out the local analysis of these gaps and our aspirations to close the gaps. We also set out our challenge against a fourth "gap" – culture, mind-sets and behaviours.

Our STP has been informed by the thorough work undertaken within the WNE Cumbria Success Regime. Transformation plans have been co-produced with clinicians and professionals from within WNE Cumbria listening to what people have told us to determine what our gaps are, and how we intend to measure improvement using the following steps:

- Where the system is below national average, the aspiration is to reach national average.
- Where the system is close to national average, the aspiration is to reach the top 25%.
- Where the system is close to the top 25%, the aspiration is to reach the top 10%.
- Where the system is close to the top 10%, the aspiration is to stay there.
- In other cases, there is a specific note explaining rationale for that area.

This process has highlighted the need for more robust measurement of system performance which is a forward development ambition in our plan.

We have detailed our Performance Trajectories for key areas in Annex H.

Health and wellbeing gap

Gaps: Our population is "super ageing", with a higher than average growth in the proportion of older people year-on-year compared to the rest of England. By 2020, nearly 25% of the Cumbria population will be aged over 65. Whilst living longer is good news, this clearly has an impact on our health and care services particularly as living longer can also often mean living with a complex need, frailty, long term conditions and/or dementia. Our analysis shows we utilise institutional care settings more than other parts of England.

WNE Cumbria's overall performance on a range of health and wellbeing indicators disguises significant inequalities at district, lower layer super output area (LSOA) and ward level. The gap in life expectancy between the most and least deprived areas in Cumbria is 9.5 years for men and 7.3 years for women, in some wards this is 8.4 years below the national average and is not decreasing. Copeland is the second most deprived district in the county, it falls within the 30% most deprived nationally in terms of overall deprivation, and within the 10% most deprived nationally in terms of health deprivation & disability. Levels of deprivation are amongst other things a key determinant of mental health disorders and children growing up in poverty are more likely to have worse physical and mental health, and do less well at school. There are six wards in WNE Cumbria which fall within the bottom 10% nationally for levels of child poverty.

This is highlighted by our hospital admissions for those under 18 related to alcohol which are almost 70% higher than the national average. Attendances at A&E for a psychiatric disorder are 45% higher in Cumbria compared to England. People with specific long-term conditions, which should not normally require hospitalisation, are more likely to be admitted to hospital in WNE Cumbria as an emergency.

We report comparatively high levels of ill-health prevalence rates within our population, meaning that we have a high treatment burden in primary and secondary care. For example, the prevalence of hypertension is c.17% higher than national average, for depression c.4% higher than national average, and for dementia c.12% above the national average. Copeland has more than twice the prevalence rate for smoking compared to Eden. In addition we perform poorly against national benchmarks for a number of disease prevalence and prevention indicators. Highlighted in Figure 5

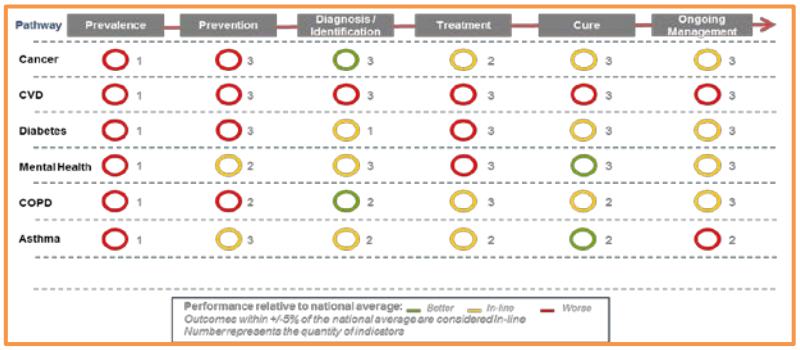


Fig 5: WNE Cumbria performance relative to national average across key care pathways

We therefore need to tackle primary prevention and address lifestyle risks, particularly in the more deprived pockets across WNE Cumbria.

Our Health and Wellbeing Aspirations:-

- Help our children get the best start possible in life and learn healthy lifestyles early and reduce childhood obesity to the best of comparator areas.
- Improve breast feeding rates to the best of comparator areas.
- Improve mental wellbeing of children and young people to the best of comparator areas.
- Increase average healthy life expectancy to the best of comparator areas.
- Reducing unhealthy levels of alcohol consumption to the best of comparator areas.
- Reducing the prevalence of smoking to the best of comparator areas.
- Tackling obesity in adults to the best of comparator areas.
- Improving the mental health and wellbeing of adults to the best of comparator areas.
- Reducing the number of falls to the best of comparator areas.
- Tackling social isolation to improve wellbeing.

Care and quality gap

Gaps: Historically, the quality of our general practice services has been high and while this continues, the pressures on these services are increasing and recruitment and retention is now a significant risk. Some acute hospital services (e.g. urgent & emergency care, secondary care diagnosis & treatment) are not always provided sufficiently promptly and core constitutional standards are not consistently met.

In WNE Cumbria, we know that we could be doing more to reduce the reliance on hospitals and care homes, providing better access to integrated rehabilitation, re-ablement and support services which enable people to continue to live more independently at home. This is especially the case for people who are frail or need multi-agency care, and people experiencing mental health distress.

Due to significant recruitment issues, the health and care system is currently utilising an expensive large temporary workforce of doctors and key other professionals. This is a major factor affecting the cost and quality of services in primary, secondary and social care, with feedback from staff that these arrangements are not able to fully cover the gap in substantive workforce where substantive leadership and service development is needed. There are also significant capacity and recruitment challenges in the independent sector domiciliary and nursing care sectors which need to be seen as part of our wider workforce

Our care and quality emerging priorities centre on consistent and equitable standards of care for all; the development and implementation of a single approach to high quality and sustainable hospital care; the establishment of integrated care communities; people better able to manage their conditions investment in a comprehensive health and wellbeing system and in enabling areas including workforce, transport and information management and technology.

Care and Quality Aspirations: We aspire to provide high quality care and support, in the right place and at the right time across all stages of life, from the promotion of health and wellbeing in the early years through to end of life. This will require us to change how we support the people of WNE Cumbria and improve services. We aspire to:-

- Support our population to better manage their own health and wellbeing so they are better equipped to prevent the development of ill health, minimise its impact, and manage its consequences.
- Invest in evidence based support which can prevent or reduce the need for expensive social and health care services.
- Work with communities to co-produce the services they use and gain local support for new service models
- In line with the Care Act, provide care and support which is proportionate to people's level of need and circumstances with an expectation of asset based assessments of people's circumstances.
- Provide people with high quality services close to home and minimise their need for hospital care with home and the community being the default care setting.
- Support our ageing population, particularly the more frail elderly, to live as independently as possible, to prevent avoidable illness and injury, and to be supported to make choices and achieve their own wishes.
- Focussing services for people with learning disabilities, physical disabilities and mental health services on recovery and independence, to manage their needs and improve their physical health, and to live a full and integrated life in society.
- Streamline the urgent care pathways to eliminate unnecessary waiting times and maximise effectiveness and outcomes.
- Increase the efficiency and effectiveness of elective (planned) care services to improve access and outcomes for citizens.
- Focus on maximising early rehabilitation and recovery following episodes of acute illness or operations
- Ensure that all clinical services are delivered safely, meeting and then exceeding national standards.

- Improve and maintain the quality of care provided in care homes and develop the care at home market to enable the take-up of direct payments / personal health budgets.

Our fundamental design principle for the above is to achieve best practice at the largest possible scale tailored locally within agreed flexibility arrangements.

Finance and efficiency gap

Gaps: Across providers (local and out of area specialist) and commissioners the STP footprint is spending £81m more that it receives in funding. Demand growth from an ageing population and a range of cost pressures mean that if we were to continue functioning as at present this gap could increase to £168m by 2020/21. The financial challenge has increased significantly since 2013 driven by investment linked to recommendations made by the national Francis report for staff staffing levels and premium costs of supplying the required workforce in key areas/professions.

Finance and Efficiency Aspirations:

We aspire to take actions in three broad areas in order to create a financially sustainable future;

1. Provider Efficiency
2. Commissioning savings
3. Integration/Consolidation of services to be more effective

1. On provider efficiency we plan to deliver annual cost improvement above historic levels through relentless pursuit of good practice in procurement, workforce shaping and supply/deployment, waste reduction and implementation of national Carter recommendations.

2. By commissioning for outcomes we will achieve allocative efficiencies. By moving towards greater integration of commissioning activities we will reduce duplication, improve pathways and improve the financial accountability of the system. We will also review the pattern and cost of services within Cumbria to ensure we are optimising recovery and independence based models and re-shape local markets.

3. On integration/consolidation of services we plan to provide clinical services through integrated models of care that are significantly more effective and efficient for patients. Locally these include Integrated Care Communities in non-hospital settings and, for hospital services, integration/consolidation and where appropriate working within clinical networks (including regionally). Some aspects of these plans require public consultation and pre-consultation work on them is well developed. We expect top quartile performance in prevention, early diagnosis, self-care, proactive care and effective urgent and elective care to all enable significant value add per £ and reduced spend overall.

Taken overall, the impact of these combined actions is to move from the "do nothing" scenario to an outcome close to financial balance over the five years to 2020/21.

Fig 6: Achieving a sustainable financial position

	2016/17 £m	2017/18 £m	2018/19 £m	2019/20 £m	2020/21 £m
Do nothing deficit	81	110	128	148	168
STP current recovery trajectory deficit	81	50	35	40	4

As the above table shows, our STP plans have moved significantly towards a sustainable position. The increased deficit in 2019/20 reflects the assumption that there will be no Sustainability and Transformation funding in that year. The residual deficit in 2020/21 relates to the South Cumbria element of the CPFT deficit, which is outside the WNE Cumbria footprint.

'The fourth gap' - culture, mind-sets and behaviours

Gaps: Local organisations have, in the past few years, worked hard to improve the care and services they provide but progress has been too slow. Staff engagement and levels of confidence from the people who use our services remains low in general although it has improved and considerable improvement has been made in some areas (for example, the extremely positive CPFT staff survey for 15/16).

We know that the scale of change required and set out in this document will only be achieved if regional and local leaders work together with a shared sense of purpose and focus on improving outcomes both with and for our communities, patients and customers. We need to recognise where we have fallen short in the past and demonstrate the right leadership behaviours, developing the capability to learn and improve.

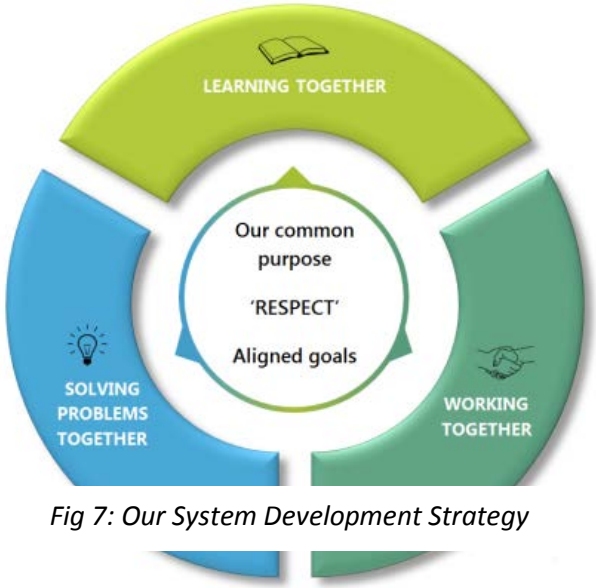


Fig 7: Our System Development Strategy

The culture and behaviour of leaders, care services and professionals:

- Many of our processes are geared to solving a particular crisis or deterioration, prioritising short term interventions over sustained, preventative and long lasting pathways of care.
- Contracts and payment mechanisms drive organisations to focus on their own income and costs, and do not yet allow concern for the whole pathway's value and viability to take precedence in decision making.
- Traditional training for care professionals has fostered a paternalistic culture where they are more inclined to shoulder the burden of care on behalf of our citizens at the expense of supported self-care and mutual aid in those they support, living with acceptable risk as a path to individual and community resilience, and moving away from a culture of risk aversion and institutional care.
- Financial pressures, issues of legal accountability and concerns around information governance have driven many organisations to be extremely cautious about sharing information, advice and best practice. While collaboration has increased greatly across care services, more work is needed to support the sharing of information, practices and advice.
- Many of our staff do not feel empowered and supported to make improvements in their services or feel that they are regarded as having a valued role to play in leading transformation of care. Organisational cultures need to be aligned in accordance with our common vision and clear shared values that underpin our joint effort and ethos of distributed leadership.

Culture, Mind-set and Behaviours Aspirations

We are committed to giving equal emphasis to closing this fourth gap, an area where true system leadership is required. Health and Care professionals must be coached, enabled and supported to make the changes needed and they must have complete confidence that the system is behind them and will back their decisions when made in line with the new approach. The required cultural shift will require a combination of formal and informal mechanisms, including better dialogue among professionals, aligned governance and improved decision making procedures linked to improved outcomes. We have set this out as a unified Organisational Development vision to;

"Work together and problem solve in a respectful way in the interests of the citizens of Cumbria and together as a system"

Underpinned by five system development objectives;

1. We will build engagement , ownership and happiness amongst staff, and the people who use our services (The Success Regime communications and engagement plan)

2. We will build leadership that consistently and unrelentingly shows, supports, directs and rewards the necessary change and development required
3. We will develop a single culture ("the way we do things around here"), and shared sense of purpose, focused on improving outcomes with and for our residents.
4. We will build capability and resilience, especially focussed on the clinical and professional practice of high performing teams and continuous system development through the mastery of modern improvement methods.
5. We will create a place that exemplifies exciting, innovative and compelling organisations and teams to work in, so that we can more easily recruit and retain talented people (The Success Regime Workforce enabling work)

Our System Development Strategy - *Learning, working and solving problems together*

- supporting staff to lead, improve and adapt what they already have across all existing services through building leadership and improvement capability through education in modern improvement science: "I do my work; I improve my work" – *Learning together*
- supporting the new emerging teams with a common improvement tool methodology and networks to work together in a way that enables them to deliver change according to the plan.–*Working together*
- making clear our system aims and create a sense of purpose, helping people develop compassionate and constructive relationships – *Solving problems respectfully together*

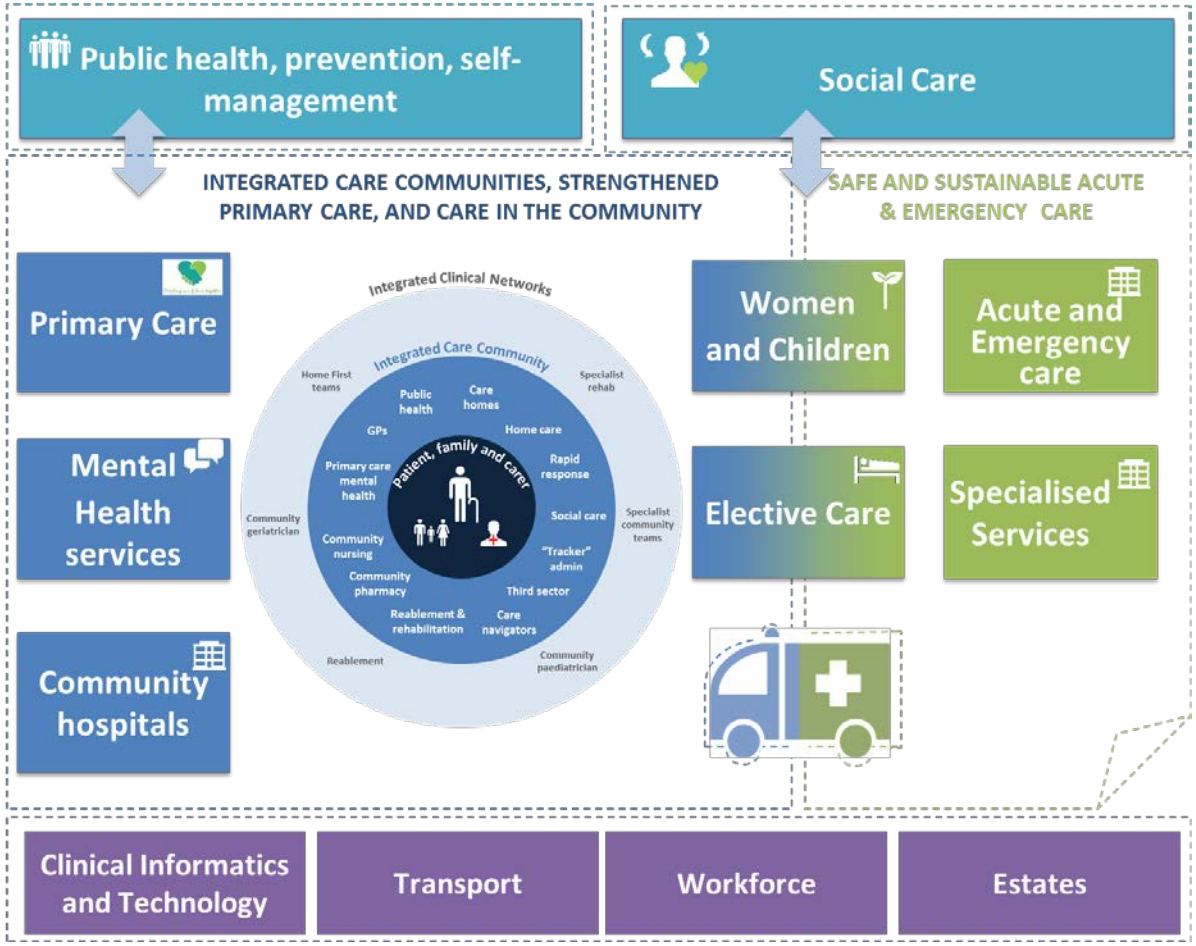


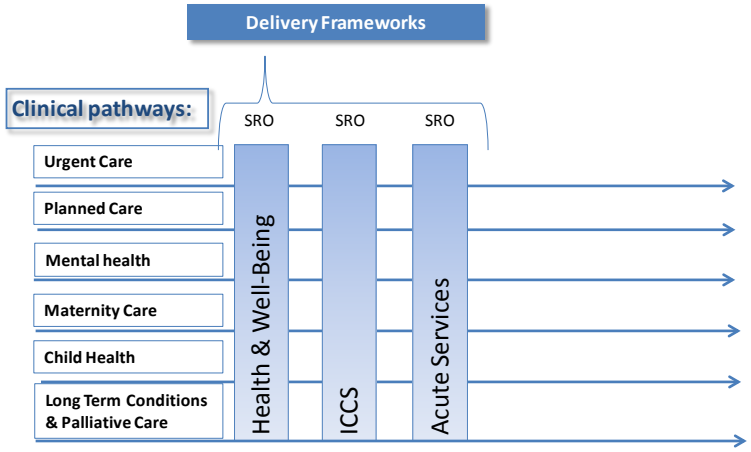
Fig 8: Key components of the WNE Health& Care System

6. HIGH IMPACT THEMES

As an STP we have agreed an overarching model that sets out how care is provided and co-ordinated across the system. Central to this is the development of Integrated Care Communities which will enable services to respond to specific local pressures.

High impact themes

We have identified a number of high impact themes that our STP will deliver through a matrix programme framework to ensure the most effective approach to programme implementation across the interconnected areas of work. The matrix makes use of 3 delivery frameworks and a number of broad "pathway" areas relevant to each.



Delivery Frameworks

Health & Well-Being – encompassing public health delivery structures/mechanisms in the widest sense including LA provider elements beyond adult and children's social care (e.g. housing, leisure), and third sector provider partners contribution where there is significant untapped potential for added value. The key aim of this area will be "communities activated for health".

Integrated Care Communities (ICCs) - the basic 'building blocks' of our clinical proposals bringing together health and social care resources and delivery on a place basis including primary, community, social and some elements of secondary care. As emergent entities, straddling a number of current organisational interfaces ICCs need intensive input and support to create a functional operational model which can provide the delivery framework within which community-based elements of clinical pathways can be delivered. The development of trust between partners through demonstrable actions will be key to their success; support and development of primary care in its own right as well as integration between partners is an essential component.

Acute and Specialist care and tertiary elements of care also have key deliverables within our transformed clinical strategy. Delivering the outcomes from consultation and building stronger clinical networks within and outside the STP footprint are key.

High impact theme 1: Prevention, self-caring and promoting independence

The Gap: Key indicators, described previously, suggest that WNE Cumbria has an underlying health and wellbeing gap and as a result the use of health and care services is higher than the national average.

Our Response: Our main focus is to reduce social isolation, prevent illness and disease and enable our citizens to live healthy and independent lives. Our commitment includes creating a health and wellbeing system which will **support and empower the population to stay healthy**.

This will include:

- The development of universal and targeted prevention services, enabled through '**health and well-being coaches'.**
- Better targeting of lifestyle services towards those who will benefit the most from them.
- Mechanism for connecting socially isolated people to local communities and opportunities.

The Impact:

The table shows the high impact we intend from our plans and how these relate to outcomes, the 10 big questions and what measurable benefits we will target in our forward implementation plans

Changes The changes we must implement to deliver benefits	Optimised delivery of a range of existing prevention services (namely Stop Smoking, Weight Management and Cardiovascular Health Checks) and implement the new Diabetes Prevention Programme.	Improved access to a wide range of information, advice and digital support services. Improved place-based provision of health and wellbeing activities to enable people to meet their own needs within their communities and workplaces	Implementing a 0-19 Integrated Healthy Child and Early Help Programme. Access to individual and family support to more vulnerable groups, through a team of Health and Well being Coaches	
Outcomes What would these changes mean?	**Citizen impacts:** • Reduced isolation and greater social networks, by encouraging support from social networks of family and friends • Identifying employment opportunities, developing skills and building self-confidence through harnessing volunteers • Greater access to services, support and networks, which will have a particular impact on rural and semi-rural communities, as online services/ networks will help to mitigate poor service accessibility. • Improved health and wellbeing as a result of lifestyle improvements	**Efficiency and workforce impacts:** • Harnessing greater resources through stronger links with the third sector, leisure sector, digital health solutions and more effective use of broader social networks. • Reducing the demands on both formal out-of-hospital settings (e.g. community hospitals) and acute settings through delivering more informal care in the community.		
Addressing NHSE '10 big questions'	✓ A reduction in childhood obesity ✓ Enrolling people at risk in the Diabetes Prevention Programme ✓ Do more to tackle smoking, alcohol and physical inactivity ✓ A reduction in avoidable admission ✓ A step change in patient activation and self care			
Measurable benefit Results that demonstrate whether the changes were successful	Health and wellbeing	Care and quality	Finance and efficiency	Leadership and culture
	• Improvement in public health levels e.g. improved smoking cessation, reduced diabetes prevalence., obesity levels.. • Improved lifestyle behaviours. • Reduced loneliness and Social Isolation. • Improved Child Health.	• Reduced morbidity and mortality rates. • Reduced admission rates into acute and formal OOH settings. • Reduced incidence /more diagnosis of heart disease stroke diabetes, kidney disease and vascular dementia.	• Contribution toward reducing the financial deficit, primarily through reduced cost of acute and formal OOH care, less workdays lost • Fewer re-admissions due to improved public health, leading to fewer treatments per patient.	• Improved staff satisfaction. • Improved multi-disciplinary approach to care. • Delivering our OD objectives • Mobilising individuals communities and places

High impact theme 2: Social Care/Community Based Care

The Gap: WNE Cumbria has a number of key gaps in the social care. These include a higher than required reliance on care home based care with resultant under development of supported self-care, re-ablement, domiciliary care and assisted technology enabled care. The provider market requires development to provide the range and presence of services required in future. As a result of these issues social care services are under significant pressure with long term admissions to residential and nursing homes higher than similar places, we have a shortage of services for people with dementia provision and the need to re-provision services to facilitate early discharge and prevent admission..

Our Response: In future the local authority sector will be targeting investment in services which prevent, reduce or divert demand, enabling individuals and activating communities to become more resilient by providing more support themselves. There will be investment in Extra Care Housing, high quality dementia and nursing care, assistive technologies, digital solutions to support self-help, telecare and support from the community sector. This will reduce the need to send people a long way from home, and reduces the risk of hospital admissions and increases the potential to achieve recovery and independence.

Changes The changes we must implement to deliver benefits	Improved access to advice and support	Service responses to be co-produced and co-designed at an individual and community level	Integration with the ICCs	Develop the community based care and support market
Outcomes What would these changes mean?	**Citizen impacts:** • Enabled self-management • Reduced admissions to hospital • Better access to support and care • Reduced reliance on statutory services • Alternatives to residential and nursing home care • Greater choice and control • Access to increased quality of services		**Efficiency and workforce impacts:** • Reduced spend on high cost placements • Greater staff satisfaction • Improved recruitment and retention across system • Transfer of activity from formal to informal systems	
Addressing NHSE '10 big questions'	✓ A step change in patient activation and self-care ✓ New whole population models of care ✓ A reduction in avoidable admissions ✓ Health & Social care integration with a reduction in delayed transfers of care. ✓ Integrated multidisciplinary teams to underpin new care models			
Measurable benefit Results that demonstrate whether the changes were successful	Health and wellbeing • Improved service user experience. • Increased independence	Care and quality • Reduced delayed transfers of care • Reduced admissions to hospital • Reduce admissions to residential • Improved CQC ratings across the sector • Increased use of direct payments • Wider range of provision in the market	Finance and efficiency • Reduced spend on high cost placements • Reduce cost of long term care following reablement/rehabilitation • Increased use of assistive technology options	Leadership and culture • Improved staff satisfaction • Improved multi-disciplinary approach to care

Specifically, plans include (subject to local agreement of partners):

- **A single "front door"** for information and advice
- **Encouraging and helping individuals** to develop their own support plan.
- Supporting people with **complex needs and at the end of life**.
- Redesigning the **re-ablement and intermediate care** pathway and technology and equipment to remain living independently at home
- Embedding Social Care Practitioners within Integrated Care Communities as part of the core MDT.
- Investing in Extra Care Housing and other models of supported living
- An integrated approach to achieve the above through our Better Care Fund

The Impact: The table shows the high impact we intend from our plans and how these relate to outcomes, the 10 big questions and what measurable benefits we will target in our forward implementation plans.

High impact theme 3: Primary Care Development

The Gap: Stabilising and developing primary care is fundamental to our new care model and delivering our aspirations (see Integrated Care Communities High Impact Theme 4). However, nationally and locally GP services are increasingly fragile. One third of all practices have applied for NHSE "vulnerable practices" funding, workload has increased significantly, exacerbated by the pressures in our acute hospitals. There are major issues affecting GP and practice nurse recruitment with 47% of GP partners planning to retire in the next 10 years.

Our response: To help stabilise and sustain primary care we are:-

- Extending the role of community pharmacies to provide a wider range of enhanced services.
- Enabling practices to collaborate to deliver an enhanced range of services including making proposals to the Estates and Technology Transformation Fund
- Improving access to general practice by enabling practices to work together to coordinate their provision of extended access.
- Supporting practices to reduce unwarranted variation and increase clinical outcomes though a new Quality Improvement Scheme and the introduction of new tools to support them.
- Realising greater efficiencies and creating more attractive models of employment, e.g. salaried GP services and integrated same-day demand services, supporting practices to become more efficient and effective through greater skill mix, economies of scale and continuous improvement and innovation, portfolio careers with varied clinical and academic job plans.

The Impact: The table shows the high impact we intend from our plans and how these relate to outcomes, the 10 big questions and what measurable benefits we will target in our forward implementation plans.

Changes The changes we must implement to deliver benefits	Sustained, high quality Primary care available to communities, rural and urban, across WNE Cumbria	Increase clinical outcomes and reduce unexplained clinical variation	Integrated care through one common IT platform	Greater co-location of primary care services with the wider out of hospital services
Outcomes What would these changes mean?	**Patient impacts:** • Enabled self-management with patients able to monitor pathway progress online • Improved clinical outcomes with reduced unexplained variation • Reduced variation in referrals • Better access to primary care services, including extended access over 7 days and the option to book appointments in or out of hours (after 6.30pm weekdays, and weekends). • More services provided out of hospital and closer to home		**Efficiency and workforce impacts:** • Release practices from onerous premises related issues, potentially leading to financial savings from operational efficiencies. • More efficient patient management pathways (e-referrals and e-prescribing) • More efficient use of scare resources through working more collaboratively and at scale. • Improved recruitment and retention by improving the range of training and job roles on offer and supporting people in their work.	
Addressing NHSE '10 big questions'	✓ A reduction in avoidable admission ✓ A step change in patient activation and self care ✓ Digital health records ✓ Access to e-consultations and other digital services ✓ Improved antimicrobial prescribing and resistance rates ✓ Integrated 111/out of hours services with single point of contact.		✓ Improved resilience of GP, retaining more GPs and recruiting additional primary care staff. ✓ Invest in primary care in line with national allocations and the forthcoming GP roadmap package. ✓ New roles e.g. associate nurses, pharmacists in practice ✓ Support primary care redesign, workload management, improved access, more shared working across practices.	
Measurable benefit Results that demonstrate whether the changes were successful	Health and wellbeing Care and quality • Improved patient experience and satisfaction • Improved access	Care and quality • Reduced admission rates into acute settings • Improved outcomes in key targets	Finance and efficiency • Contribution toward reducing the financial deficit, primarily through reduced cost of acute care • Sustainable General Practice through efficiency and shift in investment in General Practice .	Leadership and culture • Improved staff satisfaction • Improved multi-disciplinary approach to care • Delivering our OD objectives

High impact theme 4: Integrated Care Communities (ICCs) & Community Hospitals

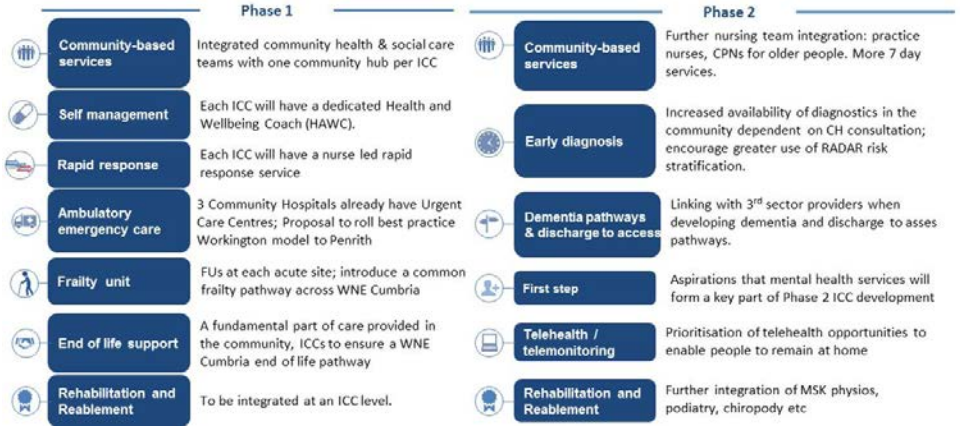
The Gap: WNE Cumbria has a mix of "out of hospital" service provision that is fragmented and over-stretched. For this reason we have higher than desired levels of demand on both primary and secondary care services, inefficient patient flow and sub-optimal recovery pathways and outcomes.

Our Response: Our plans are to optimise care outside hospitals through a significant programme to implement "Integrated Care Communities" (ICCs) and wrap around specialist community provision, covering eight areas across the WNE Cumbria geography. ICCs will wrap care around patients by bringing together public health, general practice, social care, community services, mental health services and community assets, including community hospitals to act as single integrated hubs, with active support from key secondary care specialists, such as geriatricians, as well as providing access to timely and appropriate acute based diagnostics.

We will also locate these ICCs within the wider context of Place Based Well Being Services such as Leisure, Sports, Housing and the third and community sectors. The ICC will be part of work underway across Cumbria County Council to embed Public Health Specialists in Area based working, building on a network of Health and Well Being Forums and on a managed network of third sector and community provision.

As ICCs mature, locality budgets will be developed. They will be able to draw on the range of services which are commissioned at STP and County level and on the existing frameworks for domiciliary, residential and other services. Where services are of a more specialist nature or cover a wide geographical footprint, they will sit at a clinical network level, where the interactions with ICCs will be fundamental to the wider system. We are planning the implementation of ICCs in two phases; depicted left.

Changes The changes we must implement to deliver benefits	Appropriate integration and coordination of out of hospital services and support from wider, acute services	Efficient configuration of community beds and integrated in ICCs	Improved access to senior and specialist skills. Increased virtual out-patient consultations	Improved access to diagnostics and multi-professional teams, including mental health services
Outcomes What would these changes mean?	**Patient impacts:** • Increased proportion of care takes place closer to / at home, reducing travel and improving access • Increased proportion of elderly treated outside acute settings. • Improved self management of illnesses, and patient confidence that they can manage their long term illnesses. • Fewer unnecessarily admissions (and readmissions) into acute settings. • Better access to primary and community services. • A joined up and seamless patient experience. • Earlier discharge/reduced length of stay		**Efficiency and workforce impacts:** • Reduced workforce pressure on general practice. • More resilient and flexible staffing models. • Improved staff experience of working in Out of Hospital settings, and therefore increased supply of workforce and resilience across OOH. • Acute centres prioritised for those with genuine need for acute services – easing demand on those settings. • Patients do not unduly stay in hospital settings due to an inability to move them either home, or into another setting (avoiding DTOCs). • Reduced professional isolation • Consistent approach with reduced duplication. • Less admin and more time to focus on patients.	
Addressing NHSE '10 big questions'	✓ New whole population models of care ✓ Integrated Teams to underpin new care models ✓ Health & Social care integration with a reduction in delayed transfers of care.		✓ A reduction in avoidable admission ✓ A reduction in emergency admission ✓ Expansion of integrated care personal health budgets ✓ Every patient has access to digital health records	
Measurable benefit Results that demonstrate whether the changes were successful	Health and wellbeing	Care and quality	Finance and efficiency	Leadership and culture
	• Improved patient experience, and satisfaction . • Improved quality of life. • More care provided locally • Higher levels of "prevention" – improved public health, e.g. increased smoking cessation. • Improved re-ablement outcomes • Reduced reliance on institutionalised care with increased number of people able to return home.	• Reduced acute admission rates, and readmission rates. • Fewer delayed transfers of care • Reduced serious incidents – e.g. with frail/elderly. • Reduced paramedic ambulance conveyances. • Reduced lengths of stay • Reduced morbidity and mortality rates.	• Reduction in number of duplicate investigations and assessment activities across out-of-hospital settings. • Contribution toward reducing the financial deficit. • Expansion of integrated health budgets and choice	• Improved staff experience and satisfaction. • Improved multi-disciplinary approach to care. • Delivering our OD objectives • Mobilising individuals communities and places



The Impact: The table above shows the high impact we intend from our plans and how these relate to outcomes, the 10 big questions and what measurable benefits we will target in our forward implementation plans.

Greater detail is included in the Finance Addendum to the PCBC.

High impact theme 5: Local Secondary Care

The Gap: Across many areas of local secondary care services we have identified significant issues of quality, performance or sustainability that present major improvement challenges. Local secondary care is experiencing significant operational and financial pressures, with particular difficulties associated with the recruitment and retention of medical and nursing staff, and consequent heavy reliance on locum and agency staff. This in turn impacts on continuity of care and whole system working, clinical leadership and the ability to improve services. In addition our current system too often causes people who reach a health and/or care crisis to not always be responded to with the right care in the right place at the right time, first time. There are also clear gaps in relation to standardisation of care and consistent use of best-practice pathways and interventions

Changes The changes we must implement to deliver benefits	Delivery of standardised care by a substantive, well-supported, trained, and motivated workforce working across traditional interfaces and roles	Improved access to specialist advice by phone/email PLUS improved ambulatory access to rapid senior assessment, specialist skills & access to diagnostic services	Earlier senior and multi-disciplinary assessment 7/7, initiation of treatment, appropriate speciality support and proactive system-wide 7-day discharge	A&E and MIUs operating as a single network, appropriate co-location of services and support from wider services; smooth timely transfer when necessary
Outcomes What would these changes mean?	**Patient impacts:** • Fewer patient admissions and earlier discharge home • Patient care compliant with 4 priority 7 day Service standards and evidence-based best-practice pathways across primary/community and secondary care • Waiting at all stages kept to a minimum and any delays explained. Patients (and families/carers where appropriate) fully aware of involved in their own care. • Multi-disciplinary and patient centred assessment and planning for those with complex needs including early discharge planning and 'discharge to assess'. • Seamless and well communicated discharge.		**Efficiency and workforce impacts:** • Consistent achievement of A&E target, fewer ambulance waits & admissions; reduction in average length of stay. • Consolidation of scarce resource to maximise efficiency • Reduction in duplicate investigations and assessment activities. • Appropriate staffing levels with staff 'working to their grade' with designated time for improvement activities. • Improved training and supervision for junior staff. • New roles and opportunities for staff to progress eg Physicians associates and Nurse/AHP practitioner 'ST3 equivalents' • Increased access to training and development activities for staff; increased staff using improvement methodologies.	
Addressing NHSE '10 big questions'	✓ A simplified UEC system and points of entry. ✓ A reduction in emergency admission and inpatient bed rates; reduced readmission rates ✓ Achieve and maintain A&E and ambulance waits ✓ Integrated multidisciplinary teams to deliver new care models		✓ Roll out of priority-day standards focusing on consultant Sunday availability and diagnostic capacity ✓ Reduction in avoidable deaths ✓ Reduce agency spend, and develop and retain staff with the right skills and values ✓ New roles such as physician associates	
Measurable benefit Results that demonstrate whether the changes were successful	Health and wellbeing	Care and quality	Finance and efficiency	Leadership and culture
	• Improved patient experience and satisfaction • Improved outcomes and reduced variation • Reduced discharge into residential care	• Reduced morbidity and mortality rates • Reduction in harm (Hogan scores) • Reduced number of serious incidents	• Reduced admissions and decreased LOS • Positive reference costs • Reduction in delayed transfers of care and bed-days	• Improved staff satisfaction. • Reduced staff vacancy rates and attrition rates. • Reinstatement of junior medical training posts. • Reputation for successful emergency care new care models

Emergency & Acute Care

Our Response: We are further developing and embedding a single-service model with standardised care across the two acute sites (Cumberland Infirmary Carlisle & West Cumberland Hospital) with the aim of improving outcomes for patients and identification of groups of patients who are likely to benefit from access to more specialised services which could be delivered on one site. This builds on recent pathway changes and subject to dialogue with the community and public consultation includes the management of patients presenting with suspected stroke as well as small numbers of seriously ill patients where clinical assessment identifies that for a particular individual, additional support/intervention would improve outcomes. We plan to provide improved access for minor trauma and minor emergency general surgery at WCH, where this can be provided safely and effectively. We plan to create an innovative and integrated 'front of house' workforce, strengthen daytime ambulatory and 'anticipatory care' services. This will closely link with Integrated Care Communities to ensure that patients and professionals can swiftly access specialist opinion and diagnostics to prevent unnecessary admission to hospital and/or deterioration in condition that would result in eventual emergency admission.

The Impact: The table above shows the high impact we intend from our plans and how these relate to outcomes, the 10 big questions and the measurable benefits we will target in our forward implementation plans

Local Specialised Services

Our Response:

To support our population access specialist services locally we plan to develop stronger clinical networks with regional centres and other providers with expertise that augments our local services. Importantly we have started this process of formal partnering with Newcastle Hospitals NHS FT and Northumbria Healthcare FT to provide clinical network support in key areas such as radiotherapy/oncology and specialist children's services.

We have systematically considered the current models, challenges and sustainability issues within each specialty service line and the potential to address these through different organisational partnerships and network approaches.

The STP has identified a major priority to renew the specialist radiotherapy infrastructure at the CIC site and has established with NHS England Specialist Commissioners and a tertiary services provider a proposal with high potential to sustain the local service well into the future as part of the North East & Cumbria Cancer Alliance. A case for the capital investment required will need to be prepared and accepted and is a major priority for the STP partners to sustain effective cancer treatment services locally into the future.

By bringing together our lower volume capacity at a local level and linking into specialist resources at a regional level, will enable us to create a robust infrastructure strongly linked with specialist pathways. It will help address service fragilities and secure local specialist access, enhance ability to achieve quality standards, allow pooling of workforce and increased efficiencies, and increase leadership capacity and recruitment/retention of staff. There are reputational, market, workforce and efficiency benefits too for our partners.

Changes The changes we must implement to deliver benefits	Securing stability and sustainability of specialised services through formal partnering with other providers	Strengthened clinical networks which build on opportunities offered by technologies including systems inter-operability and use of telemedicine
Outcomes What would these changes mean?	**Patient impacts:** • Improved access to specialised services and high-quality modern therapeutic interventions based on need • More local access to specialised services delivered in WNE and through use of technology • Reduced waiting times • Improved clinical outcomes through speedy access to specialised diagnosis and treatments	**Efficiency and workforce impacts:** • Delivery of cancer constitutional targets • Enhanced opportunities for joint posts across WNE Cumbria and Newcastle (and with other providers) • Reduced agency spend • Enhanced leadership • Development of strengthened clinical networks that promote research and development opportunities • Implementation of new ways of working to support multi-disciplinary team working across multiple sites (e.g. video conferencing etc,)
Addressing NHSE '10 big questions'	✓ Achieve at least 75% one-year (all cancers) and diagnose 95% of cancer patients within 4 weeks. ✓ Hospital networks, groups or franchises to share expertise and reduce avoidable variations ✓ Reducing agency spend and developing and retaining a workforce with the right skills and values	

Measurable benefit Results that demonstrate whether the changes were successful	Health and wellbeing	Care and quality	Finance and efficiency	Leadership and culture
	• Reduction in inequality in access to specialised services • Improved outcomes including increase in 1 and 5 year cancer survival rates • Improved satisfaction	• Improved outcomes – cancer targets • Reduced admissions • Increased R&D activity including clinical trials in WNE Cumbria • Improved travel times • Repatriation of WNE residents back to CIC	• Reduced agency spend • New ways of working support greater efficiency • Access to modern IT solution (e.g. telehealth) • Reduction in cost of transport	• Strong formal clinical networks in place providing peer support and challenge: joint audit against standards • Increased staff satisfaction

We expect these collaborative arrangements to be rapidly introduced and underpinned by formal agreements.

The Impact: The table above shows the high impact we intend from our plans and how these relate to outcomes, the 10 big questions and what measurable benefits we will target in our forward implementation plans.

Elective Services

Our Response:

Through its improvement work, the Trust remains on target with its recovery trajectories to meet constitutional standards in elective care. As part of this it continues to establish the new West Cumberland Hospital as a high volume elective centre creating capacity at CIC for unplanned and higher risk surgery. As a system priority we plan to secure sustained delivery of the referral to treatment 18-week performance metric; the six-week diagnostic metric; and the 62-day wait cancer metric and continue to improve delivery of high quality locally available care through the following key actions;

- A full system wide focussing of outpatient activities so that we provide a more balanced and localised overall approach to elective care.
- Redesign of MSK pathways including rheumatology (hip & knee, spine, foot & ankle, upper limb, paediatrics) to form an integrated service with community/primary care.
- Redesign of ophthalmology pathways (cataracts, glaucoma, AMD, Minor Eye Conditions, and Paediatrics) to form an integrated service with community/primary care.
- Introduction of integrated models for chronic pain and for surgical pre-assessment
- Repatriation of elective work currently undertaken outside the county.
- General surgery quality improvements that will ensure that the right person sees the right patient at the right time.

Changes The changes we must implement to deliver benefits	Integrated best practice pathways and provision of care across acute and community settings, supported by clinical protocols and access standards	'Lean' processes and procedures with high theatre and outpatient utilisation rates on all sites which maximise available capacity; increased diagnostic capacity in some key areas	Appropriate co-location of services and capacity for support from wider services (e.g. emergency surgery, interventional radiology, ortho-geriatrics, critical care)
Outputs What would these changes mean?	**Patient impacts:** • Reduced waiting times • Increased self-management options • Improved patient choice and care closer to home; ability to access treatment at the most appropriate setting. • Increasingly streamlined processes for patient pathways with improved communication between and with professionals, and reduced duplication of assessment • Reduced cancellations for outpatient, day case and in-patient care • 90% of elective admissions are less than 24 hours. • Early repatriation of those initially managed at CIC • Improved personalised follow-up of care including self-management	**Efficiency and workforce impacts:** • Increase elective activity levels and maximisation of day case and OP procedures • Reduced lengths of stay • Meeting constitutional targets for RTT and cancer; • Appropriate staffing levels and bed configurations • Reduced cancellations for outpatient, day case and in-patient care • High risk surgery supported by access to 24/7 critical care beds staffed by intensive care medicine consultants and to critical care outreach	
Addressing NHSE '10 big questions'	✓ Improving choice ✓ 95% diagnosis of cancers within 4 weeks (see also specialised care) ✓ Referral to treatment times.		
Measurable benefit Results that demonstrate whether the changes were successful	Health and wellbeing	Care and quality	Finance and efficiency	Leadership and culture
	• Improved patient experience and satisfaction • Increase in 1 and 5 year cancer survival rates	• Reduced morbidity and mortality rates. • Reduced number of serious incidents / no never events. • Reduced emergency admissions • Maximised achievement of best practice tariff standards	• Reduced demand in primary and secondary care • Reduction in numbers of duplicate investigations and assessment activities. • Repatriation of elective activity retaining 'Cumbrian Pound'	• Improved staff satisfaction • Improved MDT functioning • Improved networking and peer support (evidence of joint audit) • Continuous clinically-led improvement programmes

The Impact: The table above shows the high impact we intend from our plans and how these relate to outcomes, the 10 big questions and the measurable benefits we will target in our forward implementation plans.

Women's & Children's

Integrated Children's Services

Our Response: We aim to create an evidence-based, sustainable, one-team model focused on integration of services across all professions and sectors, to improve health outcomes and experience for children, young people and their families. Changing epidemiological factors has meant an increase in children with complex long term conditions, technological developments have enabled a children's health service delivery model that is much more community-based and multidisciplinary.

Our proposals include

- Support for children and young people to be healthy and safe
- Focus on quality and better health outcomes.
- Developing the interface with ICCs and networks within a place based approach.
- Provision of short stay paediatric assessment Units (SSPAU) at both sites.
- Changes to in patient care with low acuity beds at WCH.
- The Development of an integrated and coordinated children's nursing service that will deliver multidisciplinary care including working with Jigsaw children's hospice as part of the integrated nursing team.
- Working collaboratively at a regional level to deliver more specialist services and improving the sustainability of services locally
- Develop a whole-system approach to promoting emotional resilience and good mental health

It is important to recognise that any future models for paediatric services will need to be considered alongside the future model of maternity services, with any changes being subject to formal public consultation.

Changes The changes we must implement to deliver benefits	Implementation of a robust paediatric assessment model and standardised pathways across both acute and community settings.	The development of one team for children – integrating services and workforce around the needs of the child	Appropriate co-location of services and development of services with ICCs footprints	
Outcomes What would these changes mean?	**Patient impacts:** • Improved co-ordination of care, outcomes and access, through integrated children's' nursing services aligned with ICCs. • Reduced hospital based care, more consultants outreaching into the community. • Rapid and appropriate assessment and treatment in short stay paediatric assessment units (SSPAU). • Better transition to adult services • Reduced waiting times • Standardisation of quality via use of children's pathways across whole system • Improved whole system CAMHS services	**Efficiency and workforce impacts:** • Integrated teams provide greater workforce resilience • Staffing levels and grade-mix reflecting varying levels of patient acuity and dependence in accordance with national guidance. • Reduced assessments, admissions and lengths of stay • Removal of duplication as teams integrate. • One team for children providing more attractive working conditions and more resilient workforce. • Consolidation of scarce resources • Better co-ordination of care. • Regional collaboration to deliver more specialist services and improve sustainability of services		
Addressing NHSE '10 big questions'	✓ Hospital networks , groups or franchises to share expertise and reduce avoidable variations. ✓ Reduce agency spend, retrain and workforce with right skills and values ✓ New roles such as paediatric nurse practitioners. ✓ A reduction in emergency admission and inpatient bed-day rates ✓ Integrated multidisciplinary teams to underpin new care models			
Measurable benefit Results that demonstrate whether the changes were successful	Health and wellbeing • Increased resilience and good mental health • More children supported in community settings. • Improved patient experience and satisfaction • Reduced safeguarding issues	Care and quality • Reduced admission & Readmission rates • Reduced duplication within services and handoffs of care • Reduced number of paediatric serious incidents. • Improved outcomes through use of best practice pathways. • Reduced waiting times.	Finance and efficiency • Reduction in number of duplicate investigations and assessment activities • Reduced overall bed days. • Reduced agency costs. • Reduced out of hours premium costs through single team configuration.	Leadership and culture • Improved staff satisfaction. • Improved multi-disciplinary approach to care and peer support. • Increased levels of training and skills development.

The Impact: The table shows the high impact we intend from our plans and how these relate to outcomes, the 10 big questions and the measurable benefits we will target in our forward implementation plans.

Improving Maternity Services

Our Response: Delivering a sustainable model of maternity services is recognised as a key priority and whilst a number of actions have already been taken to improve and modernise care there is need to further change the current model of care with its 2 distant low volume maternity units. In doing so we must take into account key interdependencies with other services, especially paediatrics and anaesthetics (both of which are also experiencing significant workforce pressures). It is important to recognise that any future model for maternity service needs to be aligned to the future model of paediatric services, with any changes being subject to the current formal public consultation. We have worked with external expert advisors to develop creative options for the future, taking into consideration the independent review undertaken by the Royal College of Obstetricians and Gynaecologists (RCOG), advice from the local Maternity Services Liaison Committee and the Strategic Clinical Network, and evidence-based best practice. We are consulting on a preferred innovative model which could see a new midwifery-led unit and elective consultant service at WCH. The model maximises local maternity provision, with emphasis on local antenatal and postnatal care, locally available midwifery-led intrapartum care for lower risk births across the patch and a necessary concentration of higher risk intra-partum care onto the CIC site.

Greater detail is included in the Addendum to the PCBC.

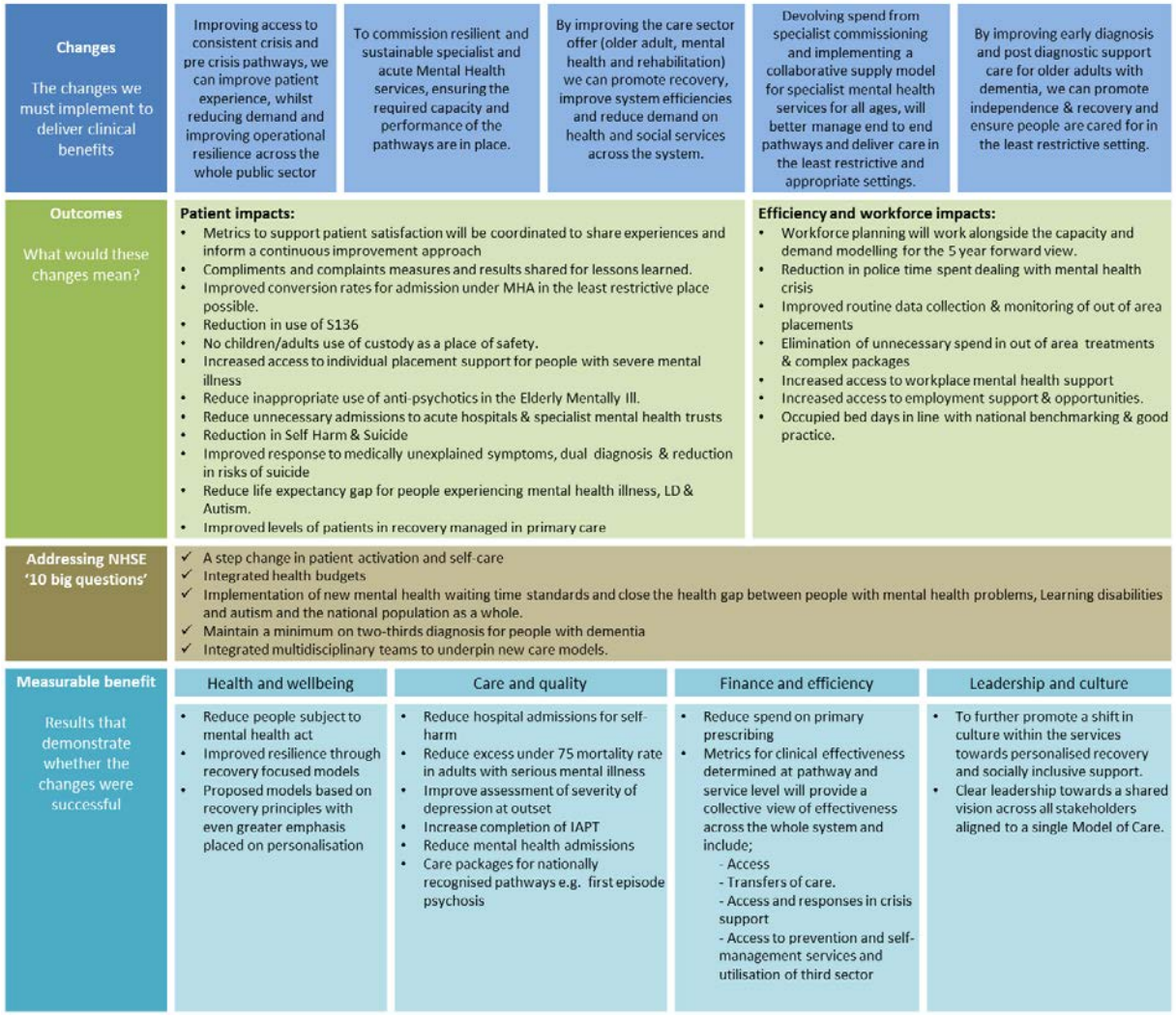
Changes The changes we must implement to deliver benefits	Increased choice for women including alongside MLUs	Midwife-led maternity pathway, except for higher-risk women who need obstetrician-led care (implementing "Better Births")	Appropriate co-location of services and support from wider services	Working as one team including access to tertiary links to alleviate issues of small unit with low levels of deliveries
Outcomes What would these changes mean?	**Patient impacts:** • Midwifery led maternity pathway, expect for high risk women needing obstetrician-led care. • All women have 1:1 midwifery care during labour. • Reduced number of instrumental deliveries. • Reduced emergency and planned C-section rates. • Increased % of midwife-led births and reduced % of obstetrician-led births. • Reduced post-partum haemorrhages. • Increased home births.		**Efficiency and workforce impacts:** • Improved coordination of care. • Availability of a health professional fully trained in neonatal resuscitation and stabilisation in maternity units. • Availability of consultant obstetricians, anaesthetist, paediatricians and midwife supervisors as required. • Reduced reliance on agency staff • Reduced staff vacancy rates and attrition rates. • Creation of new roles: Advanced Midwifery Practitioners • Staff access to peer support from specialist centre.	
Addressing NHSE '10 big questions'	✓ Improving maternity services and reducing rate of still births, neonatal and maternal deaths. ✓ Reduce agency spend, retrain and workforce with right skills and values			
Measurable benefit Results that demonstrate whether the changes were successful	Health and wellbeing	Care and quality	Finance and efficiency	Leadership and culture
	• Reduced levels of intervention. • Increased levels of breast feeding • Improved patient experience and satisfaction	• Reduced morbidity and mortality rates (neonatal, perinatal and maternal rates). • Reduced number of serious incidents / No never events. • Reduced instrumental deliveries. • Reduced emergency and planned C-section rates. • Increased % of midwife-led births and reduced % of obstetrician-led births. • Reduced post-partum haemorrhages. • Increased home births.	• Contribution toward reducing the financial deficit. • Reduced length of stay • Reduced agency spend.	• Improved staff satisfaction. • Improved emphasis on training and skills development. • Improved multi-disciplinary approach to care.

The Impact: The table above shows the high impact we intend from our plans and how these relate to outcomes, the 10 big questions and what measurable benefits we will target in our forward implementation plans.

High impact theme 6: Mental Health

The clinical proposition for mental health improvement across the WEN Cumbria STP is also integral part of a Cumbria-wide Mental Health Transformation programme, focused on the delivery of a whole system vision for mental health improvement and has identified five priority areas for improvement:

- Implementation of the Crisis Care Concordat and improvement in services to support people experiencing a mental health crisis;
- Primary care mental health provision, including the need to address health inequalities;
- Increased involvement of the third sector as providers of a wide range of services;
- A system of care that supports and actively promotes recovery; and
- Review and implementation of the dementia pathway for Cumbria.



Changes The changes we must implement to deliver clinical benefits	Improving access to consistent crisis and pre crisis pathways, we can improve patient experience, whilst reducing demand and improving operational resilience across the whole public sector	To commission resilient and sustainable specialist and acute Mental Health services, ensuring the required capacity and performance of the pathways are in place.	By improving the care sector offer (older adult, mental health and rehabilitation) we can promote recovery, improve system efficiencies and reduce demand on health and social services across the system.	Devolving spend from specialist commissioning and implementing a collaborative supply model for specialist mental health services for all ages, will better manage end to end pathways and deliver care in the least restrictive and appropriate settings.	By improving early diagnosis and post diagnostic support care for older adults with dementia, we can promote independence & recovery and ensure people are cared for in the least restrictive setting.
Outcomes What would these changes mean?	**Patient impacts:** • Metrics to support patient satisfaction will be coordinated to share experiences and inform a continuous improvement approach • Compliments and complaints measures and results shared for lessons learned. • Improved conversion rates for admission under MHA in the least restrictive place possible. • Reduction in use of S136 • No children/adults use of custody as a place of safety. • Increased access to individual placement support for people with severe mental illness • Reduce inappropriate use of anti-psychotics in the Elderly Mentally Ill. • Reduce unnecessary admissions to acute hospitals & specialist mental health trusts • Reduction in Self Harm & Suicide • Improved response to medically unexplained symptoms, dual diagnosis & reduction in risks of suicide • Reduce life expectancy gap for people experiencing mental health illness, LD & Autism. • Improved levels of patients in recovery managed in primary care			**Efficiency and workforce impacts:** • Workforce planning will work alongside the capacity and demand modelling for the 5 year forward view. • Reduction in police time spent dealing with mental health crisis • Improved routine data collection & monitoring of out of area placements • Elimination of unnecessary spend in out of area treatments & complex packages • Increased access to workplace mental health support • Increased access to employment support & opportunities. • Occupied bed days in line with national benchmarking & good practice.	
Addressing NHSE '10 big questions'	✓ A step change in patient activation and self-care ✓ Integrated health budgets ✓ Implementation of new mental health waiting time standards and close the health gap between people with mental health problems, Learning disabilities and autism and the national population as a whole. ✓ Maintain a minimum on two-thirds diagnosis for people with dementia ✓ Integrated multidisciplinary teams to underpin new care models.				
Measurable benefit Results that demonstrate whether the changes were successful	Health and wellbeing • Reduce people subject to mental health act • Improved resilience through recovery focused models • Proposed models based on recovery principles with even greater emphasis placed on personalisation	Care and quality • Reduce hospital admissions for self-harm • Reduce excess under 75 mortality rate in adults with serious mental illness • Improve assessment of severity of depression at outset • Increase completion of IAPT • Reduce mental health admissions • Care packages for nationally recognised pathways e.g. first episode psychosis	Finance and efficiency • Reduce spend on primary prescribing • Metrics for clinical effectiveness determined at pathway and service level will provide a collective view of effectiveness across the whole system and include; - Access - Transfers of care. - Access and responses in crisis support - Access to prevention and self-management services and utilisation of third sector	Leadership and culture • To further promote a shift in culture within the services towards personalised recovery and socially inclusive support. • Clear leadership towards a shared vision across all stakeholders aligned to a single Model of Care.	

The Gap: There are a number of service areas which are not commissioned within Cumbria such as perinatal, forensic, and primary care mental health services. Cumbria shares the same challenges faced by mental health services nationally and the services face further challenges because of the population (approximately 500,000 people) is dispersed across the 2nd largest county in England. Models of care that work well in an urban environment do not easily translate (and deliver benefits) into Cumbria's rural geography. Small numbers of people requiring highly specialised services travel out of area because it is not always feasible to provide these services in Cumbria and it is difficult to recruit to vacancies in some essential and specialist roles. Workforce recruitment is challenging across the county, especially in the areas of qualified staff, and medical staffing.

Our response: The recently published Five Year Forward View for Mental Health makes 58 recommendations to be implemented by 2020/21. The national commission for the review of psychiatric inpatient care for adults makes a further 12 recommendations. This compelling evidence reinforces the need to make

whole-system step change in how we deliver mental health crisis support, putting it on a par with other emergency services 24/7, and providing a greater range of care and support close to home, as alternatives to mental health hospital admission.

To support the development of a co-produced whole-system model of care for mental health across Cumbria, we are using a framework to allow us to quantify the balance of investment made across the full range of mental health provision and support, so that we can make informed choices about how we will shift the balance of resource into more locally accessible alternatives to hospital care. This is an all age approach and includes dementia and support to children and young people where there are clear interdependencies.

The Impact: A number of positive health impacts for people (people using services and carers) including;

- Improved mental health wellbeing by increased awareness, prevention, resilience and support available more widely and accessibly.
- Reduced deaths from suicide
- Improved treatment and recovery options delivered innovatively within community assets and local based services including primary care.
- Improved crisis prevention, responses and enhanced options for sustained recovery.
- Improved longer term health outcomes for people living with severe mental illness in our communities; such as increased life expectancy through enhanced opportunities for employment, suitable housing and rehabilitation to prevent mental ill-health related disability.
- Enhanced diagnosis, advice, treatment and support for people living with dementia in our communities.

7. CRITICAL DECISIONS AND ISSUES

Our plans include a mix of; Continuous improvement to achieve high value across the board efficiency/waste reduction. Re-engineering of our health and care system to introduce integrated care at all levels to optimise the system's quality and financial sustainability and a small number of proposals that require public consultation in order to create more sustainable and safe services for the future. Critical decisions and issues in our STP are;

- ***Delivery of immediate stabilising improvements*** including; integrating local services, sharing support services, partnering with network partners , ensuring robust cross-system contingency planning and improving our service performance by achieving agreed trajectories including 16/17 control totals, constitutional standards and implementing Carter review themes and ambitions.

- ***Finalisation of the Post Consultation Business Case of the "The Future of Healthcare" consultation*** setting out the overall service strategy and the outcomes from formal public consultation. Key issues being consulted upon are summarised as;
    - changes to acute urgent and emergency care,
    - changes to paediatric services,
    - changes to maternity services, and,
    - changes to community hospital services
    - all within the context of our overall STP care model.

- **Forward plans to realign our system** to move from fragmented/ isolated organisations to more cohesive "Accountable Care" based working. Our STP has started to explore the options to move forward collaboratively with a view to selecting a forward path to be implemented from 17/18 onwards.

8. CLOSING THE FINANCIAL GAP

Financial challenge

In 2016/17 WNE Cumbria health is currently spending £81m more than it receives in funding under the system. Based on current services and resource utilisation (including in out of area specialist commissioning), by 2020/21 an estimated additional £168m of funding could be required above expected allocations in order to keep pace with expected increases in demand and cost pressures.

The cost of delivering services in WNE Cumbria is higher than the national average as well as its peer group. The higher costs identified suggest that there is opportunity to provide services more efficiently through cost improvement programmes, for example delivering reductions in agency costs. In addition national benchmarks indicate the potential for WNE Cumbria to reduce its activity, particularly non-elective activity, through prevention, other demand management initiatives and providing more care in settings outside hospital (home, care home or other community setting).

Mitigations have been developed to address this financial challenge. These focus on radically improving efficiency through integrated & consolidated care with WNE Cumbria aiming to be in the top decile. The following sections discuss each of the mitigations in turn.

Business as usual efficiency; There are three components to the efficiency mitigations that total £86m over the 5 year plan: Provider efficiencies, Shared organisational arrangements, and CCG and specialist commissioning efficiencies.

Services Outside Hospital

In the "Out of Hospital" model pathways and activity flows are changed to shift patients to more cost effective settings of care, often closer to home. The primary mechanism by which "out of hospital" interventions will be delivered in WNE Cumbria is through integrated care communities (ICCs).

These "out of hospital" impacts reduce the financial challenge by £42m by 2020/21, representing reduced cost of hospital services of £63m less £21m investment in "out of hospital" services.

Options for hospital service reconfiguration

Reconfiguration of services across hospital care achieves efficiency benefits obtained by maximising economies of scale across different hospital sites and redesigning the service offer to be more sustainable. The evaluation of options identified the following preferred options:

- For maternity services, the provision of a consultant led maternity unit, an alongside midwife-led maternity unit and a special care baby unit at Cumberland Infirmary Carlisle along with a full range of antenatal and postnatal care. At West Cumberland Hospital in Whitehaven a standalone midwife-led maternity unit for low risk births, open 24 hours a day 365 days a year, with antenatal and postnatal care delivered by both consultants and midwives and with consultants on site between 8am and 8pm.
- For children's services, the development of an inpatient paediatric unit serving West, North and East Cumbria based at Cumberland Infirmary Carlisle along with a short stay paediatric assessment unit. At West Cumberland Hospital, Whitehaven there would be a short stay paediatric assessment unit for children requiring short term observation and treatment. There would also be some overnight beds at Whitehaven for children with less acute, low risk illnesses but children who needed more acute inpatient admission would be transferred to Carlisle.
- New Ways of Working across acute and emergency care.

These preferred options have been used for the purposes of the STP financial model. These options reduce the financial challenge by £1.2m by 2020/21.

Options for community service reconfiguration

The consultation around the reconfiguration of community hospital inpatient beds includes options for consolidating the total number of inpatient sites from 9 to 6 with a total bed base of 104. The preferred community option has been identified with a total net benefit by 2020/21estimated to be £0.9m.

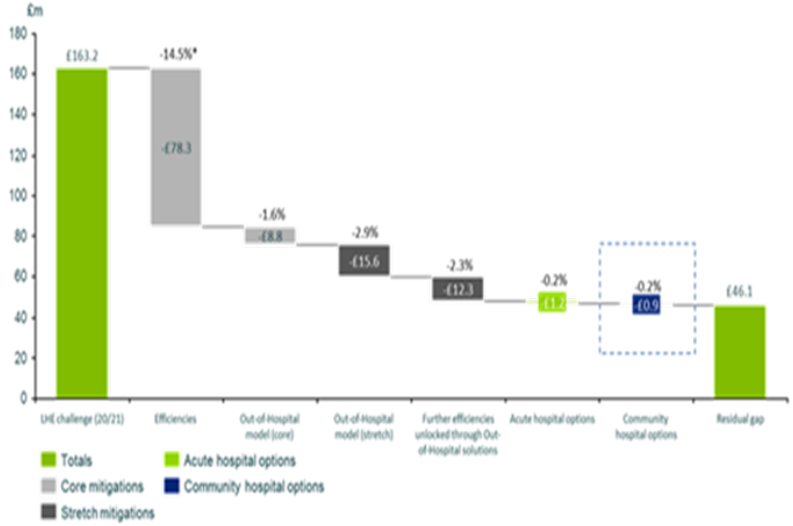
Additional planned investments & transition costs

There are a number of additional planned investments, including in national priorities, which are not linked to the reconfiguration options considered. Some of these are within the scope of the financial analysis included with other areas subject to funding separately. There are a number of excluded capital expenditures for example investment in specialised services, primary care and the Cumbria wide mental health strategy subject to future business cases and capital financing. Transition costs refer to costs associated with implementing the plan. These include programme costs, double running costs, services needing to remain open across multiple sites on a transitionary basis, and staff training. Initial estimates suggest potential implementation costs would be approximately £22m over the 4 years 2017/18 and 2020/21.

Summary of five year financial position

The new ways of delivering care to the local population in WNE Cumbria described in the previous sections drive a more financially sustainable position.

Fig 9: Summary of year 5 position



(Source: Success Regime financial analysis. %s relate to total 5 year provider expenditure of c. £540m)

The identified solutions around efficiency, ICC rollout and preferred options for reconfiguration, leave a residual financial challenge in 2020/21 of £46m. As such, greater change will be required to achieve financial sustainability.

Residual NHS financial challenge

A range of mitigations are considered in this section:

- Additional mitigations;
- The potential impact of indicative 2020/21 STP funding including transformation; and
- Alternative options to mitigate the financial challenge.

Two additional areas have been identified which could further reduce the financial challenge **within** the current preferred acute and community options:

1. **Additional specific mitigations** – these comprise of additional initiatives which could deliver further cost savings for WNE Cumbria and include consolidation savings through developing networks to deliver pathology services; role development within workforce delivery to support greater staffing efficiencies; and the potential economies of scale opportunities within GP services. These mitigations could reduce the financial challenge by £6m by 2020/21.

2. **"Out if Hospital" greater service change** – this comprises increasing the benefits assumptions within the "out of hospital" model. In particular this includes increasing the reduction in non-elective admissions over five years from 19% to 25%; and reducing the reinvestment rate required to deliver the out of hospital interventions services e.g. as part of the ICCs from 50% to 40%. Flexing these assumptions could reduce the financial challenge by a further £6m.

Post these mitigations this leaves WNE Cumbria with a £34m residual challenge in year 2020/21.

Indicative 2020/21 STF funding including transformation

In order to support STP footprints in developing plans for their areas in 2020/21, in May 2016, NHS England has published, on an indicative basis, the total additional funding which could be available in 2020/21 from all sources. The WNE Cumbria allocation is £25m.

Of the £25m additional funding, it is understood that £13m relates to service transformation and £12m for sustainability. The transformational funding is fully utilised within the STP plans; £6m within the out of hospital and hospital services initiatives described above and a further £7m to deliver national priorities around primary care, cancer and mental health. Receipt of the full £25m STF will therefore reduce the residual gap by a further £18m in 2020/21.

The investment is included in the STP template progressively over the period 2017/18 to 2020/21 while, in accordance with guidance, the full assumed funding is included only in 2020/21. In practice we would look to invest as funding is made available.

After the mitigations to this point, a financial challenge of c. £16m remains. This is based on the preferred options put forward into public consultation:

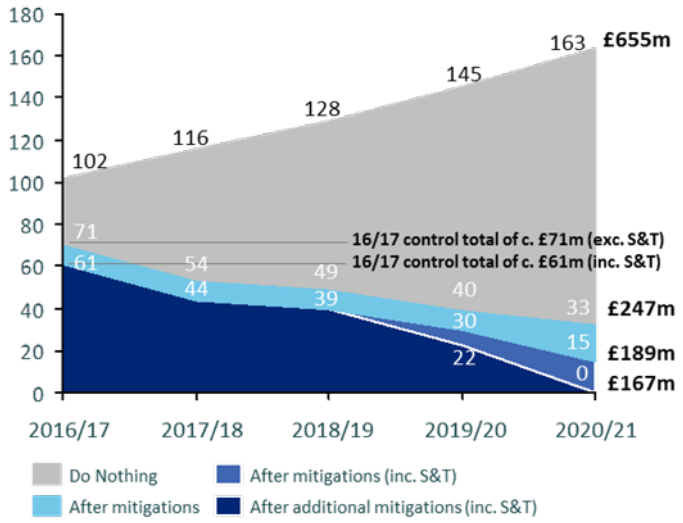
1. New Ways of Working in acute and emergency medicine;
2. Consolidation of women and children's services as summarised above; and
3. New Ways of Working for community hospital inpatient beds.

Potential revenue support required

Revenue support in the form of transitional funding is required to account for the phasing in of the mitigations considered.

The overall transitional funding requirement is in the region of £167m to £247m. The transitional implementation funding requirement (£22m) would be in addition to this.

Fig 10: Financial Analysis



Source: Success Regime Financial analysis

9. MAKING IT HAPPEN

Our Sustainability and Transformation Plan is ambitious and should be regarded as an implementation plan to transform health and care for our population. Our implementation programme looks to harness the full potential of all local partners in our STP footprint including community assets beyond the statutory organisations. We are working together in our revised governance arrangements to deliver our STP for the long term. Key risks and issues are;

1. **Leadership**. Across recent periods, the local health economy has witnessed significant change within the leadership positions of its key organisations. In partnership with the Success Regime and the Cumbria County Council ***The STP process has further strengthened leadership capability and capacity by;***
   - Creating a collaborative leadership environment across local health and social care organisations. Local providers will formally join the Health and Wellbeing Board by end of 2016 in order to ensure whole system engagement in strategic transformation and implementation. This will ensure alignment with the strategies and plans of Cumbria County Council Adult & Children's services and Public Health and Communities programmes.
   - Establishing a System Leadership Board by October 2016 which is melds the Success Regime and STP programmes into one supported by a provider side system delivery Board focussed on implementation and an integrated commissioning group focussed on commissioning.
   - Putting in place binding partnerships between NCUHT and 2 FTs rated 'outstanding' by the CQC and with active discussions underway to a new organisation form in WNE brings further capability and capacity to local leadership.
   - Delivering CCG boundary changes that focus strategic commissioning specifically on the challenges in WNE Cumbria by April 2017.
   - Reinforcing integrated commissioning between health and social care
   - Ensuring that the three STPs in the North East and WNE Cumbria work closely together in implementing wider system programmes in for example Workforce, IM&T and specialised services.

2. **Governance structure**. Achieving significant transformational change in a short period of time requires a well-structured and fast-paced governance approach which may be difficult to achieve within the local context. The measures set out above demonstrate that the ***STP is establishing governance structures that are streamlined and effective for implementation of our plans***

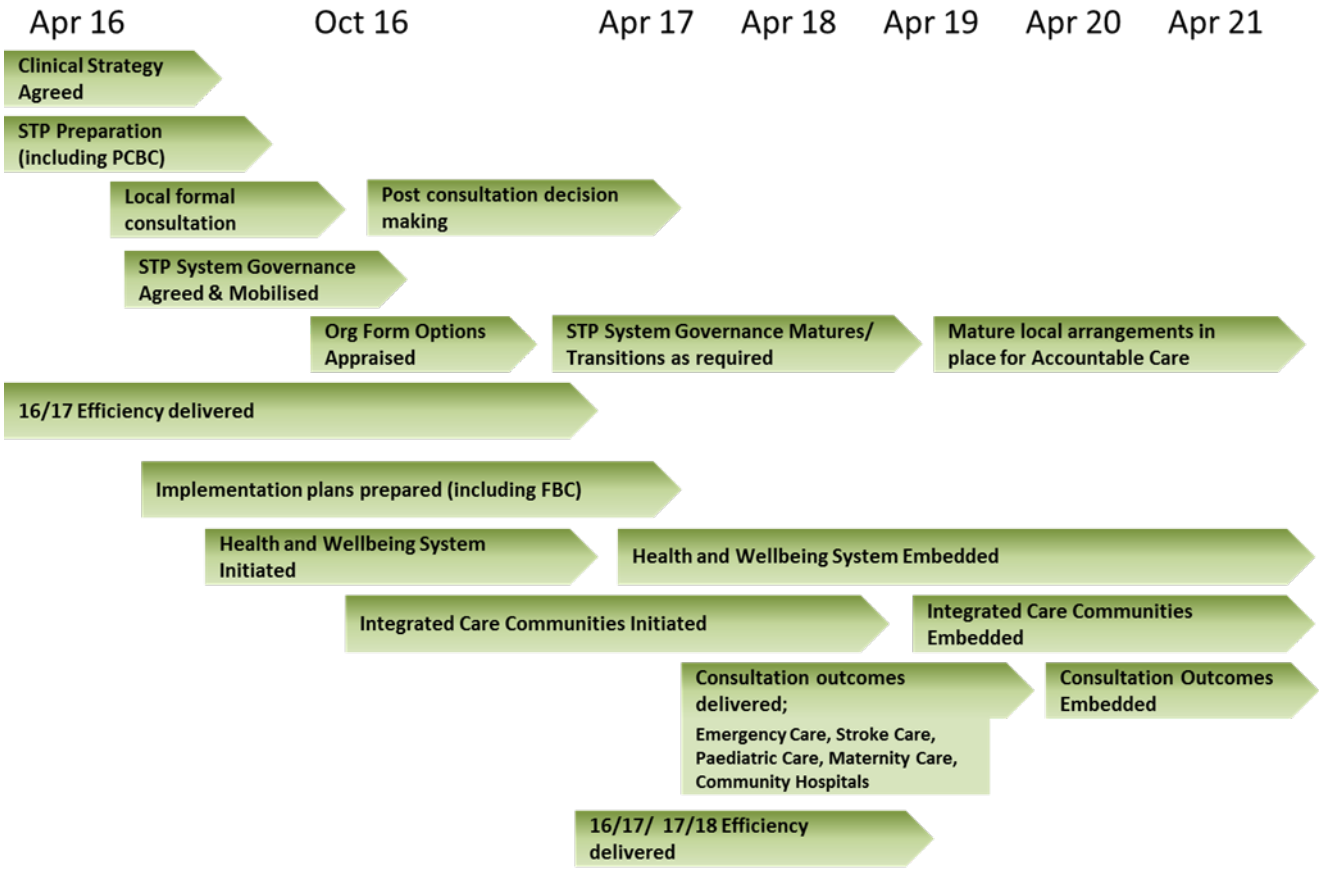
3. **Challenging track record**. The health economy has delivered limited improvements against its efficiency targets over the past years. ***The STP partners have all agreed and commenced action to achieve control totals in 16/17 and associated S&T fund performance requirements as well as significant improvements in constitutional standards . These are being effectively performance managed.***

4. **Immediate pressures**. Local pressures may inhibit the ability to deliver transformational change in a fast and efficient manner. ***The STP partners have made progress on stabilising actions and have enhanced levels of resilience arrangements in place through the local A&E Board. These continue to be monitored closely.***

5. **New Care Models**. working to harness the full potential of the emergeing new care models we will utilise them in practice to support our overall system STP. **This may inclue application of MCP contracts within our Integrated Care Communities where appropriate and learning from across the NHS in models appropriate to our STP.**

Implementation Plan

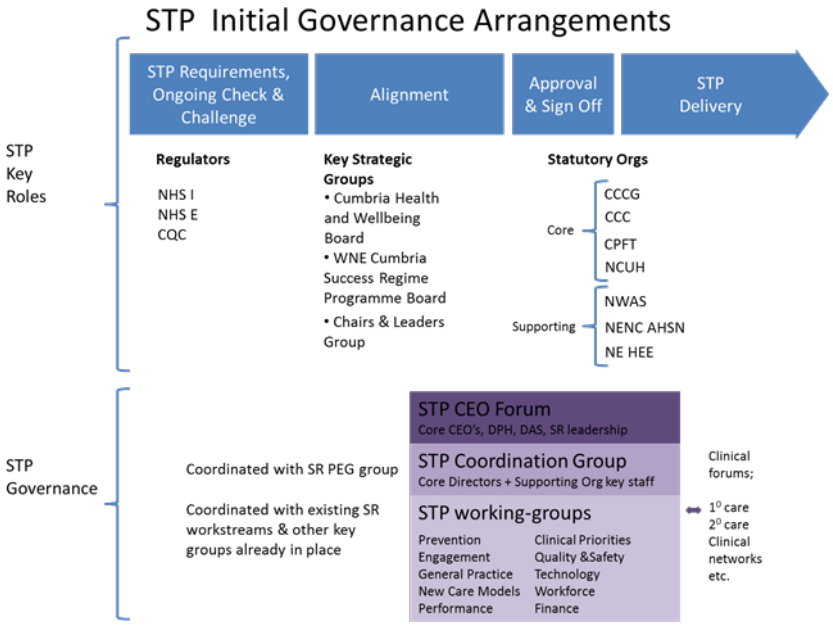
Our STP implementation plan is summarised as;



ANNEXES

Annex A: STP Governance

Our Sustainability and Transformation Plan was initially supported by effective governance as set out below;



Having passed our Pre-Consultation Business Case within the Success Regime process and having started public consultation we are now maturing our governance arrangements to explicitly transition from the Success Regime to effective local strategic leadership arrangements for the future.

Annex B: Engagement & Communication

Our STP builds on work undertaken in the WNE Cumbria Success Regime and local organisations in engaging citizens, service users & carers, patients, staff and leaders in the future. Our approach is shaped to ensure all levels of our community are informed, aware, engaged and participating;

We have therefore been concentrating our efforts on informing and building awareness across all people in WNE Cumbria through the Success Regime. As we move our STP forward we are planning to build more opportunities for participation and co-production through community mobilisation and asset based development. We are working with local authority partners to ensure our approach to these is aligned/within the existing community development infrastructure within the county.

In supporting our overall approach to enabling people to take more responsibility for their own health we are also taking forward in our STP more opportunities for people to become empowered in their participation with health and care services through;

- Co-production – e.g. where services are developing/implementing improvements etc.
- Community Resilience – e.g. volunteering, first responders etc.

- Participation – e.g. expert by experience etc.

Public Consultation commenced on 26th September 2016 following local OSC and national PCBC processes and will run for a minimum period of 12 weeks.

Information and Awareness activities from Sept 15 to May 16;

Awareness/Information Activity	Coverage
Staff Engagement Meetings	32
Public Engagement Meetings	10
Attendees at Public Meetings	1800 (approx)
Listening Events	4
Attendees at Listening Events	452
Questionnaires Completed	357
Engagement Meetings with Specific Stakeholders	85
Online Engagement Responses	231
Letters Received	140
Engagement Vehicle Sites Visited	86
Engagement Vehicle People Engaged	4210
Success Regime Twitter Feed followers	370
Success Regime Facebook Page likes	202

Consultation Process and Timelines

19 August – NHS Finance and Investment Committee (FIC) meeting

31 August - Final consultation document after NHS England FIC feedback.

8-14 September – Relevant Board Approval

26 September – Consultation Launch & document made public

Jan – Feb 2017 - Period of Reflection

Feb – March 2017 - Decision Making process and development of Full Business Case

Annex C: Enablers

Digital Roadmap and Informatics

Clinical informatics and use of technology are already major enablers of our vision for WNE Cumbria to improve patient care and provide front line clinicians with the tools to improve both efficiency and quality of care.

We aim to become ***global digital exemplars*** for our work in implementing e-referrals and resource matching across the Cumbrian health and social care system, including care homes and hospices, which is unique, in the UK.

We also lead the field in Information Governance, through our Information Sharing Gateway software, jointly developed with Lancashire, which is being rolled out across the North of England

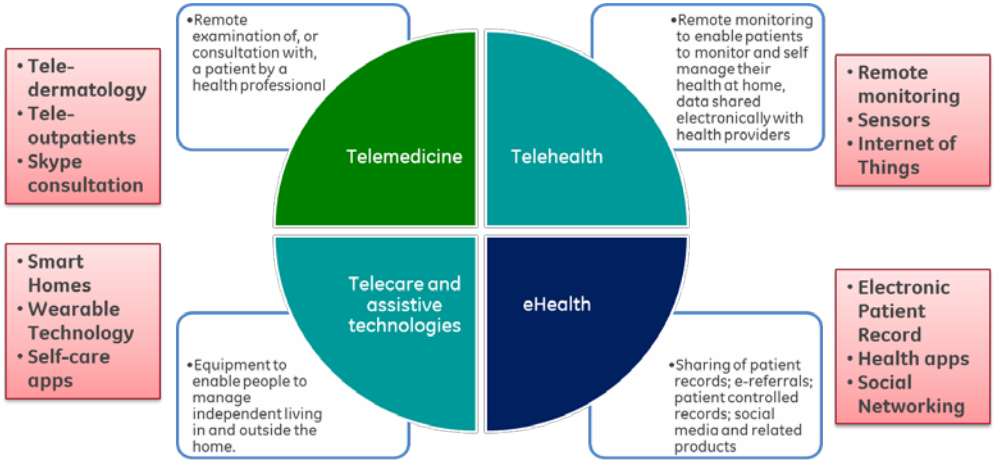
The development of the STP and LDR offers an unprecedented opportunity to start to bring its entire health and care economy into the digital lives of our communities. To achieve this, we have agreed seven system-level principles:

Our Seven Principles

1. All providers will move from paper-based record-keeping to interoperable electronic records.
2. As a foundation for integrated care, electronic patient record (EPR) systems will be interoperable and accessible to clinicians in both primary and secondary care settings.
3. Interoperability will be extended to care homes, hospices and other providers as appropriate.
4. A single electronic tool for transfers of care between teams, services and organisations will be used to ensure e-referrals and resource matching is seamless for people accessing services or following pathways of care.
5. Social care will be supported through use of the NHS number in its electronic systems.
6. ICC models of care will be exemplars in the use of technology-enabled care.
7. Use of mobile technology will be the norm for our workforce and people using our services.

People in WNE Cumbria will be able to:	Health and social care staff in WNE Cumbria will be able to:
• View their information through online access to their records, supporting them to make better decisions about their health and social care and take more control of their well-being. • Add to their information and their records, feeding in details they may have gathered from apps and wearable devices. • Routinely use digital apps, wearable devices and online resources to be well-informed, active participants in their care, making informed decisions and lifestyle choices. • Connect online with health and social care services; appointments online, order repeat prescriptions, check test results, access their medical record, secure email and video conferencing with clinicians and care professionals in a way that suits them, improving access for themselves to services. • Use digitally-enabled services to monitor long-term conditions and daily tasks to support independent living.	• Capture information electronically at the point of care delivery. • Use information and electronic care to deliver co-produced, co-ordinated care around the personalised needs of the patient and their carer. • Have access to online decision support, to advice and guidance, supporting knowledge development enabling effective clinical networks to thrive. • Foster a 'digital first' philosophy to designing and delivering new services, to promote mobile, flexible, digitally-enabled service and workforce models. • Have the skills to work effectively in a digitally-enabled environment

Our work will be based around four key domains outlined below:



Transport

Transport is a critical enabler for patients and service users to access services when needed and be supported by families during care. The region presents significant challenges in relation to distance from home to (and between) health and care sites (including tertiary centres). In addition, there is poor road access, and unusually high reliance on public transport in some areas (particularly in West Cumbria)

What we are doing to respond to transport challenges

- We have completed a comprehensive, baseline assessment of non-emergency transport to healthcare based on thorough analysis of current service provision; benchmarking and evidence based best practice. This has resulted in a number of key recommendations and stretching objectives approved by the System Leadership Board including a single Transport Strategy, leadership and co-ordination for the patch
- Development of options to maximise the use of third sector, voluntary organisation and public transport provider contributions to complement

NHS provision, including exploration of the potential for a single point of access to travel information and signposting

- A *Code of Professional Practice* to take better account of transport needs, with work to smooth patient flows and improve experience; work with staff to raise awareness of travel and transport issues when booking appointments, planning discharge etc.
- Two new car parks at CIC, creating 395 spaces by Christmas 2016.
- The establishment of clinical pathways which will enable direct transport of patients from community settings to the most appropriate hospital.
- The new Patient Transport Service (PTS) incorporating a number of quality improvements including:
    - Text-ahead service, to inform patients when their transport will arrive.
    - Streamlined quality standards, particularly around the journey arrival and collection times.
    - Revised process for applying the eligibility criteria to ensure equitable access to the service.
- Review of discharge support services to ensure availability and optimal efficiency at into weekends and evenings to assist in timely discharge.
- The development of a business case for Wi-Fi enabled shuttle buses to operate between sites – to improve access for patients/families, and more efficient cross-site working by staff.
- Further development of alternatives to hospital when an ambulance is called, such as 'hear and treat' 'see and treat', 'see and convey', acute visiting schemes and telemedicine opportunities, as well as further development of community first responder schemes.
- Action to implement the recommendations from an external expert report on transfers and retrievals, including the development of joint posts with the Great North East Air Ambulance (GNAAS), closer working with GNAAS to ensure air retrievals where indicated, and strengthening of transfer procedures between sites.
- Action plans to address issues identifies in recent survey of patient experience of transfers.

workforce

We recognise that the health and care workforce needs to evolve and change to deliver a more efficient and effective service. Emerging thinking on new models for services require ambitious plans to develop new ways of working, maximising opportunities for existing staff and attracting people to work with us. Some of these changes can and will be with the skill set of the existing workforce, some will be the introduction of new and alternate roles, whilst others will be where and how staff are deployed.

Continuing to deliver a workforce that has an enhanced skill set and competencies that works responsively, with compassion, delivering high quality patient care, including prevention, across boundaries and has the right attitude to deliver safe sustainable patient care, is key to delivering efficiency and real term savings.

Our workforce recruitment and retention will benefit from strengthened working with educational partners, NHS England and Health Education England (HEE). We are already making progress in joint work across NCUHT and CPFT in terms of recruitment branding and streamlining processes; a GP Recruitment Collaborative has been established to explore how best to attract and retain GPs. In addition in order to deliver the scale of change needed all STP partners have developed a "ten-point plan" with detailed implementation plans to drive this work forward, the high level actions are outlined below.

	Action
1	Produce a workforce and investment plan
2	Establish a new national clinical taskforce to be piloted in the WNE Cumbria
3	Accelerate the development of extended and new roles / skills / behaviours
4	Focus on "Growing Our Own" workforce locally through a new Centre for Excellence
5	Devise a prioritised 'NHS in Cumbria' reward and recognition strategy
6	Develop the first national teaching system accredited by local education and national partners
7	Develop a recruitment hub
8	Promote Cumbria through an NHS covenant and Local Enterprise Partnership (LEP) commitment
9	Enhance the employer brand/employer of choice initiative, support employee engagement and wellbeing
10	Invest in leaders and talent

Organisational/System Development

The Organisational/System Development work as outlined in Section 5 is about supporting health and care system improvements and change through our people. Success is when professionals work together, showing leadership and alignment to the system and when they problem-solve respectfully and deliver improvements together in the interests of the people who use our services.

To achieve success, the OD approach will:

- Add value to existing OD plans within organisations and align them to our system plan.
- Engage the hearts and minds of our professional workforce, involving staff at all levels, building leadership and improvement capability and helping them really believe that we can be successful.
- Focus on working together in multiple and cross organisational 'teams' coordinating and improving care around the needs of our citizens.

Work has already started and a number of building blocks are in place:

- A commitment to learn together through CLIC, common tools and a model for improvement.
- A number of development programmes in place within individual organisations and links to support networks such as the North West Leadership Academy (NWLA) and Advancing Quality Alliance (AQuA) and Skills for Care.
- A body of evidence and clear 'manifestos' such as the Berwick Report and the work of Michael West to guide our plans.
- A nucleus of knowledgeable, experienced and engaged people to lead and support development.

An exercise to map the development programmes and OD resources that are currently in place across organisations has been undertaken and a system OD plan has been agreed. The high-level plan relates to building leadership and improvement capability in all staff through developing our existing OD programmes and through introducing new and specific OD interventions to targeted teams/groups of staff that are critical to the delivery of the SR programme.

Key deliverables include;-

	Action / Initiative
Learning together	
All staff	CLIC improvement programmes & Forerunner clinical skills programme
Targeted*	Programme to support specific groups using established common tools and models.
Working together	
All staff	CLIC collective leadership programmes
Targeted*	Programme to support specific groups e.g. team development, leadership using established tools and models.
	CLIC System leadership programme to support integrated care teams
Solving Problems respectfully together	
All staff	Using organisational values and behaviours to agree 'how' we will work together respectfully in teams across the system.
	Agree a common narrative and develop a comms plan & engagement programme
Targeted*	Coaching skills – 2-day programme
	Action learning sets

**Targeted programmes are likely to combine all three elements in to a single specific programme tailored to the needs of the group.*

Estates

We recognise that no single aspect of our health and social care system can be considered in isolation, and therefore the work undertaken through the WNE Cumbria Success Regime has ensured a "whole system" approach is taken to inform our proposals for change. The current estate in WNE Cumbria is fragmented, largely due to the sparsity of the population and the physical geography of the area with two district general hospitals, eight community hospitals and many primary care premises. As we progress new models of care, embrace new technology and ways of working, the expectation is that this will have a significant impact on our estate requirements and our plans will need to reflect this. The NHS also funds the provision of premises for primary care. The buildings owned/ leased by practices; in some cases, from NHS Property Services Ltd or CHP Ltd. We recognise that there are several immediate challenges that need to be worked through, to provide the foundations for future changes, specifically:

- Ensuring the continued expert contract management of Private Finance Initiative funded estate which accounts for approximately 50% of expenditure on NHS estate in WNE Cumbria, maximising the potential for adaptation and releasing cost.
- To agree the business case of the next phase of the WCH development to release double running costs.
- To support the development of locally-owned ICC estate plans which focus on the opportunity to co-locate services and maximise the use of good quality estate releasing buildings that are no longer suitable for the provision of modern health and social care. This should include primary care estates plans.
- Appraising potential options for wholesale strategic estates partnering (ownership and development) across all organisation in both WNE Cumbria and beyond (e.g. Morecambe Bay).

These priorities have informed our seven-point plan (summarised below):

1. Increase utilisation and optimise use of the estate
2. Optimise the primary care estate through engagement with practices and a strategic approach to estate planning and delivery. Investigate system approaches to future ownership models for GP premises.
3. Implement joint and robust governance over the estate through frameworks with all partners across the system
4. More explicit links with local authorities and consultation and engagement with local communities.
5. Manage supply side partners – PFI; LIFT; and NHS PS
6. Ensure prominence within governance arrangements to ensure deliver estates element of STP. Build capacity and capability within organisations. Consolidation of in-house services.
7. Align to or better the Carter metrics and emerging metrics for Mental Health and Community Services.

Annex D: Pre-Consultation Business Case (PCBC) and Addendums

http://www.wnecumbria.nhs.uk/publications-documents/

Annex E: Briefing Notes

http://www.wnecumbria.nhs.uk/publications-documents/

Annex F: Implementing Prevent and Divert: A Cumbria Health and Social Wellbeing System

http://councilportal.cumbria.gov.uk/documents/s45827/Implementing%20Prevent%20and%20Divert%20A%20Cumbria%20Health%20and%20Social%20Wellbeing%20System.pdf

Annex G: Our Approach to Shared Support Services

Our STP outlines a number of transformation plans that are built on increased integration and shared ways of working. Shared support services are an important enabler for this.

There is a strong track record of providing and purchasing shared support services in place in West, North and East Cumbria. NHS organisations already utilise a variety of shared arrangements for procurement, payroll, information governance, financial services, internal audit and registration authority services. These are well established and will be reviewed tactically so that these are aligned where necessary over time if not already fully aligned. The main drivers are to enable the planned future system transformation/integration more effectively and to support economies of scale and deliver resultant efficiencies. Our STP financial model includes a significant requirement to reduce cost of support services.

In summary our agreed approach is to achieve the following;

1) **Establish** a strong case for public service shared support services for the citizens of West, North East Cumbria to be a common vision to be achieved over 5 years for all organisations present within the STP footprint. Initially focusing on all NHS and the tier 3 local authority as core constituent participants. We recognise that for our local authority partners this vision may include a hybrid approach where some may move to fully integrate shared services with the NHS and others don't whereas within the NHS our vision would be to share across all areas.
2) **Align** current shared arrangements through tactical decisions on external providers where this is necessary/advantageous.
3) **Implement** further local shared service provision within the local NHS as an enabler to move into (1) above in major support service areas as an immediate stabiliser/enabler for transformational integration and to signal our wider visibly within our STP footprint.
4) **Spread** shared approaches across a wider potential pool of services to be shared in subsequent phases once (3) is achieved).

The impact of this approach will be;

- Improved services for citizens/patients/organisations.
- Improved efficiency and value for money – contributing to cost savings within our STP financial plan.
- Improved resilience and stability for our STP organisations.

As an STP we have agreed the above approach to support our clinical service strategy and wider health and wellbeing strategy. We are also considering wider organisational form developments towards being a system that delivers "accountable care". As the organisational form journey develops we anticipate ensuring our shared support services arrangements support and enable this. We are therefore developing shared system governance for our STP to take forward our system governance. This includes the joint approach to communications and engagement with all stakeholders on common issues including our plans for shared support services.

We have identified 3 specific early NHS shared support services; **IM&T, HR & Estates.** These are identified as each of them is a key enabling area for our clinical strategy and each is facing some degree of current instability/imperative that requires enhancement in the immediate term.

In addition, we have identified an opportunity to utilise **shared pathology services** within our wider pathology clinical network beyond our STP boundary. Early discussions on this have taken place and we are aiming to consider detailed proposals and agree implementation plans from April 2017.

We have identified as part of our wider NHS STP financial planning process a required financial benefit of £4.4m to be achieved from our 5 year shared services consolidation programme. The proportion of benefit derived from the 3 candidate areas is not yet calculated but is expected to be high as each of these are large support services with significant costs. We anticipate completing this in our next steps.

The intention is to move towards NHS shared support services between NCUH and CPFT over the next 12 months with a phased approach.

Detailed implementation plans have not yet been developed and will need to be as part of our next steps. To achieve this we will need to ensure adequate project management support is in place. Our STP governance has been reset to recognize the need to programme govern the move to shared support services within the “our infrastructure” working group.

Annex H: Performance Metrics

The Measureable Impacts of the STP

The STP will improve performance across our system in each of; Health and Well-being, Care & Quality, and Finance & Efficiency. These improvements will be reflected in our performance against constitutional standards, in health outcomes and in delivering patient activity and finance.

A comprehensive performance framework is being developed across all the clinical workstreams and this will link in with national operational plan metric and local performance indicators. A smaller set of key performance indicators have been identified to demonstrate the measureable impact of the STP as a whole.

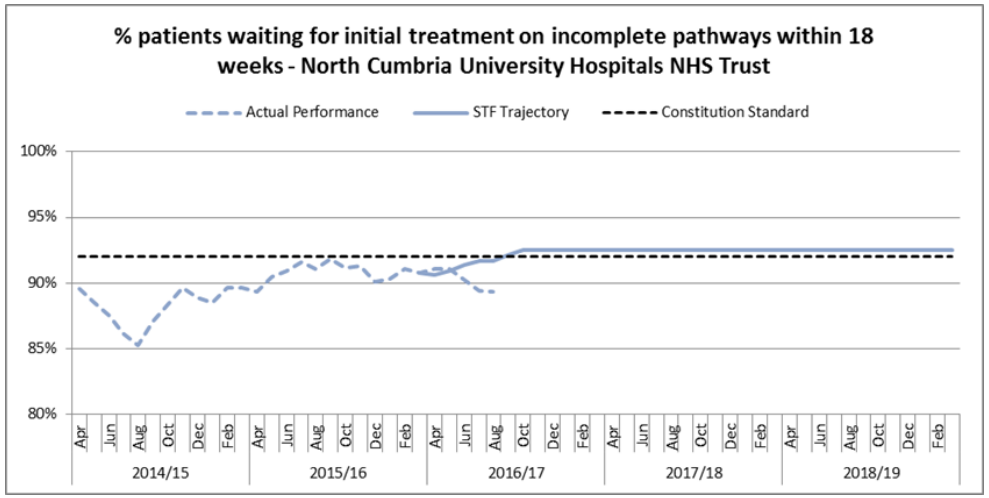
Health and Well-being

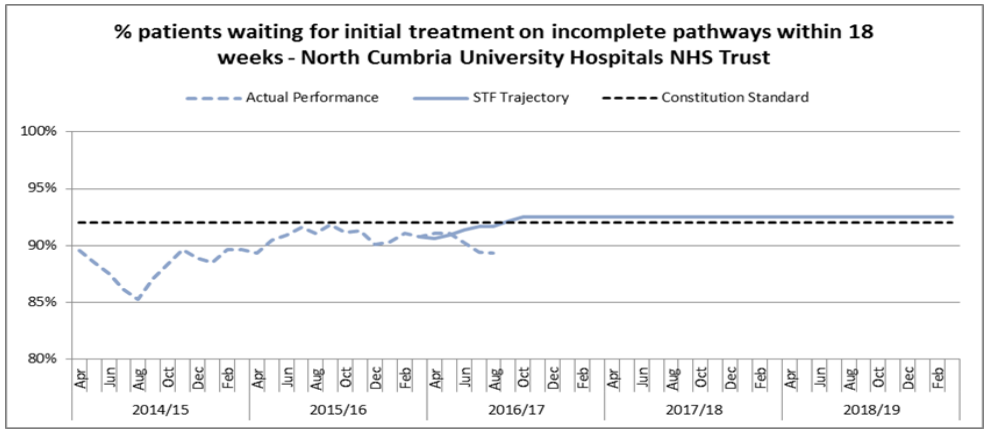
Through national and local benchmarking, including the RightCare programme, Cumbria has been identified as having high premature mortality rates for circulatory and respiratory conditions. With the focus on the respiratory and circulatory pathways across the clinical workstreams, there is the aim to reduce premature mortality rates to the average of our 10 most similar CCG areas by 2020/21. Note that, as mortality rates are not published for WNE Cumbria, a whole Cumbria rate has been used as a baseline.

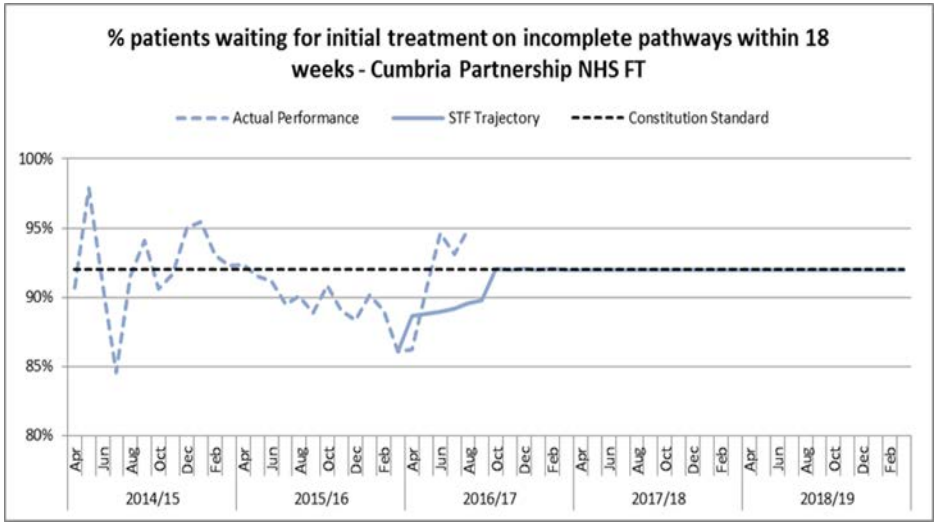
Under 75 directly age-standardised Mortality rate (DSR) per 100,000 popn	Year								
	2012	2013	2014	2015	2016	2017	2018	2019	2020
Coronary heart diseases	42.7	42.7	42.7	42.7	42.5	42.2	41.2	39.75	37.15
All Circulatory diseases	75.2	75.2	75.2	75.2	75	74.25	73	71	68.45
Bronchitis, emphysema, & COPD	16.1	16.1	16.1	16.1	16	15.75	15.35	14.7	13.97

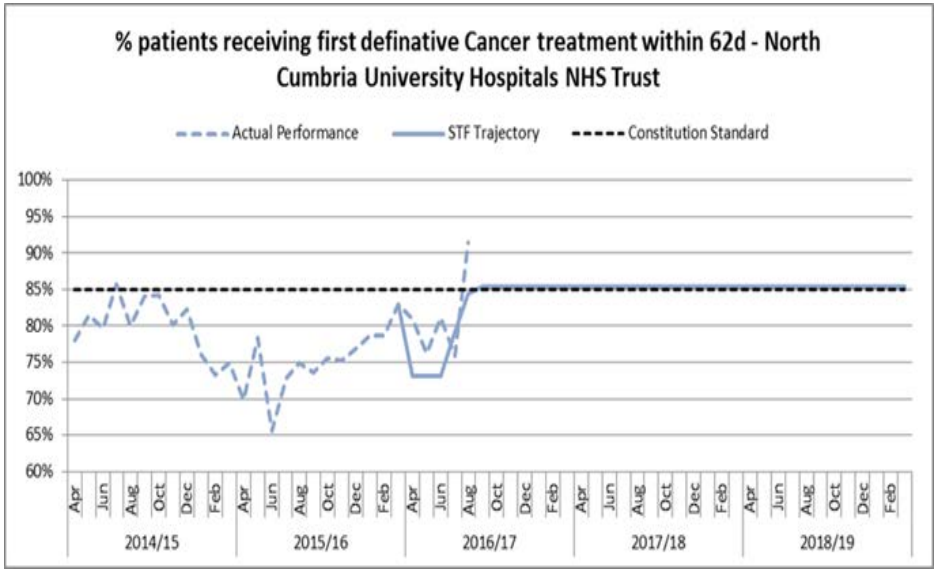
Care and Quality

As a health economy over the last few years WNE Cumbria has not achieved some national quality standards as set out in the NHS constitution. In 2015/16, we agreed performance trajectories that describe how we will meet these key standards by the end of 2016/17. The STP will ensure that these standards can be met in a sustainable way across the health economy over the next 5 years.





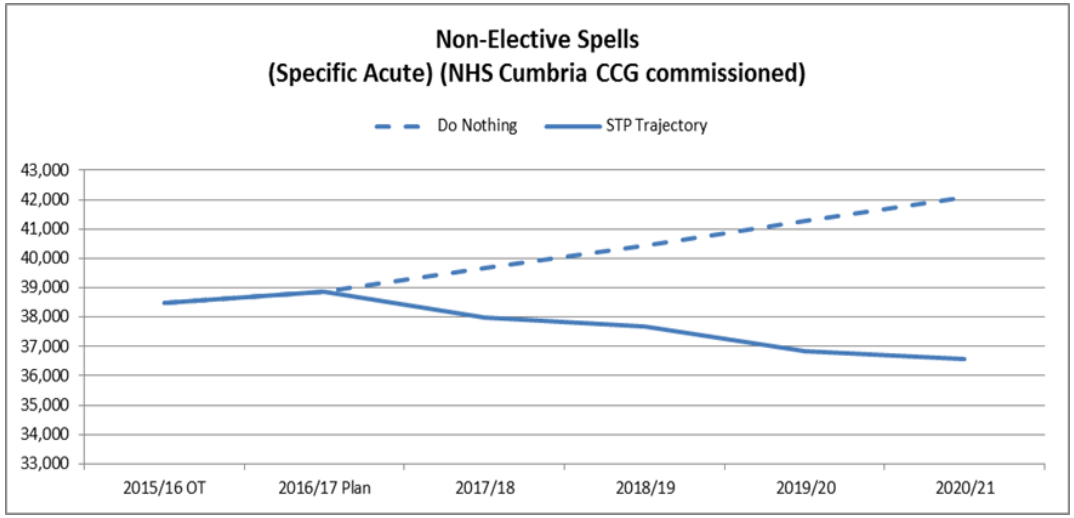




Finance and Efficiency

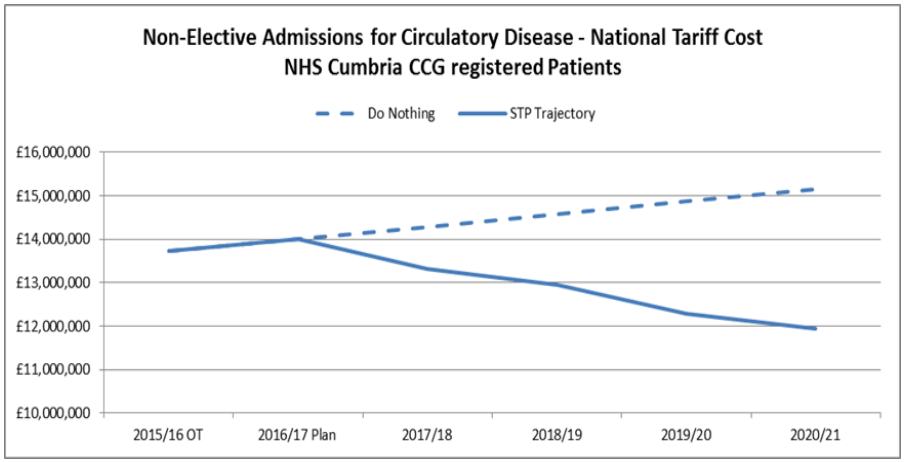
The STP aims to reduce unnecessary emergency admissions to hospital. The expected reductions in overall non-elective admissions have been modelled in line with the Out of Hospital Model.

	Non-Elective Spells (Specific Acute) (NHS Cumbria CCG commissioned)					
	2015/16 OT	2016/17 Plan	2017/18	2018/19	2019/20	2020/21
Do Nothing	38,493	38,878	39,655	40,449	41,258	42,083
STP Trajectory	38,493	38,878	38,005	37,699	36,858	36,583

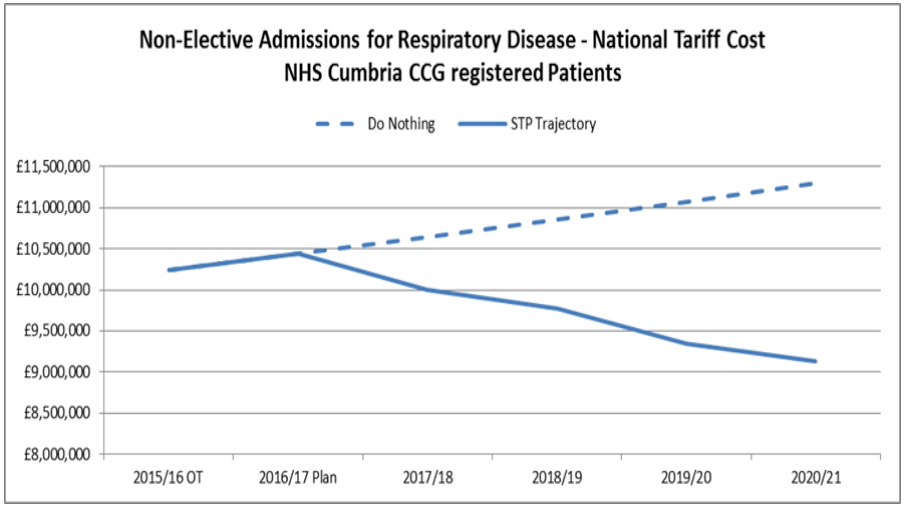


As part of this model, specific reductions are expected in non-elective admissions for circulatory and respiratory conditions and in elective admissions for musculoskeletal conditions. The opportunity to make these reductions has been identified through national benchmarking provided through the RightCare programme. We aim to reduce admissions to be in line with our 10 most similar CCG areas by 2020/21.

	Non-Elective Admissions for Circulatory Disease - National Tariff Cost NHS Cumbria CCG registered Patients					
	2015/16 OT	2016/17 FOT	2017/18	2018/19	2019/20	2020/21
Do Nothing	13,727,319	14,005,021	14,285,122	14,570,824	14,862,240	15,159,485
STP Trajectory	13,727,319	14,005,021	13,317,784	12,958,594	12,282,673	11,935,026



	Non-Elective Admissions for Respiratory Disease - National Tariff Cost NHS Cumbria CCG registered Patients					
	2015/16 OT	2016/17 FOT	2017/18	2018/19	2019/20	2020/21
Do Nothing	£10,239,296	£10,436,048	£10,644,769	£10,857,664	£11,074,817	£11,296,314
STP Trajectory	£10,239,296	£10,436,048	£9,996,815	£9,777,742	£9,346,942	£9,136,469



	Elective Admissions for Musculoskeletal Conditions - National Tariff Cost NHS Cumbria CCG registered Patients					
	2015/16 OT	2016/17 FOT	2017/18	2018/19	2019/20	2020/21
Do Nothing	£19,476,636	£19,868,551	£20,265,922	£20,671,241	£21,084,665	£21,506,359
STP Trajectory	£19,476,636	£19,868,551	£19,203,937	£18,901,266	£18,252,706	£17,966,409