Our Vision for Health and Care Services across Morecambe Bay

By 2025 Morecambe Bay will have a well-deserved reputation as one of the best health and care systems in the world. Promoting wellbeing and preventing ill health will be our prime purpose with mental health, children’s, and older people’s services receiving equal priority with all other areas of care.

Working here will be an experience that attracts high performing, compassionate staff who are as drawn to our culture of achieving excellence as they are to the beauty and variety of our landscape.

Specialist teams, including hospital consultants will increasingly work in the community, sharing their expertise with GPs and community teams. These health and care professionals will work in a partnership of trust with patients as equal partners to keep people fit and well. When people are ill they will receive high quality care and support to help them to manage their own condition - mainly within their own homes or local community.

If people do need to go into hospital to receive care they will have confidence that they will be treated with dignity and respect. They will expect to recuperate at or near home, freeing up beds for those who really need them. A&E departments will be seen as the last rather than the first port of call.

The funding we receive will fairly reflect the needs of our local populations enabling us to make the best use of every NHS and Social Care pound, meaning that as well as maintaining existing services we can take advantage of new technology and advances in medicine at an early stage to provide even better outcomes for our patients.

People will live longer and in terms of their health and well-being will have a better quality of life wherever they live, whatever their income. When people reach the end of their lives, wherever possible this will be at home in the comfort of familiar surroundings or in a specialist place of care such as a nursing home or hospice.
The Better Care Together programme is the review of health and care services across Morecambe Bay which will turn this vision into a reality.

Our Strategy outlines a new and ambitious way of delivering better care for the people across the Bay, based upon detailed work carried out in the period October 2012 – June 2014.

At the end of June 2014 we submitted a Strategy to NHS England and Monitor, the regulator of Foundation Trusts. Both of these organisations have a statutory role in providing advice and scrutiny to ensure that any proposals for change put forward by local NHS organisations meet appropriate quality and financial standards. As we are asking them for financial and developmental support to underpin our proposals, their agreement is essential for us to deliver our Strategy.

In July and August last year NHS England and Monitor provided us with feedback about our proposals and identified a number of areas where additional work was required. This document responds to the points raised.

This is not a consultation document. This Strategy has been produced to provide our staff, local communities and regulators with an overview of the work of the programme, to share our recommendations based on the work done to date, and to provide a focus for further discussion about the future of local health and care services. This will shape the direction for the development of detailed business cases and action plans. No decisions have been made at this stage, and the Strategy is likely to continue to evolve following feedback from our stakeholders including NHS England, Monitor and the Clinical Senate. The proposals for maternity may need to be reviewed depending upon the findings of the Morecambe Bay Investigation, being led by Dr. Kirkup and the Cumbria and Lancashire North Maternity review by the Royal College of Obstetricians and Gynaecologists.

If you have any further questions about this document or would like a printed version please feel free to contact us via our website: www.bettercaretogether.co.uk or call the better care together team on 01524 518 638.
1. Our Executive Summary

When things go wrong in our local hospitals it hits the headlines, and the quality, safety and financial issues experienced by our hospital Trust have been well publicised in recent years. But the less well known story in Morecambe Bay is not about what happens inside hospitals – it’s about what isn’t happening in the primary, community and social care services that most of us rely on for most of our healthcare needs.

Precious lives are being lost because we aren’t doing enough to support people to prevent them from becoming ill in the first place. Then, when people are ill, we don’t always give them the advice or tools to manage their own condition and prevent crises from occurring - so all too often they end up in a hospital bed with all the upheaval and distress that this can involve.

Our local communities deserve much more. We owe it to them to be clear about what has gone wrong and why and our proposals for fixing this for the future, so that we can restore public confidence in local health and care services. This is why all the health and social care organisations that deliver services across the Bay have united under the banner of the “Better Care Together” programme to co-design high quality adult, children’s and mental health services that will be safe, affordable and fit for the future.

The result is a range of proposals shaped around our unique geography and demographics, and is based on sound clinical evidence, national and international best practice and detailed analysis by independent third parties. This work has been led by hospital doctors, GPs, nurses and social care colleagues who have been passionate about finding out what local people and our partners think of their health and care services and their aspirations for the future. The findings of this extensive engagement have influenced the solutions that we are proposing.

At the heart of our Strategy is a “population” based approach to promoting wellbeing and providing care in which people and their needs are the focus rather than processes and buildings. Responsibility for health and care will become a true partnership between the people needing to access services and those who provide them. People will be enabled to make lifestyle choices that will keep them healthy for longer and to take control and manage their long term conditions with local clinical teams integrating the support and technology they need around them. This will include more effective use of video links, texting and other telehealth facilities which will reduce the need for patients to travel whether from their own or their nursing care home.

Our local GP practices will become the way for people to gain access to all care including hospital services. GPs will work closely with a wide range of other health and social care colleagues to ensure people’s needs are met, and to cut through the red tape that causes unnecessary barriers, delays and expense in the existing system. Hospital consultants will work alongside these new teams in the community to share their expertise, so that more staff are able to help patients cope with the long term conditions that so many of us will encounter in our later years.
Over the next two years our focus will be on making these changes happen which will require radical changes in both community and hospital based services. We have a detailed plan which outlines exactly how we will deliver this through a range of projects aimed at ensuring that we have consistent standards of care without reducing the ability to tailor this to the specific needs of local people. Therefore some projects are Bay wide whereas others focus solely on South Cumbria or North Lancashire.

By ensuring that community based services become the first port of call for most people, our local hospitals will be able to focus on providing excellent care to fewer patients who really need it. The reduced pressure on hospital services will drive up service standards, costs will fall, lengths of unnecessary hospital stays will reduce and waiting times will improve.

Many out-patient clinics will take place in the community with hospital consultants travelling to patients rather than the other way around. People will only attend these clinics when they really need to, rather than getting caught up in a cycle of unnecessary appointments caused by an outdated system.

Subject to the outcome of the Kirkup investigation it is our intention that modernised emergency care and consultant led maternity units will remain as core essential hospital services in Barrow and Lancaster even though we know that these services cost us far more to deliver than the funding we receive to provide them. However the distances between our hospital sites, and the consequent travelling times for patients and their families, coupled with the fact that Barrow has a number of industries of strategic national importance including nuclear and defence facilities, mean that it would be unsafe to attempt to reduce or remove these services.

Our research has shown that in addition to the pressures caused by inadequacies in primary, community and social care, the other major contributing factor to the failings in our hospitals is the challenge of providing acute services to a relatively small population spread across three geographically diverse sites.

This is why our medium term proposal (2-3 years) is that the majority of inpatient elective surgery is moved onto two sites. The work we have undertaken to date suggests that this should be on at Royal Lancaster Infirmary and Furness General Hospital. This would help to solve historic problems with staffing, drive up surgical standards and improve outcomes and patient experience for people across the Bay.

A key question for many is the future of Westmorland General Hospital. We see this continuing as a local hospital, but also becoming a vibrant hub for a range of community and specialist services to meet the needs of the South Lakeland population. An element of this could be creating a centre of excellence for eye care and surgery building on the macular degeneration service and extensive eye surgery that already takes place. Alternatively the site may become a centre of excellence for day case surgery. Whatever happens most existing services will remain as surgery only accounts for a modest percentage of activity on this site. We will work with local people and our partners over the next 12 months to develop these ideas further. We remain open minded about what the final options could look like as long as they meet the overall objective of providing high quality, safe and affordable services. The reason we are sharing our thinking at this stage is to allow us the opportunity to have the honest conversations needed to achieve this. In the meantime we are fully supportive of the local campaign to bring radiotherapy to the site.

...By ensuring that out of hospital services become the first port of call for most people, our local hospitals will be able to focus on providing excellent care to fewer patients who really need it...
Although 525 fewer in hospital jobs will be needed in the future, this will happen through natural wastage and a reduction in agency staff. However our culture will change, and everyone from consultants to health care assistants will need to work more flexibly to deliver care when and where our patients need it. We will provide the support and training needed to achieve this, and for many staff this will provide exciting new development opportunities.

The approach we describe in this Strategy will require some radically different service models. The Five Year Forward View just published by NHS England echoes our proposals for integrated out of hospital care built upon GP practices, supported by specialist teams. It also recognises the challenges of viability faced by small District General Hospitals and suggests one option would be for them to become part of an integrated local care provider along with community and primary care services. We believe that the opportunities presented by the Forward View are crucial to creating the environment to enable us to succeed.

These proposals resolve most but not all of our financial deficit. Nevertheless our consideration of over 130 options and the work we have done so far indicates that our recommendations represent the most clinically safe and financially viable proposal for local people. Our plans do provide a solid platform for us to build upon and we need to act quickly to prevent further deterioration of our position. We will continue to challenge ourselves with ambitious targets for closing the gap further. We will also be working with NHS England to seek support to review the way that funding is allocated to reflect our unique local challenges.

We have been mindful that the NHS and Local Authority partners in North Cumbria and the rest of Lancashire are also undergoing changes and will continue to work with colleagues as our proposals develop to ensure that they complement rather than compete with plans within those localities.

We live and work here. Our families are reliant on the same services as the people we serve. We want to provide the best possible care within the realities of the budgets available to us and recommend the Better Care Together Strategy as a credible and exciting way forward for our local health economy.

Signed: Better Care Together partners
2. Our Case for Change

Most of the time, local people are proud of their local NHS. So are we. But we owe it to our communities to be honest about the fact that our hospitals, GP surgeries and other primary, community and social services are struggling to consistently meet their needs now, let alone in the next decade and beyond. We must change the way we do things to save the NHS for future generations, and to ensure all of us can look forward to a healthier future.

Andrew Bennett, Chief Officer, Lancashire North Clinical Commissioning Group and Senior Responsible Officer, Better Care Together
Why we need to make changes

Background

As a country, we are facing a number of challenges as to how we provide health and care services now and in the future. The population is ageing and while it is good news that we are living longer, the numbers of us living for many years with long-term conditions such as heart disease, diabetes and hypertension are rising at an overwhelming rate and the NHS is struggling to cope.

More locally, people will be well aware that the NHS in Morecambe Bay has experienced more than its fair share of problems. In the recent past we have sometimes let our patients and their families down with devastating consequences. There have been a number of high profile reviews and inquiries in recent years which have dented staff morale and public confidence and had a negative effect on our reputation and ability to attract high quality permanent staff.

It tends to be the failings in our local hospitals which hit the headlines. Many improvements to hospital services have been made under the leadership of the Chief Executive Jackie Daniel and her management team, but problems remain and the University Hospitals of Morecambe Bay NHS Foundation Trust has recently been put into “special measures” by Monitor on the recommendation of the Care Quality Commission.

The timeline (see page 12-13) shows some of the highs and lows of the Trust in recent years,

We are clear that our responsibility is to the public and not to individual organisations. However experience tells us that when the Trust has the right support and resources in place, it can deliver significant improvements, and become one of the best in class. For example in 2012 the Trust’s stroke services hit a low. Joint working between the Trust and Lancashire North Clinical Commissioning Group led to service investments including Stroke Clinical Nurse specialists, dedicated service Managers, weekly Stroke meetings, staff training and leads for nursing and therapies. As a result the service rose from the bottom of the Advancing Quality Alliance (AQuA) scoring to a place in the top four. The service also secured a nomination in the “Professional Excellence Category” 2014 Stroke Association Awards. Another impressive step change in quality is the improvements to the Heart Failure Service.

All the health economy partners agree that the problems in our local health economy are not about an organisational failure or day to day management issues. The only way that we can guarantee great care within the realities of the budgets available to us is to focus our support and resources on people, not buildings and by providing care as close to home as possible.

We know that the less well known story in Morecambe Bay is that some of the root causes of the hospital’s problems begin in primary, community and social care. This is why local Clinical Commissioning Groups (CCGs) and partner organisations have expressed their strong support for the hospital. We know that it is essential for us to work together to find lasting solutions to the financial and quality challenges that we all face and want to solve.
Figure 1. Timeline

- **2008**
  - Problems at FGH maternity services first identified

- **2009**
  - Police launch investigation into maternity services at UHMBT

- **2010**
  - CQC announces 8 week investigation of A&E at RLI and FGH

- **2011**
  - UHMB first Acute Trust to launch Lorenzo
  - CGC gives UHMB good rating for use of resources and Fair for quality
  - CGC give UHMB a good rating
  - UHMBT CQC rating Fair/Good
  - Medical Unit 2 at RLI refurbished
  - Chemotherapy services begin at WGH

Figure 1. Timeline
Jackie Daniel appointed as Chief Executive

Better Care Together Programme starts

Heart Failure services improve to a higher ranking of 11/24 on the previous year

90% of patients would recommend UHMB (F&F test)

Improvement Board established

Advice and Guidance pilot shortlisted for award by HSJ

UHMB Trust Board approves a further £3m of funding for additional nurse staffing

Stroke services improve to a higher ranking of 4/24 on all previous years

Chief Executive resigns at UHMBFT

UHMB announces it needs to make £30 million savings

Kirkup Inquiry into maternity services at UHMBT launched (ongoing)

UHMBT receives an inadequate rating from the CQC

2012

2013

2014
A unique geography needs a unique approach

Those of us who live in Morecambe Bay know that it contains a unique variety of landscapes and communities. Within our boundaries we have Barrow-in-Furness, a fairly large town with a strategic industrial base set in a glorious but remote location with high levels of deprivation; small, picturesque but isolated villages such as Hawkshead and Coniston; a proportion of the stunning Lake District National Park; and Lancaster, a well-connected historic City with two University campuses. Students rub shoulders with tourists, Sellafield scientists with local farmers, the affluent with the less well off. Some of our communities travel for many of their amenities, others have them all on their doorstep.

Ironically the very things that make the Bay such a special and attractive place to live and work also create challenges to providing great care.

At the moment the University Hospitals of Morecambe Bay NHS Foundation Trust operates as a network of hospitals across South Cumbria and North Lancashire, providing patient services from five sites, three of which are considered our ‘main’ hospitals (Furness General Hospital in Barrow, Westmorland General Hospital in Kendal and Royal Lancaster Infirmary in Lancaster).

Whilst our population of around 365,000 sounds large, in most urban areas that number of people would be served by just one or two hospitals.

This matters because the funding for health provision in the Morecambe Bay area is worked out on the basis of the number of people served, so our big geographical footprint and sparse population means we have to stretch the money usually used to run one or two hospitals over three main sites. This doesn’t take into account our smaller community hospitals at Ulverston and Morecambe.

The long distances between our main hospitals in Barrow, Lancaster and Kendal also means that we often need to duplicate services, so we have higher running costs – it is not unusual to take three, or even four hours for a return journey between Barrow and Lancaster. Historically, our relative isolation from major city hospitals also means we often have difficulty recruiting to specialist roles, piling further pressure on our resources as we are forced to cover vital clinical work with expensive temporary staff. This has become even harder in the light of the problems reported in recent years. These practical and reputational issues also have an impact on our primary and community services.

These challenges mean we are struggling to provide safe, high-quality care for everyone while living within our means. For some time, the hospital has been effectively spending more than it receives to provide services, and the two local Clinical Commissioning Groups who are responsible for how the majority of local NHS money is spent cannot afford to fund this gap. Continuing to invest is the right thing to do at the moment, because our patients always come first. For example by 2015, the University Hospitals of Morecambe Bay NHS Trust will have invested around £8m into front line staffing over a three year period. Primary and community care have also received investment including GP surgeries and health centres. The Kendal Gateway centre (a one stop health hub run by six different charities) and STiNT Plus, a multi professional community team that supports people at home preventing admission to hospital.

However if we carry on as we are, we will eventually compromise our ability to invest in new services and equipment. Health services will then stagnate, with people in the Bay unable to take advantage of the latest clinical advances. And like our own finances at home, something has to give when you continually overspend - for us, it cannot be quality or safety.
365,000 population across three main hospital sites = gaps in safety, finance and patient care

...the very things that make the Bay such a special and attractive place to live and work also create challenges to providing great care...
Delivering services around the patient, not around buildings

Over the last two years, the hospital Trust and its commissioners, Cumbria Clinical Commissioning Group and Lancashire North Clinical Commissioning Group in partnership with a range of other NHS organisations and our two County Councils have been reviewing health and care right across the Morecambe Bay area. We have been looking at how we can best deliver services in the future to meet the challenges we are facing, both in the hospital and also outside of hospitals in our communities and neighbourhoods.

This process has involved doctors, nurses, midwives and health and social care professionals both from within the hospital and outside of it, looking at best practice examples from across the UK and further afield, as well as taking advice from other experts. We have also spoken with thousands of members of the local public and asked them about their views on health and care services, both now and in the future.

As a result of this clinically led work, a proposal has been developed where the hospital Trust, GPs, community, mental health providers, social care providers and third sector colleagues would come together, breaking down old ‘organisational barriers’ to deliver services around the patient. No more “this isn’t my responsibility” or “it’s not in my budget”. This transformation would see care in many cases delivered more locally to a patient, such as in a health centre, and create new and speedier links with the hospital consultants and specialists.

The NHS has a strong track record of providing specialist, expert advice, but is not always as good at coordinating the practicalities to ensure that the advice is properly acted upon. Our proposals will see specialists work as one team to serve local communities and neighbourhoods, providing a single contact point for patients. This will put a stop to individual clinicians having to go round in circles to get the help a patient needs, which often means delays and additional anxiety, confusion, worsening of the patients’ condition and ultimately more care needed.

Our approach means we will be able to provide earlier diagnosis and treatment of conditions, make better use of hospital resources including where clinical staff are based, reduce the time taken by our patients making unnecessary trips to hospital (e.g. outpatient appointments that could take place in the local GP surgery) and prevent the health of our patients deteriorating when it shouldn’t.

We have no proposals to close hospitals, but this new way of working will mean that our hospitals will look and operate differently in the future. Community facilities will be needed closer to people’s homes to provide clinics and other services traditionally provided in hospital.

In addition to the benefits for patients, this new focus on community care will open up many rewarding career opportunities for staff who are prepared to work more flexibly. For example, at the moment 82% of our nursing and midwifery staff currently work in hospital, compared to the 32% of nursing which is “acute based” in areas of the country where the focus on community care has been in place for some time. There won’t be a sudden dramatic exodus of staff from the hospital into community roles, because under our proposals in-hospital roles will become less pressurised and more attractive than they are currently. However, over time the ratios of staff working in a hospital setting versus those working in the community is likely to change dramatically as we fit in with the needs of patients rather than the other way around.
Finding the solution, together

Together with external experts, we have carried out detailed research to better understand the current pressures facing the local NHS. This work has provided an independent overview of the challenges facing the Bay and the opportunities for solving them. This independence is important because in theory every health economy could argue that it is a special case and needs additional funding. Our case is based on sound quantitative evidence, as well as other qualitative information from our patients and the public.

The detail behind our local challenges is available in a report called a “baseline assessment” which is on our website. This confirmed that thousands of people across Morecambe Bay are being admitted to hospital unnecessarily and are staying in hospital longer than they need to because we haven’t got the right support in primary and community care: often staff are reluctant to discharge into the community believing that the hospital is the safest place to be – this is inconvenient for patients, very expensive, and puts unnecessary pressure on our hospitals, making it impossible to provide consistent high quality care let alone take advantage of innovative technology. Our proposals aim to reduce the number of hospital admissions by more than 9000 over the next five years.

One of the most critical things that the report highlighted was to work in the way we do at the moment, across three major sites, costs us an extra £18m a year, compared to other hospitals serving the same numbers of people. This means that it doesn’t matter how efficient the hospital Trust becomes, it will always have this additional cost to provide services safely over the coming years.

In short, our unique challenges mean that we will always struggle to “balance the books”. This is why our health economy has an on-going “gap” of £26.3 million – which will rise to £71 million in 5 years if we do not act now.

Jackie Daniel, Chief Executive, University Hospitals Morecambe Bay NHS Foundation Trust

We are reassured that the recently published NHS Five Year Forward View echoes the need for the NHS to receive more funding to deliver on the challenges it faces.

...Our proposals aim to reduce the number of non-elective hospital admissions by more than 9000 over the next five years...
The public voice

When we started the Better Care Together programme, our focus was on care in hospital as this is where we seemed to be experiencing most of our issues.

Clinicians examined four key areas: planned care; unplanned (emergency) care; maternity; and paediatrics, and asked an independent market research organisation called TNS BMRB to find out what people thought of these services now, and what they would like to see in the future.

TNS used a range of methods including interviews with staff; focus groups and one to one discussions with the public; surveys and deliberative workshops. A report containing their findings is available on our website:

www.bettercaretogether.co.uk

As part of their work 10,000 questionnaires were posted to randomly selected households in the Morecambe Bay area and 10,000 of these were also left in GPs, pharmacies and similar outlets. Nearly 4,000 completed questionnaires were received. This research alongside our own extensive engagement programme – which included a two week bus tour of 11 localities throughout the Bay - found that although people were prepared to travel for some specialist services the exceptions were maternity; A&E (unless an acceptable alternative could be offered); and routine childrens’ services.

We also found that people wanted much better access to their GP and other community services, and were frustrated at the lack of communication between different care agencies:

The treatment was fine but I had to make five trips to the GP to get referred, and I never received an appointment letter. The consultant then wasn’t aware of my condition as my notes weren’t sent to the hospital. The next appointment wasn’t booked and I had to push for it.

Someone stopped taking medication, hit his partner; partner had called Dane Garth* but got nowhere. Neighbour called police and referred to social services, this is now affecting the child. What support for people, no one to see her? What is available? If health workers knew his history, why did they not send his GP to him? (*An acute mental health and patient unit run by the Cumbria Partnership Foundation Trust out of Furness General Hospital).
These stories chime with the experience of our GPs who listen to the frustrations of patients every day. Many patients struggle to understand that they need to invest time and money to travel to and attend out-patient appointments only to be told that they are fit and well; lack of communication between organisations is a recurrent theme; people get tired of telling their story over and over again to different professionals; and people find the current system confusing and overwhelming which is why they so often turn up in A&E because they simply don’t know where else to go.

Similar themes are reflected in many of the patient stories about their experience at the Trust.
Patient Stories

Patient stories are relayed to each board meeting and when things haven’t gone well there are recommendations about steps that could be taken to prevent similar incidents in the future. These stories are also available for staff to listen to on their internal website. Where there are areas of poor performance these often highlight the need for improved communications between staff and patients.

Patient stories we have heard include poor integration between NHS organisations during Jade’s pregnancy; the need for improved communication across NHS administrative systems with John having to chase for his own surgery and follow up appointments; and the distress caused to Sue by the delay of scan results.

Better nursing care is a predominant theme whether pain relief for Oliver in a children’s ward or at end of life care. One patient story talks of inadequate nursing care in the last weeks of Henry’s life where there was no assistance with toileting and a failure to replenish medication. Joan spoke about sitting in a corridor in the Emergency Department worried and waiting to be triaged for her third stroke saying, “Must’ve known the situation, that it was dire for me to be seen”.

Tom’s story is an example of what shouldn’t happen at the end of life. The current set up of care services led to Tom, aged 84, being taken to hospital for regular 8.30am treatments (rather than being treated at home by a District Nurse as he had been previously) by his wife who struggled to cope. It saw Tom being admitted to hospital where his dressing was left for days instead of being changed daily and an occasion of spending 30 minutes pulling an emergency call bell. His wife was there when Tom died in hospital, listening to a doctor talking about “letting him go” whilst desperately hoping Tom couldn’t hear the doctor. She left the ward, with no support; no-one came to check on her and no-one came to ask if she was ok.

Under our new proposals, many of these patients, particularly those at the end of life or needing nursing care, would be treated most of the time in the comfort of their own homes, or within their local communities, leaving staff at the hospital with enough time to properly care for those people who can only be treated in hospital.

We must learn from the past. Our hospitals have previously suffered from a lack of investment in staffing, problems with recruitment (an on-going issue) and a lack of joined up thinking and working with other health and care providers – the patient has not come first.

It’s not all doom and gloom of course. Every day hospital staff do fantastic work and we get things right most of the time – the Trust receives a lot of positive feedback direct from patients and their families via its website, letters, and surveys, and these positive stories are also shared at Board meetings. One of the few advantages of being in “special measures” is that we are continually working with the Care Quality Commission to monitor our standards, and we challenge ourselves on a daily basis to meet these. But “most of the time” isn’t good enough, and we want to move away from a cycle of crises and reviews as we move into an era where demand for services is going to reach an all time high. Through developing the right systems and culture we are aiming to become and be recognised as one of the leading health and care systems in the country rather than being perceived as one of the worst – and ultimately we want to be world class.

...We must learn from the past...
3. Our Vision for Out of Hospital Services

For many people their local hospital symbolises the NHS, but the reality is that the majority of us should receive or access most of the care we need from our GP surgery.

GPs and other community and social care services hold the key to reducing this traditional reliance on our hospitals and to increasing the scale and quality of care provided in the community. This will take the pressure off our hospitals and allow them to focus on providing great care to fewer patients.

We want to place far greater emphasis on keeping people healthy and well in order to lead longer, more illness-free lives: preventing rather than treating illness. We also need to do far more to help those with mental illness. Strengthening the support and advice available in the community will help us work far more closely with patients and carers to achieve this.

Our clinicians have looked at what works well nationally and internationally and built on this to develop a model of care. This sets out a particular way of working to make sure that services are arranged around patients rather than the other way around, and to get some consistent standards across Morecambe Bay. There will still be flexibility to make sure that individual areas can offer the right support to the specific needs of their communities – so for example some areas will have slightly different patient profiles: some with high levels of older patients; some with single mums with young families; and some with a large population of students so the emphasis on health services for these communities will match more accurately their needs. The model has been put together to meet the needs of children and patients with mental health needs as well as the general adult population.
Figure 3. Out of Hospital model of care

We will develop a range of services around the patient and his/her General Practice through what we call an “Integrated Core Team” in Lancashire and “Primary Care Communities” in Cumbria. The figure below begins to introduce this dynamic new model:

The out of hospital model works a little bit like the clock in Big Ben. There are lots of important things happening behind the scenes to make the clock work but most people are only interested in how it looks and whether it tells the time. In this case, the integrated core team represents the clock face, but all the other components are essential to ensuring that the system works as well as it should.

Dr Hugh Reeve, Chair, Cumbria Clinical Commissioning Group
What's better for patients?

Many of the improvements we are making are “behind the scenes” so from a patients’ perspective the biggest difference is simply that things will work much more smoothly than they do at the moment with fewer frustrating delays, communication failures and unnecessary travelling. There will be more consistent standards of care across the whole of the Bay - for example people won’t have to take pot luck as to whether or not their local GP practice is big enough to offer extended opening hours.

There will be far fewer “handoffs” with the responsibility for patients being passed from one agency to another. An integrated core team will take responsibility for all patients and where people have complex needs (usually a mix of problems which require significant treatment or support). This team will track them in and out of hospital to help reduce their time in hospital and to ensure that they don’t get “lost” in the system. Patients will not constantly need to tell their “story”, and will receive support to prevent crises occurring in the first place, and to help them return home as quickly as possible.

Patients and carers will know their key contacts and enjoy continuity of care – something that patients with complex problems have told us is really important to them. This will provide a far more personalised service and reduce the anxiety that many people experience when they are feeling unwell.

As our IT systems become more sophisticated, communications between different organisations will radically improve which will also improve outcomes for patients and service users.

Patients will follow the same journey through the system (often referred to as a “pathway”) in every locality and over time this will eliminate duplication of care as well as improving standards and ensuring a consistent approach. Specialists will oversee the whole population of people who have a particular type of disease, and with their teams will provide support, mentoring and coaching to the GPs and community teams who will provide most of the care to patients.

For example in Morecambe Bay we have high levels of respiratory diseases such as Chronic Obstructive Pulmonary Disease (COPD) and Asbestosis due in part to the type of industry here (for example nuclear and submarine), as well as the fact that many people smoke. The burden of these diseases coupled with the remoteness of our geography and the difficulties in recruiting staff as described in our Case for Change, puts a lot of pressure on our hospitals as people simply aren’t diagnosed with these conditions early enough.

The current situation is just the tip of the iceberg – we estimate nationally over a million patients with ongoing respiratory disease are undiagnosed and they are likely to end up going to A&E to be treated for what they believe are “one off” symptoms because they have not yet been diagnosed as having a long term condition.

We have looked at how other areas have dealt with this successfully and in bigger urban areas such as Nottingham and Liverpool the focus has remained on patients being treated in hospital in beds put aside for this purpose – however unlike us these cities have large pools of specialist consultants who can look after these patients whereas our consultants are already overstretched. Other areas such as Southport have been very successful in treating patients in their own communities and this is the approach that we are taking.

The “pathway” for dealing with these types of conditions will change to become far less hospital focused. For example, Hospital consultants who specialise in respiratory diseases will deliver community clinics alongside GPs, district matrons and other community based staff. This will teach and train the staff to become “upskilled” and empowered so that they are able to rapidly review patients, spot signs of disease at an early stage and work with them to manage their own conditions as appropriate within the community. They will also have early access to hospital without going through usual A&E or formal hospital OPD appointment. This will prevent patients having to go to A&E in distress, as well as reducing unnecessary hospital visits for follow up appointments as the expertise needed to help them will be available closer to home. Prevention is always better than cure and in the case
of respiratory diseases the evidence is that whilst interventions like nebulisers can stabilise patients, they can do nothing to improve their health in the long term. The most effective way of dealing with these types of diseases are measures like giving up smoking, and a community based team is far better placed to provide the support that patients need to achieve this than hospital staff. Over time the new model will save lives by helping people make the right choices so they don’t become ill in the first place, enhance quality of life for patients living with these conditions and give individuals the right advice and support to look after themselves much of the time. This is essential when you consider that for every 3-4 hours most people with long term conditions spend with a care professional, they spend 5,000 hours on self-care each year. At the same time we will saving money by minimising the numbers of people needing treatment and treating them in a less expensive part of the system.

What does this mean for local GPs?

Often previous strategies have forgotten about General Practice, or simply paid lip service to it, and have failed to deliver all they have promised. Our proposals for a new model of out of hospital care places GP practices centre stage, recognising that integrating General Practice with the rest of the system is a key to success.

Some of our practices in South Cumbria and North Lancashire are already leading the way in running “pilots” for parts of the out of hospital model. For example, GPs in Morecambe have recently been successful in their bid for resources from the Prime Minister’s Challenge Fund which from August 2014 has been helping to fund longer opening hours for GP surgeries and improved access over weekends for X-ray services and minor injuries.

Over 100 GPs and hospital consultants have been involved in piloting the referral support system for Advice and Guidance in North Lancashire. This scheme has reduced the need for hospital outpatient appointments by enabling GPs to seek advice from consultants on behalf of patients via a confidential email exchange. This service has been demonstrated to a national GP conference and is also shortlisted for an award from an industry magazine the Health Service Journal which aims to recognise excellence and innovation within the sector.

Dr Alex Gaw, Chair, Lancashire North Clinical Commissioning Group
In Cumbria, local GPs are a key part of the Millom Alliance, along with the Cumbria Partnership NHS Foundation Trust, UHMBT, the voluntary sector and the community as an equal partner. These partners are working together with the aim of improving local health care through the best use of the available funding and resources. If all goes to plan this type of scheme will be rolled out more widely across South Cumbria and North Lancashire.

We need to move rapidly from pilots to delivering change in General Practice provision at real pace. Practices need support to change their operational models, which will enable them to create more capacity to improve access for urgent problems and will also allow GPs to focus more on patients with complex problems. This will involve improving the skill mix within practice teams and also redesigning the way patients consult with GPs and nurses, making greater use of modern technology.

General Practice also needs to move away from the traditional corner shop model to working at scale. The challenge is to achieve this in such a way that patients still feel they are looked after by GPs and teams who know and understand them. This is particularly important for people with long term problems and those coming towards the end of their lives.

Working at scale may mean practices merging to form much larger practices, or coming together in groups known as “Federations”. These groups allow practices to share “back office” functions, create innovative posts to work across a number of practices, and also share some services – it isn’t always sensible or efficient for every practice to try and do everything.

Working within a Federation will also allow practices to speak with a single voice and to work more effectively with partners such as the hospitals Trust or Community Trusts. This will be crucial in delivering this Strategy – General Practice must have a strong and effective voice.

We recognise the need to support the development of these larger practices or Federations, and also to help them develop effective partnerships with other providers, using the example of what is happening at Millom as a template. A Federation has recently formed in Lancaster and Morecambe, and discussions are underway between practices in South Cumbria.

The proposals by NHS England to allow greater involvement by CCGs in the commissioning of General Practice services (currently they have little responsibility for this) will help unlock the obstacles that are slowing down changes in General Practice. Both CCGs involved in this Strategy have indicated a willingness to take on greater responsibility for this.

Many of our current GP practice buildings are outdated with poor access and do not comply with the standards set out by the Care Quality Commission. In order to address this we are aiming to make significant investment in a number of new building schemes. Two schemes are being developed in Lancaster which could provide modern accommodation for several general practices. One of these is on the same site as the Royal Lancaster Infirmary and the second site is yet to be determined. The latter will be developed so that it can accommodate GPs, social care and community providers, with a particular emphasis on young families. The total expected capital cost for this is £30m. We will also be bringing together up to six practices with community services in Barrow at the Alfred Barrow site at a cost of £12m. This could potentially provide a base for the North West Ambulance Service, district nursing, mental health services, a pharmacy, a Children’s Centre, a Rehabilitation and Physiotherapy Centre and social workers. These planned investments will supplement the three state of the art health centres that have recently opened across the South Lakes.
How does this match up with the strategy for Social Care services?

Colleagues in social care have been key partners and made a major contribution to developing the Strategy. Social care is experiencing similar pressures to the NHS, and if we keep the system as it is then the activity that social care workers will need to deal with will increase by 2% each year at a time when budgets are being heavily reduced. As the number of people over 85 is set to double over the next twenty years, social care would not be able to cope and inevitably even more frail older people would end up spending their last days in hospital, putting more pressure on staff and making it impossible to maintain high quality standards of care.

This Strategy cannot and does not set out to solve all of the financial challenges facing social care, but our shared desire to put people at the heart of our new model means there won’t be any batting back of costs between organisations. The NHS and Social Care Better Care Fund Plans for both Cumbria and Lancashire mirror the Better Care Together Strategy in their aims of making tangible reductions to the numbers of unplanned patient admissions into hospital through fully joined up working.

Assumptions about the reduction of activity have been made within these plans, however these have now been superseded by the Better Care Together work.

Health and Well Being Strategies and the wider economic plans for Cumbria and Lancashire are also completely aligned with the Better Care Together programme and the respective CCG operational plans.

The new Out of Hospital model supports the desire within social care for staff to be able to work differently to provide a better and more cost effective service for clients. For example the Integrated Core Team, together with the back-up of the Health and Social Care Co-ordination Centre and Care Navigation Function will be able to provide much of the support that is by default done by social workers. This will free up their time and expertise to work on more targeted intervention and complex issues such as safeguarding, working with vulnerable people and in difficult family situations. The Rapid Response team will work proactively to address urgent needs so that fewer patients need to access hospital emergency care and waits for social care to support discharge arrangements will be minimised.

This will be a far more cost effective and time efficient approach to health and social care. Currently GPs tend to call social workers for support even though they are often not the best person to deal with day to day issues and are an expensive resource. In the future a Social Care Support Worker will be able to work with “Care Navigators” (usually GPs and District Nurses) to help patients access short term care.

The out of hospital model also does much to meet the wider goals of social care in terms of increasing social capital, improving social inclusion and tackling loneliness by putting people in touch with relevant local schemes.

It also supports the work of the Public Health Departments of our Local Authority Colleagues who have the lead role on promoting well-being and self care.

In addition to the well known Public health services such as stop smoking services, other initiatives will further develop this agenda e.g. Community Groups (gardening clubs, food banks, walking groups, time banks etc) and the Growing Well project in South Lakeland supporting people with severe mental health problems. New care pathways will develop which incorporate supported self-care (e.g. anticoagulation pathway, cancer survivorship) and the quality and effectiveness of existing pathways/programmes which support self-care eg. the expert patient programme.
What this means for Community Services

Our Community services providers Cumbria Partnership NHS Foundation Trust, Lancashire Care NHS Foundation Trust and Blackpool Teaching NHS Hospitals Foundation Trust have played an active part in the Steering Group and Programme Board to work jointly on potential future solutions across a number of shared challenges.

The integrated core team is a natural step forward for existing community staff, some of whom already work closely with local neighbourhoods e.g. District Nurses. Mental health teams will welcome the opportunity to move from a locality focused structure to the neighbourhood working with community colleagues. The core team will ensure equity of access to both physical and mental health, with clear routes into community specialist services. In turn staff that are employed by an acute organisation but already spend the majority of their time in the community e.g. colorectal nurses, can integrate further with the core team for patient benefit. Colorectal nurses are those who work with individuals who need a colostomy bag, an ongoing life-changing event which can be very distressing for the patient. In the new system these nurses could work directly to draw on the expertise of mental health colleagues to quickly secure the right psychological support for patients.

Similarly the integrated Rapid Response Team and Health and Care Co-ordination Centres will work with their mental health team colleagues to address important issues such as social isolation and more easily access important services such as crisis resolution home treatment to support family and carers. Meanwhile the expertise of Allied Health Professionals (e.g. physio and occupational therapists) for both in and out of hospital can support a quicker return to recovery and rehabilitation at home working alongside core team members and specialist community nurses e.g. respiratory nurses.

In the future the Referral Support System will widen the opportunities for both health and social care staff to access the expertise of other colleagues. It will also aid speedier patient diagnosis and access to a range of therapies whether physiotherapy in the community or mental health support such as low level and high level Integrated Access to Psychological Therapies.

As part of the Millom pilot, there will be greater use of intermediate care and full assessment of older adults before discharge from hospital so that wherever possible there are no direct admissions hospital into residential homes. This will help more frail older adults to return to their own homes if rolled out across the rest of the Bay.

We expect that the new Out of Hospital service model impacts not only on the care that is provided but also on recruitment by offering new and transformational job roles. This will help with recruitment to the community and mental health sectors for staff who want to work differently and who want to be a part of the ambitious journey of improvement. New roles such as that of the Assistant Practitioner who can carry tasks such as dressing changes, catheter care and routine bowel care will create additional capacity for Registered Practitioners. This daily collaborative working and sequential learning across medical nursing, social care, mental health care and therapies etc. will prove a valuable recruitment tool in a competitive market where over half of England Trusts are seeking to recruit more staff – although of course it cannot solve the national recruitment and training challenges that the NHS is facing.
The role of the Third/Voluntary sector

Better Care Together promotes a much more proactive approach to working and planning with colleagues in the voluntary or “third” sector. These staff often know more about “what’s out there” to help patients and public than anyone else e.g. claiming carer benefits, so their role in the Integrated Core team is essential to its success. Age UK, Help Direct and other such third sector organisations are community assets and for many people are, and will be, the first port of call for some of these very practical measures that have a big impact on people’s wellbeing.

A number of these organisations have, and are playing a crucial role in the development of the Better Care Together Strategy by participating in engagement events and design events e.g. the PwC Care Design Groups, the Clinical Summit and hosting events. Cumbria Youth Alliance held focus groups and assisted with questionnaires in Barrow-in-Furness, and Age UK South Lakeland hosted a listening event in Kendal. Their attendance at deliberative events has seen feedback which has influenced care design and will be crucial in the success of out of hospital initiatives, in which many third sector organisations are keen to play a key role in. The Better Care Fund in Lancashire aims to tackle the triggers that can tip people into care – loneliness, poor nutrition, isolation and the Integrated Health and Well-being Framework will work with Third Sector Services at a local level e.g. Help Direct.

Involvement from the voluntary sector will be crucial going forward and will build on current partnership successes e.g. Growing Well: an enterprise outside Kendal which offers opportunities for people recovering from mental health problems to build their confidence and skills through to the new Compass Project (running in South Lakeland), which aims to reduce pressure on hospitals caused by avoidable emergency admissions. The third sector represents the same diverse range of stakeholders in and outside of hospital; the NHS and Social Care recognises the value of this expertise and experience.
In the future, our plans will see many staff travelling to locations which are more convenient to patients, and hospitals treating only those people that need to come to a hospital.

Take accident and emergency for example. When a patient can’t access health or care advice out of normal hours, or a GP or other healthcare professional can’t get the urgent support or advice they need, then the A&E is often where they turn to.

Over time, our proposals will see a reduction in patients with non-life threatening conditions being referred immediately to the A&E. Instead they will be treated by the new Integrated Core team. When an emergency admission to hospital is required, then the A&E will still be there to do what they do best, caring for those patients that need lifesaving and immediate treatment.

Our three main hospitals in Lancaster, Kendal and Barrow will continue to play important but different roles to support our local communities. As a result of earlier diagnosis of conditions, care could be provided closer to the patient with some hospital staff working out in the community. This means we will be able to redesign hospital services and invest in community services making Morecambe Bay healthcare safer, more effective and fit for purpose. An example is the Same Day Health Centre in Morecambe which sees minor injuries and fractures delivering a safe, local alternative to A&E for non emergency care.

Ulverston Community Health Centre offers outpatient services, physiotherapy and X-ray services while Queen Victoria Hospital in Morecambe also offers outpatient services such as urology, dermatology and cardiology. As Better Care Together aims to deliver a greater degree of care in local neighbourhoods, these facilities will continue to act as valuable community assets.

In order to retain some key emergency and critical services across our sites to benefit everyone in Morecambe Bay, we have to find other areas in which changes can be made. We are therefore recommending that we consolidate some services to ensure they are viable, safe and of a sufficiently high standard. In assessing the options around this we have needed to balance a whole range of issues including quality, staffing, patient outcomes, travel, estates, cost effectiveness and deliverability. Having considered all these factors we have concluded that in the medium term (2-3 years time) there is a strong case for providing the majority of inpatient elective surgery from two rather than three sites, and for providing some specialist services from one site.

Through a combination of working with people to keep them fit and healthy; treating more people in the community; and in some cases using less invasive ways of treating people it stands to reason that we will need fewer beds in the future. We estimate that this could be up to 150 fewer beds across our hospitals and this will be a key measure of our success, alongside better outcomes for those who can only be treated in-hospital.
At the moment out-patient appointments are automatically arranged at set points in time rather than when patients really need them. Under our proposals we are putting together “protocols” and support to help patients manage their own conditions and make individual decisions about whether follow up appointments are needed. We estimate that by putting people not process at the centre of the outpatient system we will require around 65 less clinics a week.

We have no plans to sell our hospitals, privatise or close them and have been very clear on this. But where needed we will work more closely with other providers, be that in the voluntary, public or private sector that can assist us. This is a move that we should have made long ago, in the way other successful hospitals have. We expect that formal collaborations and networks of providers are likely to develop further in the years to come.

The work to date is testament to how well we can work as a local health care system; however the public are still frustrated by the red tape that means that mental health, hospital, GP, community and social care are all managed separately. Our proposal is to find a way to create a new way of working which may result in a single organisation, often called an ‘integrated provider’ operating the majority of services in future.

**How it could work for one patient?**

“John is one of the 10 million people in the UK with arthritis, a condition with no cure and which can affect people of all ages, including children. For eight years John has attended the Royal Lancaster Infirmary, meeting with a consultant several times a year, as well as specialist nurses and other healthcare professionals such as physiotherapists and podiatrists.

Whilst happy with the care, John is frustrated. The hospital is a 20 mile round trip from his home and the clinic often runs late, John has to book the morning off work just in case and as a single parent, sometimes pays for additional childcare. The specialist medication he requires is delivered to his home and needs to be refrigerated, but they only deliver when John is at work. John also requires regular blood tests to be taken to monitor any side effects of his medication, however there is often a difficulty taking blood and he has to tell different nurses every time the best place to take it from him. A challenge John has faced at the hospital is that the clinic for arthritis is at the bottom of a hill, and when his condition is at its worse, he has to use walking sticks, making it really painful to walk between different services when needed, such as x-ray, pharmacy and the blood clinic.

If our proposals are successful, things could become very different for people like John. Imagine the difference it would make if his local health centre was only a few miles from his home and provided a ‘one stop shop’ experience, offering an arthritis clinic where John could see a specialist nurse on a regular basis. How convenient it would be if whilst he was there, he was able to collect his medication from the on-site pharmacy. If further expert advice is needed, a secure dedicated computer link to the hospital could enable the nurse to ask specific questions of the consultant, perhaps even sending a digital image of painful swollen joint if needed.

Ideally John would also be able to book in to see a specialist (phlebotomist) each month for his blood tests, including at weekends, making it much easier for John to keep up with this important routine and reducing his time off work. The health centre staff should be able to access John’s preferences, as can the hospital via a shared computer system, meaning they always take the blood from the back of his hand as he has asked - after all, John knows his own body better than anyone.

The new service should also be coordinated with other clinics taking place that day in the health centre, enabling John to get further support, such as dietary advice. For some people arthritis can restrict movement, which can lead to becoming isolated and possibly depressed. The service we are planning will be looking to provide such support, with a specialist team of health professionals responsible for John – providing early intervention before the condition worsens – keeping John healthier for longer.”
What this means for our hospital sites?

Although we firmly believe that health care needs to be about services not buildings, the fact remains that many of us remain attached to the concept of a “hospital” as a safety net to protect us from the worst that could happen. In some ways the worst is already happening because some people are going to hospital when it simply isn’t in the best place for them to be – and more to the point if we get things right in primary and community care most of us won’t need to go there at all.

Under our proposals, hospitals will be freed up to provide the kind of care that most of us should only have cause to access for a very small proportion of our health needs. However, we have also listened to what the public have said about their local hospitals and taken this into account when developing our proposals.

Royal Lancaster Infirmary & Furness General Hospitals

Emergency care and treatment, and obstetric care will continue to be focussed at both Royal Lancaster Infirmary and Furness General Hospitals alongside specialist surgical and planned care. As these sites already have full emergency facilities and are large enough to be expanded, our recommendation is that the majority in-patient elective of surgery should transfer from Westmorland General to these two sites.

Focusing surgery on two rather than three sites will increase the quality of care and outcomes for patients across Morecambe Bay including those from the South Lakes. This move would ensure that we have enough permanent specialist staff to cover rotas effectively across two sites, so we won’t need to cancel operations at short notice – this can happen now due to travelling times between sites and an overstretched team and causes delays and distress to our patients.

For surgical teams the more they concentrate on a particular type of surgery, the more proficient they become, so as part of our quest for excellence, some specialist services may in future be
concentrated on either Royal Lancaster Infirmary or Furness General not both. We don’t know which specialist procedures will be affected yet as our hospital doctors are still looking into exactly how this would work, but any such changes will be clearly communicated to patients and are likely to form part of any future consultation on changes to hospital services.

Moving forward this will also allow us to use our operating theatres much more efficiently by moving to a seven day a week service with increased weekend and evening access to fit in with people’s lifestyles and working arrangements. Surgical equipment and theatres are expensive so focusing on two rather than three sites for surgery will also allow us the scope to invest in bringing our major surgical facilities up to a much higher standard which will benefit everyone.

As set out in the finance section, we intend to invest in our current hospital buildings to make them fit for purpose. We can’t afford to rebuild our hospitals, but we are planning on making them fit for 21st century health care, and in many cases they just are not currently up to the standards our communities should be entitled to expect.

Our hospitals need to be designed around the patient; ensuring services are close to each other and can fully support the demands of a modern health care environment not just now, but well into the future. To demonstrate why this matters we only need to look at the Lancaster Royal Infirmary where there is one unit where the hospital spends in excess of £250,000 a year on patient transport within the hospital site because two parts of the hospital are built on vastly different levels, with no ability to build a cost-effective physical connection.

We aim to start with improving access by developing two new multi-story car parks at Lancaster – one for staff and one for patients as this work is not reliant on our proposals to move surgery to fewer sites. Then in stages we will improve how each department at each of our hospitals support each other. Having services based around the needs of our patients will make them safer and more efficient.

Moving elective surgery to fewer sites will require additional capital (one off) investment of around £15 million. This investment comprises three new day case theatres at RLI and one at FGH, together with one new in-patient theatre at RLI. This could then accommodate all the surgical activity transferred from WGH. This figure assumes that other funding will cover related works at RLI that will allow the bct programme to be delivered at this cost.

For surgical teams the more they concentrate on a particular type of surgery, the more proficient they become, so as part of our quest for excellence, some specialist services may in future be concentrated on either Royal Lancaster Infirmary or Furness General not both. We don’t know which specialist procedures will be affected yet as our hospital doctors are still looking into exactly how this would work, but any such changes will be clearly communicated to patients and are likely to form part of any future consultation on changes to hospital services.

Mr George Nasmyth
Medical Director (March 2012 to January 2015)
University Hospitals of Morecambe Bay NHS Foundation Trust
Westmorland General Hospital

As the diagram below illustrates, the Westmorland General Hospital site is home to services provided by the University Hospitals of Morecambe Bay NHS Foundation Trust, the Cumbria Partnership Foundation Trust and Lancashire Teaching Hospitals.

The original County hospital was built with the aid of public bequests and subscriptions, and both it and its modern replacement have been a source of local pride and affection over the years. Members of the local community would like to see it to continue to play an important role in providing the health and care services of the future for the South Lakes Community.

We agree, and believe that there is enormous potential and an exciting opportunity for Westmorland General Hospital to evolve into a thriving community resource where important health and social care services work together to meet the non-urgent health and care needs of communities mainly, but not exclusively, in the South Lakes. An element of this could be creating a centre of excellence for eye care and surgery building on the macular degeneration service and extensive eye surgery that already takes place on the site.

Alternatively there may be a case for retaining or expanding day case surgery on the site, and we will continue to explore this option with a wider pool of clinicians, staff and stakeholders.

Figure 4. WGH - Services at a glance
Our commitment to the provision of services on this site remains clear, and we will build on our conversations across the health and social care system over the next two years to fully define the future of WGH. What we can’t do is pretend that there is the opportunity to bring back an extensive range of emergency and complex surgical and other services back to this site.

**Keeping vital services local**

Historically we have concentrated surgery for people requiring complex care at Royal Lancaster Infirmary or Furness General Hospital because they then have access to full emergency care facilities and specialist staff.

Only low risk patients are operated on at Westmorland General and in some cases they end up being transferred elsewhere because of the need for further support. Given the pressures described in our Case for Change and based on our work to date it no longer seems to make clinical or financial sense to continue to use the Westmorland General site for the non urgent surgery in which an overnight stay is required. However there may be a case for developing the site as a centre of excellence for eye surgery or other types of day case surgery, and this is being explored in more detail.

Surgery accounts for a small proportion of activity at Westmorland General, so most people using the hospital will not be directly affected by this change. Local people will still be able to have their babies at the Helme Chase unit. The GP led Primary Care Assessment Centre will still offer treatment and advice 24 hours a day/7 days a week to deal with a range of minor injuries and ailments, and offer convenient access to some diagnostics including x-rays and blood tests. Minor procedures such as vasectomies and carpal tunnel and non-urgent cardiac procedures will continue to take place along with MRI scanning, bowel screening and other diagnostic services including the lithotripter which treats kidney stones. Patients needing chemotherapy and dialysis will continue to receive treatment and support and it will be business as usual for clinics and treatments for a range of conditions such as diabetes and asthma. Our highly rated macular service will also continue to be available, along with the Langdale Wards and the Day Hospital.

These services will complement the improvements we are making to local primary and care services, and South Lakeland communities will continue to receive urgent and specialist care at surrounding major hospitals, which will have had the investment in new theatres, equipment and staff training described earlier. Patients will be discharged back home or into community based facilities more quickly than in the past as there will be additional support to help them recover within familiar surroundings.

...Patients will be discharged back home or into community based facilities more quickly...
What could the site look like in the future?

We believe that there is an exciting opportunity for Westmorland General to evolve into a thriving resource where important health and social care services work together. Adult Social Care services are currently based in accommodation in Kendal centre. However, there may be a possibility of relocating some social care staff to Westmorland General which could help provide a convenient “one stop shop” for residents – particularly frail older people - as well as further strengthening the relationships between NHS and social care colleagues. Patients and their families tell us how confusing and distressing it can be when different organisations fail to communicate properly. The more we can do to build a culture of trust, information and the resource sharing between different teams of staff the better the experience of those we care for, so we are working with the Adult Social Care team at Cumbria County Council to see if we can make this work in practical terms.

The South Lakes currently has 33% of people over 60 compared to a national average of 23%, and this is set to rise to 60% by 2035. This will mean an increased need for day to day nursing care and in particular support for patients and their families to cope with dementia. This is not a role that a hospital can fulfil, so we will be working closely with the County Council to explore the possibility of a range of additional support options on the site to meet the needs of the local population. This kind of increased support would ensure a much better experience for patients, many of whom have to stay in hospital even when it is not the best place for them because there is nowhere else for them to go.

There is also the potential for the site to provide a facility supplying the kind of mobility aids and lifestyle enhancing equipment that many members of the community will need in the years ahead. This would give people the opportunity to see and try out such equipment, and would fit well with our vision for the site as a health and social care hub.

Although there is not enough room for the Westmorland General site to host a major emergency hospital, there is some spare land on the site. This could also be used as a base for equipment or facilities which would benefit the whole community.

In addition to the convenience of locating such facilities on the site, the rental income would make a small but noteworthy contribution to reducing our overall financial deficit, and could also make financial sense for our local authority colleagues who also need to find ways of reducing their costs without compromising on service delivery.

Cumbria Partnership Foundation Trust’s 5 year Strategic Plan confirms the Trust’s intention to define the range of inpatient and community-based mental health services it needs to sustain in appropriate facilities across Cumbria. At some point this Strategy may impact on current inpatient mental health provision at Westmorland General. Westmorland General will remain a centre for the delivery of community based physical and health services. We will continue to work with the Cumbria Partnership Trust to monitor this and the review will of course be in the public domain so local people will be able to express their views.

As we firm up our ideas about the future use of the site we will be exploring these further with community groups, partners and staff. This is the approach that has been taken with the Millom pilot, where an Alliance has been established with the local community as an equal partner to make best use of the available resources in terms of people, buildings and money.

Radiology will remain on site and we are supportive of our local MP’s campaign to bring radiotherapy to WGH.

Our recommendations to focus surgery on two sites would not and should not happen without a formal consultation. More detail about this is set out in Chapter 9.
...The South Lakes currently has 33% of people over 60 compared to a national average of 23%...
5. Our Stakes in the Ground

We have been very open with our staff and the public that we have needed to look at all the possibilities for providing services to find the best way of providing safe, high quality affordable care for patients. Having said that, the two Clinical Commissioning Groups have always been clear that the need to save money must never compromise patient safety, and that what works well in more urban areas such as Manchester will not necessarily work for our communities.

At the beginning of the Programme we did think that a fundamental change to our hospitals was likely to be the way forward. As running three separate hospitals is so expensive, and makes it extremely difficult to maintain high standards we did look in some detail at the possibility of building a brand new hospital to support everyone within the Morecambe Bay area. However the research we did proved that this “single site option” would cost far more money to build than we would ever save by moving services from the other hospital sites and had major safety implications in terms of lengths of transfers for patients needing emergency care or maternity services.

The “stakes in the ground” are the services that we believe are essential in ensuring that we continue to provide the right services necessary to offer a safe health system for the people of Morecambe Bay.

The “stakes in the ground” for maternity may need to be reviewed depending upon the findings of the Morecambe Bay Investigation, being led by Dr. Kirkup. and the Cumbria and Lancashire North Maternity review by the Royal College of Obstetricians and Gynaecologists.
Furness (Cumbria CCG)

- Consultant led obstetric unit plus minimal supporting services (e.g. SBCU and paediatrics)
- Full urgent care & emergency medicine service & A&E
- Children’s short stay and assessment service

South Lakes (Cumbria CCG)

- Consultant led obstetric services in both FGH and RLI, supported by paediatrics
- A strong primary care community in Kendal
- Urgent care triage service with basic diagnostics and stabilisation services
- Step up/down elderly care
- Access to 24/7 emergency and urgent care in both FGH and RLI

Lancashire North CCG

- Access to 24/7 emergency and urgent care (providing emergency medicine and critical care sufficient to stabilise and then treat some in short stay, or move as required)
Local commissioners have some discretion about which services they buy, and in the event that a local provider is at risk of failing financially, they also have a responsibility to designate a range of services that they believe are essential to keep delivering safe care to their local communities. These are called Commissioner Requested Services (CRS), and we have used the framework provided by Monitor to help us establish what these are in Morecambe Bay. Using this criteria, a service was taken as a stake in the ground if:

- Patients experience material harm in the absence of the service
- Absence of the service would give rise to health inequalities between socio-economic groups
- The service is clinically interdependent with another stake in the ground service

Having followed this process, our proposal is for consultant led maternity and A&E services in Barrow and Lancaster to be retained. We are also proposing to keep the midwife led maternity service at Kendal while still supporting home births for expectant mothers. These proposals are made while recognising that both maternity and A&E are the areas in which it costs us far more to deliver services than the amount we receive to provide them. Paediatric services are an essential support for obstetric services and therefore will also remain at RLI and FGH.

This is an area where we believe providing safe services for our local population trumps all other considerations. The distances between our hospital sites, and the consequent travelling times for patients and their families, coupled with the fact that Barrow has a number of industries of strategic national importance including nuclear and defence facilities mean that it would be unsafe to attempt to reduce or remove these services. Barrow also has high levels of deprivation and moving services away from the area could further increase health inequalities.

We looked in detail at an alternative way of providing A&E called Assess Stabilise and Transfer to see whether we could manage with a single A&E site at RLI supported by an urgent care centre at FGH. However, this model was not supported by the College of Emergency Medicine, or the North West Ambulance Service, and NWAS stated that “an AS&T model would require all the front line skills of a properly staffed District General Hospital”.

As the Stabilise and Transfer model was based on the transfer of those patients requiring more than 48 hours of in-patient care it was recognised that this would have a disproportionate impact on the elderly, and indeed would not fit with the BCT clinical model for the provision of care closer to home. It was felt that it would result in additional risks to patient safety and quality of services, inconvenience to patients and their families, and would not generate sufficient savings to mitigate those risks.

We also considered whether we could move maternity services to fewer sites, but the risks of regularly transferring women in labour over such long distances were deemed to be too high. Sir David Nicholson the former Chief Executive of the NHS documented his support for the retention of maternity services at FGH during a visit to the hospital in 2013. There is a big difference in calculating the mileage between sites and the realities of travelling along inaccessible country roads which can sometimes only be appreciated having undertaken the journey personally.

...our proposal is for consultant led maternity and A&E services in Barrow and Lancaster to be retained...
6. Our Strategy and options development processes

How we have developed our Strategy

The BCT Strategy has been developed with input from a wide range of stakeholders. This work originally began in 2012, and has continued ever since, but there was a particularly intensive programme of engagement once we had begun to narrow the options down in spring 2014.

Stakeholders is a generic term used to describe everybody with an interest or “stake” in making sure that services work well. As health is everybody’s business, our list of stakeholders is extensive and includes local councillors, clinicians and practitioners from across the NHS and social care, Health Watch, Age UK, and members of the public.
Five delivery principles have underpinned the development of the Strategy.

1. Focussing on patient’s experience, rather than organisational interests
2. Engaging our patients and stakeholders from programme conception to identification of the preferred clinical model
3. A clinically led solution from start to finish
4. A robust qualitative and quantitative framework to underpin and evaluate the options
5. A focussed governance process to drive the process and hold it to account

The programme has deployed a rigorous approach to governance, with groups established to drive programme accountability, responsibility and delivery.
How we developed our options

The BCT programme developed a range of ways for improving services by considering the stakes in the ground by locality, the Commissioner Requested Services analysis described above, the out of hospital model, feedback from our extensive public engagement, and the need to deliver hospital services as efficiently and effectively as possible.

This was a robust process which resulted in a long list of 132 options. This was then prioritised down to a shortlist of six options that were considered for evaluation.

Table 1. The shortlist of six options

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

The six shortlisted options are described in the table below. All of the shortlisted options contain a consistent offering with regards to Out of Hospital (OoH), Urgent care, Women’s and Children’s care and Planned in-patient care. Options A to F differ in the way that day surgery will be delivered in the new model of out of hospital care.

The shortlist of six options was qualitatively and quantitatively evaluated at a high level by the programme’s Clinical Reference Group (CRG) a group of local GPs, nurses, surgeons and physicians who have been leading the BCT work throughout the life of the programme.
These options were also tested out with stakeholders including informed members of the public at a half day workshop in June 2014. Whilst participants expressed a view that they did not have enough detailed information to make an informed decision at that stage, based on the available information their preferred option was B, which would retain some day case surgery at all three main hospital sites.

Two evaluation sessions were held with the Clinical Reference Group. A three step evaluation process was followed by the programme in order to arrive at a clinical model from the initial six shortlisted options.

At the time that this work took place (June 2014) the Clinical Reference Group identified options A, B, and E as the 3 options to be included in the final shortlisted options. These all involve: the five elements of the Out of Hospital model implemented in each locality; maintaining current access and service levels for urgent care and women’s and children’s care across the three sites; and consolidating in-patient planned care from the WGH site onto the RLI and FGH sites. The key differences are where day surgery is carried out:

- **Option A**: consolidated on RLI and FGH
- **Option B**: delivered on all 3 sites (albeit with the potential to consolidate some specialties on particular sites)
- **Option E**: consolidated on RLI and WGH.

In order to develop the financial model underpinning the Strategy we have used Option A, which at the time the work took place (June 2014) was the Clinical reference Group’s highest scoring model from a qualitative and quantitative perspective. However, we have been very clear that before we take any of the options forward, we will undertake further work to develop a clear business case with a detailed assessment of all 3 options, subject the proposals to assurance by the NHS Clinical Senate and undertake public consultation.

### Table 2: Our three step evaluation process

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
</table>
| **Step 1:** Qualitative Ranking of Options | 1. Four qualitative evaluation criteria and weightings were developed by the programme’s Clinical Reference Group and Delivery Group  
2. In facilitated table groups, the CRG evaluated the six options using the criteria, supported by colleagues from the in-hospital Group and Delivery Group  
3. Options were then ranked – the highest qualitative score receiving a 1, the lowest qualitative score a 6 |
| **Step 2:** Quantitative Ranking of Options | 1. Four qualitative evaluation criteria and weightings were developed by the programme’s Clinical Reference Group and Delivery Group  
2. In facilitated table groups, the CRG evaluated the six options using the criteria, supported by colleagues from the in-hospital Group and Delivery Group |
| **Step 3:** Overall Ranking of Qualitative & Quantitative Evaluation | A facilitated session was run with the CRG members, supported by colleagues from the In-hospital Group and Delivery Group to consider which three options would be included in the final shortlisted options |
7. Our Financial Position

For a number of years the Trust has been experiencing significant financial problems and currently has an underlying financial deficit of £26.3 million, and therefore is reliant on one-off, short-term funding solutions to enable it to meet its on-going financial obligations (e.g. pay staff wages, purchase drugs and dressings, etc). This approach is not sustainable.

Like every other hospital in the country the Trust has an on-going Cost Improvement Plan (CIP) to make sure that it continues to do things in the most efficient way to make the best use of every NHS pound. However, given the magnitude of the deficit along with dealing with the impact of new cost pressures, it is clear this approach alone cannot solve the financial problems.

In addition, given both CCGs are significantly above their target funding allocation then a solution based upon the Trust receiving additional income for the services they provide would simply shift rather than solve the financial problem.

The Case for Change reflects “whole system” approach, which is based upon a 5-year plan that:

- Reduces the overall amount of services provided in the hospital system by establishing new pathways of care in the community. This new approach enhances significantly the existing services in health and social care in the Morecambe Bay area, and also allows the hospital to reduce its costs.
- The plan also ensures that key hospital services (e.g. A&E and maternity) are retained to provide appropriate access levels for our population. To enable the hospital to provide these services within the available resources then some non-emergency services will be consolidated on to the two main sites in Barrow and Lancaster. This enables the Trust to use its resources more efficiently and reduce costs.

By 2019/20, based on the highest scoring option identified via the work done to date, the overall annual saving are forecast at £18 million and therefore cover approximately 70% of the gap. Nevertheless our consideration of over 130 options demonstrate that these proposals would provide the most clinically safe and financially viable solution for local people. Our plans do provide a solid platform for us to build upon and we need to act quickly to prevent further deterioration of our position.
However, there is a significant amount of work to be undertaken over the next five years to move from “where we are now” to “where we plan to be”, as illustrated in the table below:

Table 3. Financial Summary

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Net investment in New Services</td>
<td>(3.7)</td>
<td>(8.3)</td>
<td>(11.2)</td>
<td>(12.0)</td>
<td>(11.5)</td>
</tr>
<tr>
<td>Benefits (reduced cost) from investment</td>
<td>0.7</td>
<td>6.6</td>
<td>16.6</td>
<td>23.1</td>
<td>29.5</td>
</tr>
<tr>
<td>Net Benefit</td>
<td>(3.0)</td>
<td>(1.7)</td>
<td>5.4</td>
<td>11.0</td>
<td>17.9</td>
</tr>
<tr>
<td>Cost of Change &amp; programme Delivery</td>
<td>(5.4)</td>
<td>(5.6)</td>
<td>(5.0)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Assumed Transitional Funding</td>
<td>8.4</td>
<td>7.3</td>
<td>5.0</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Net Benefit to Morecambe Bay Health Service</td>
<td>0.0</td>
<td>0.0</td>
<td>5.4</td>
<td>11.0</td>
<td>17.9</td>
</tr>
</tbody>
</table>

To enable this to happen we are requesting significant support in a number of areas as illustrated below:

- Revenue funding of around £21 million across the first three years to allow us to invest in new services outside hospital. These need to be up and running, before reducing the hospital provision (i.e. implementation and “double running” costs).
- Around £48 million of capital funding to enable the hospital footprints in Barrow and Lancaster to be expanded to manage additional activity (along with revenue support for the associated costs).
- A capital investment value of £43 million in new primary care infrastructure in Lancaster and Barrow. The figures shown above do not reflect the revenue investment from NHSE for the GP element of these schemes.
- £6 million of IM&T infrastructure to ensure health professionals have the appropriate clinical information to care for patients whether in hospital or outside.
- Agreement in principle for external funding to cover some of the structural costs of in hospital services that cannot be provided at the national tariff, or locally, until the full benefits described within this Strategy come into effect. The NHS has an approach to manage this called tariff modification. This would be a potential future solution to for managing the residual gap.
Approaches to Managing the Residual Funding Gap

As previously noted the current case leaves a residual annual funding gap of around £8 million per annum. However, this should not act as an obstacle to progressing with the plans as they stand, but rather there is an acknowledgement that further work is required to address this issue. There are a number of areas worthy of further investigation that could be applied to address this outstanding amount and are consistent with the issues identified in NHSE “Five Year Forward View”:

Potential Funding Growth

Our delivery plan identifies savings of up to 70% of our financial gap, which is consistent with the NHSE “Five Year Forward View”. If the overall performance of the UK economy allows for the levels of staged funding growth identified in the “Five Year Forward View” then this could provide additional resource into the Morecambe Bay health system to address the remainder of our gap. However, all organisations are committed to looking other ways of doing so.

Stretch Targets

The current forecast of £18 million savings represents the most likely view of the achievable savings from the programme. However, further modelling work has been assessed the potential savings generated if every scheme delivered to the full potential across all specialities. This work has indicated a “best case saving” of around £24 million per annum, and once the new ways of working have become embedded then targets will be reviewed and further work will be undertaken to assess the feasibility of delivering these “stretch targets”.

New Models of Care Provision

The current models are based upon changes to the clinical approach and changes to care models within the existing local NHS framework. The “Five Year Forward View” identifies that there are new contracting and organisational forms that could be used to support the delivery of more integrated health systems across the NHS. The ethos of Better Care Together is to ensure that patients are actively supported in accessing “the right care, at the right time, in the right place” and provides a solution that is much simpler than present and looks to a much more integrated approach. In addition, the solution moves us away from the current “standard” NHS approach to contracting as the cost for some episodes of care will actually increase, offset by savings generated by an overall reduced volume of activity.

Therefore, the Morecambe Bay health system would appear well placed to evaluate the potential merits of some of these opportunities (such as Primary and Acute Care Systems, or a capitated budget approach) as a result of the Better Care Together process. It would be anticipated that moving down such a route may provide further synergies in the local health system over and above those identified in Better Care Together thus potentially releasing additional resources over and above those already identified in the programme.
8. Our roadmap for future services

Our people

Our proposals create some really exciting opportunities for our workforce, and also some quite different ways of working. A Workforce Change Enabling Group will provide leadership, support and delivery of the development of a workforce planning and education commissioning strategy across the local health economy. Core membership includes senior representation from all of the four provider organisations; both Clinical Commissioning Groups; both of our universities (Lancaster & Cumbria); both of our Local Authorities; the Associate Dean of Postgraduate Medical Education and the Local Education and Training Boards (LETB).

The BCT Strategy presents the local health economy with the opportunity to design and invest in a new, modern out-of-hospital workforce that has the flexibility and agility to deliver care closer to patients’ homes. This will require a ‘system-wide’ attraction, recruitment & retention strategy that:

- over time, reduces investment in the in-hospital workforce so as to allow greater investment in the out-of-hospital workforce
- continues to attract new staff via local, national & international recruitment
- protects existing services from de-stabilisation during periods of transition
- minimises any ‘double running’ of services

Our challenge is to recruit and retain a workforce who can sustain the momentum and commitment in the course of this journey. For the first time we will have a system owned plan that we can share with existing and potential new staff, and can articulate the vital role they can play in creating our success story as we develop our services and our reputation.

...we will enable new and existing staff from across the local health economy to effectively carry out the out-of-hospital roles...
We aim to achieve this through three broad phases of work:

**Table 4. Roadmap Phases**

<table>
<thead>
<tr>
<th>Phase</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase 1</td>
<td>Workforce &amp; Education Planning (November 2014 – January 2015)</td>
</tr>
<tr>
<td>Phase 2</td>
<td>Stakeholder Engagement (February 2015 – June 2015)</td>
</tr>
<tr>
<td>Phase 3</td>
<td>Transformation (July 2015 – October 2019)</td>
</tr>
</tbody>
</table>

Work within phase 1 has included a workforce intelligence exercise to model the high-level impact that the Strategy will have on the in-hospital workforce, based on the assumed activity shifts. This exercise has demonstrated that over a 5-year period, the total staff released by the BCT Strategy would equate to approximately 525 whole time equivalent (WTE) staff, with a 5% margin of error either way.

Staff turnover and retirement averages 9.5% of the total workforce every year. Therefore we will be working with our commissioning colleagues to identify how best to release staff who wish to work in the in community whilst maintaining safe staffing levels for those being treated in hospital. Nurses will continue to be required in both the hospital and the community.

Workforce calculations indicate that the workforce required to support the delivery of the out of hospital model equates to approximately 331 WTEs.

The BCT Workforce Change Enabling Group will drive the necessary modelling and recruitment and training strategies to support this.

The workforce changes for the out of hospital model will require a projected investment of £11 million.
Our technology

Imaginative use of innovative technology is an essential part of our plans.

Our informatics group includes representatives from across our partnership organisations. They focused on agreeing the systems design to support implementation of the Out of Hospital model. It was agreed by the Informatics Group that the IM&T model will consist of 4 overlaying Solution Groups:

- Initial Access systems, for Patients and Integrated Core Team
- Core systems, to drive the Operations for Integrated care
- Back Office systems, to support management and reporting of Integrated care operations
- Infrastructure solutions, to provide seamless Integrated care across the health economy

Within these 14 IM&T areas, solutions will be put in place to achieve our vision, see table below: 14 IM&T solutions.

A significant investment requirement (£6m) has been identified to either build or procure these solutions. We are seeking funding for this through potential specific sources of funding for technology development (i.e. to cover system implementation costs). The plan reflects that ongoing revenue costs will increase (e.g. user licence costs), although this figure has been abated for current system costs that will be superseded by the new technology.

The importance of IT as a key enabler has been highlighted within the NHS Five Year Forward Plan.

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Table 5. 14 IM&T solutions

<table>
<thead>
<tr>
<th>Solution Group</th>
<th>Required Solution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Access</td>
<td>1 Contact Centre Solution</td>
</tr>
<tr>
<td></td>
<td>2 Online Booking</td>
</tr>
<tr>
<td></td>
<td>3 Self-Care</td>
</tr>
<tr>
<td></td>
<td>4 Knowledge Management</td>
</tr>
<tr>
<td></td>
<td>5 Referral Support</td>
</tr>
<tr>
<td>Core</td>
<td>6 Integrated Care Record</td>
</tr>
<tr>
<td></td>
<td>7 Care Planning and Management</td>
</tr>
<tr>
<td></td>
<td>8 Risk Stratification &amp; Analysis</td>
</tr>
<tr>
<td>Back Office</td>
<td>9 Information Management</td>
</tr>
<tr>
<td></td>
<td>10 Performance Management</td>
</tr>
<tr>
<td>Infrastructure</td>
<td>11 Network</td>
</tr>
<tr>
<td></td>
<td>12 Data Storage</td>
</tr>
<tr>
<td></td>
<td>13 Active Directory</td>
</tr>
<tr>
<td></td>
<td>14 Email</td>
</tr>
</tbody>
</table>
Our Estates

The implementation of option A, our highest ranking option, would impact upon the estate across the whole of the local health system. The impact is summarised below:

**Table 6. Impact on estates**

<table>
<thead>
<tr>
<th>Change proposed</th>
<th>Impact on estate</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Out of Hospital</strong></td>
<td>Implement the Out of Hospital model, which will shift significant levels of both inpatient and outpatient activity into OH care settings</td>
</tr>
<tr>
<td><strong>In Hospital</strong></td>
<td>Make changes to the location of In Hospital services</td>
</tr>
</tbody>
</table>

The overall approach to develop the estate in response to the preferred clinical model in the BCT Strategy is to:

- Make best use of existing estate and accommodation in the local health system for both Out of Hospital (OH) and In Hospital care
- Exploit opportunities for sharing facilities across health and other partner organisations to optimise use of public sector assets

**Our car parks**

Overall, in future we should actually need less parking on our hospital sites than we have at the moment because fewer people will be going into hospital which means fewer visitors and so on.

The position at the RLI is slightly different because this is already an extremely busy car park and a new car park will be built here whether or not our Strategy receives the support needed.

**Transport**

The Technical Transport Working Group has overseen the work assessing the transport impact of the proposals in this Strategy. The group included representatives from both Clinical Commissioning Groups, the hospital Trust, both County Councils and North West Ambulance Services (NWAS) who were directly engaged in the evaluation of transport implications. The assessment included the impact of proposals on:

- Ambulance services – both non-emergency and emergency transport
- Patients
- Staff
Our Ambulance services

There may be some change to ambulance requirements arising from the impact of integrated care teams across the local health system necessitating transport outside normal hours. At this stage of development, the BCT Programme has assumed that the increase in transport requirements would be offset by the impact of reduced activity in hospitals through the implementation of the Out of Hospital model. The detailed impact will be confirmed during the design phase.

Impact on patients

Further information on the impact of our highest ranked option in terms of transport will be available following the release of the Health Impact Assessment Report.

Impact on staff

The current distribution of staff working at WGH shows that a significant proportion live in the South Lakes area and work locally. If in the medium term the majority of surgery was consolidated at RLI and FGH then the impact of the changes proposed in this Strategy would principally be on this group of staff:

- Changes to the location of elective surgery could result in additional travel costs for South lakes based staff because some of them would be travelling a longer distance to work. These staff would be entitled to excess travel costs for a period of four years, which would be negotiated as part of changes to job roles
- Proposals will also drive a favourable financial benefit as they should help reduce the overall level of travel costs between sites which is currently some £1.7m per annum.

The precise impact will be determined when more detailed planning is undertaken, however at this stage, it is reasonable to assume that the impact on staff travel costs from changes to services at WGH will be neutral.

...Our proposals create some really exciting opportunities for our workforce...
9. Our approach to engagement and consultation

Engagement has been at the heart of this programme. We have listened to thousands of people and used a wide variety of ways to find out what local people think about services now and what they would like to see in the future. A detailed report summarising this activity and feedback is available on our website.

It would be dishonest of us to pretend that we can always do exactly what people want, but wherever possible we want to be able to take into account what patients and local people say. Our local clinicians have been passionate about making sure that the voices of their communities are heard, and in addition to all the formal engagement that has taken place, our GPs and other clinical colleagues have been able to bring a wealth of experience to the development of these proposals by drawing on their day in/day out interactions with patients.

Although our proposals are not approved yet, we think it is important that local communities, staff and partners are aware of the type of recommendations that our clinicians are making and the reasons behind these recommendations so that they can be involved in informed discussions about the future of their services well in advance of any formal consultation.

When we began this project we thought we might be embarking upon a traditional NHS consultation about major changes to our services such as a reduction in maternity or A&E services. Our research has demonstrated that these radical solutions are not right for our communities, and would not resolve our underlying financial problems, so our focus on the next two years will be on the development of out of hospital services. We will build a structured engagement programme around this so that patients and local people have the chance to work with us to shape the solutions around their specific localities.

If things go to plan and our Strategy gains the funding and support it needs, we would need to develop a more detailed business case, and get further clinical assurance that this is the right thing to do from the NHS Clinical Senate, before consulting with the public and stakeholders. This is why we want to have open and honest discussions with staff, the public and other stakeholders at this stage. We do not anticipate that a Consultation would take place before 2016. If our proposals gained formal approval implementation could not take place until after the new theatres and other physical changes were completed in 2016/17.
Even if the recommendations within the NHS Five Year Forward View for smaller hospitals to receive more funding come into effect this would not solve the quality challenges of stretching our clinical staff across three sites, so we do not believe that this will affect our proposals for surgery. However the timescales involved allow us to thoroughly explore the implications of the View and any additional benefits that could arise for our communities and allow our stakeholders to continue to help shape our plans.

We will work closely with all our local Overview and Scrutiny Committees, and in particular the Joint Overview and Scrutiny Committee for Cumbria and Lancashire, to agree an appropriate programme of engagement and consultation to support the development and implementation of our Strategy.
The Better Care Together Strategy sets out our intention and high level proposals to create forward thinking and effective health and social care services in Morecambe Bay. It fully aligns with the NHS England Five Year Forward View, demonstrating that even with the very specific geographic and demographic challenges facing our health and care economy we have created an ambitious but credible and affordable solution.

There is no time to lose – we owe it to our local communities to address the fundamental issues facing our health and care economy. It is essential that we gain wider system support to make the changes needed to guarantee our communities high quality, safe, sustainable services.

We are therefore encouraged that NHS England and Monitor are supportive of the overall direction of travel for our proposals, subject to the development or more detailed business cases and action plans. They will continue to work with us over the coming months to help us identify appropriate sources of funding, and to provide external assurance that any changes to services remain in the best interests of local people.

The Better Care Together programme has already strengthened relationships between health and care professionals across the whole Morecambe Bay health economy, preparing us for the challenges ahead. Our Strategy and delivery plan demonstrate that we can create the modern, innovative health and social care system that our local communities deserve, and we are now asking NHS England and Monitor for their support to help us realise this vision.

Nigel Maguire, Chief Officer, Cumbria Clinical Commissioning Group