REPORT TO THE EXTERNAL OVERVIEW AND SCRUTINY COMMITTEE FROM COUNCILLOR ELAINE WOODBURN, LEADER OF THE COUNCIL

NORTH CUMBRIA CLINICAL STRATEGY

Acknowledgement: Thanks to Councillor Ian Hill for his expertise and advice during the development of this report.

1. INTRODUCTION AND BACKGROUND

1.1 A process of clinical engagement and leadership in North Cumbria, across GP commissioners, senior hospital consultants and other clinicians across secondary, community and primary care have been working together to agree clinically sustainable models of care over the last 6 months.

1.2 The overall strategic direction remains that set out in the Closer to Homes strategy and the models will provide the key foundations for separate but linked challenges North Cumbria health care faces.

- Long term sustainability
- A revised business case for the redevelopment of WCH
- The need to align secondary care capital investment and resources with specific community developments in West Cumbria
- The need to contribute to efficiency savings set for the NHS

1.3 Members will recall the vision and aims of Closer to Home were : -

- We want to help more people keep fit and well for longer.
- We want greater involvement of patients and citizens in shaping the delivery of services and managing their own care and conditions.
- We want to provide more services in the community by strengthening the capacity of community and primary care services, including providing local beds where necessary.
- We want to complement these local services with acute hospitals providing the specialist services that they are uniquely able to provide and to the standards of the best in the country.
- We want services to reflect local priorities, with local doctors, nurses and other professionals playing a greater role in setting local priorities.
- We want services which are more responsive to what patients and their families need,such as fewer and shorter admissions to hospital
- We want to repatriate and re-provide as much secondary care as possible within Cumbria

2. THE NORTH CUMBRIA CLINICAL STRATEGY – WEST CUMBERLAND HOSPITAL

2.1 Members will note the attached strategy covers a lot of areas but the priority area within this report is the affect of this strategy on the West Cumberland Hospital. The main area of concern is the two options within the strategy for the ITU; one retaining an ITU on both sites; the other just having a treat and transfer from WCH to the Carlisle Infirmary.

2.2 In recent discussions both representatives of the GP's and Hospital Clinical Lead Team strongly supported the need for an ITU at the WCH - a view strongly voiced at the recent public meeting.

2.3 It is worth noting that the strategy has yet to be costed to ensure it can be delivered within the budgets available.

2.4 If there is no ITU at the WCH then that will prove to be the end of the hospital as we know it, the recognition for training will be lost and the breadth of clinical experience will be reduced. If that happens then the WCH could become no more than a community hospital, and that would be fatal for the recruitment and retention of quality clinicians and nurses. The enthusiasm or whatever that guide those intent upon reducing the scope of activity at the WCH need to start providing evidence that support their opinions. Thus far with regards to the options for the ITU these have been very vague and totally unconvincing.

3. CONCLUSION

3.1 In conclusion the strategy is a vague document and does not define what it is saying. Neither does it demonstrate that its ideas are financially affordable and sustainable. It also makes no comment on the hidden costs of loss of productivity of clinicians working between two sites or the cost to families if they have to travel further or look after relatives at home and the costs that come with that. Community based services themselves have a long and not always distinguished history and more concerning is the difficulty to cost these services fully. There is no attempt within the report to allay this fear.

3.2 Any decision made must be based on clinical need. The NHS cheque book has limitations but there is worrying evidence that longer distances are associated with higher mortality. The option to not have an ITU at WCH has to be judged with this evidence in mind.

3.3 Therefore it is recommended that it is essential that the WCH has the services and departments it needs to support the healthcare needs of Copeland and beyond, and to aid this Copeland Borough Council supports the retention of a ITU at the WCH and agrees to write to NHS Cumbria relaying this support. The OSC is asked to support this recommendation.

Attached: North Cumbria Clinical Strategy

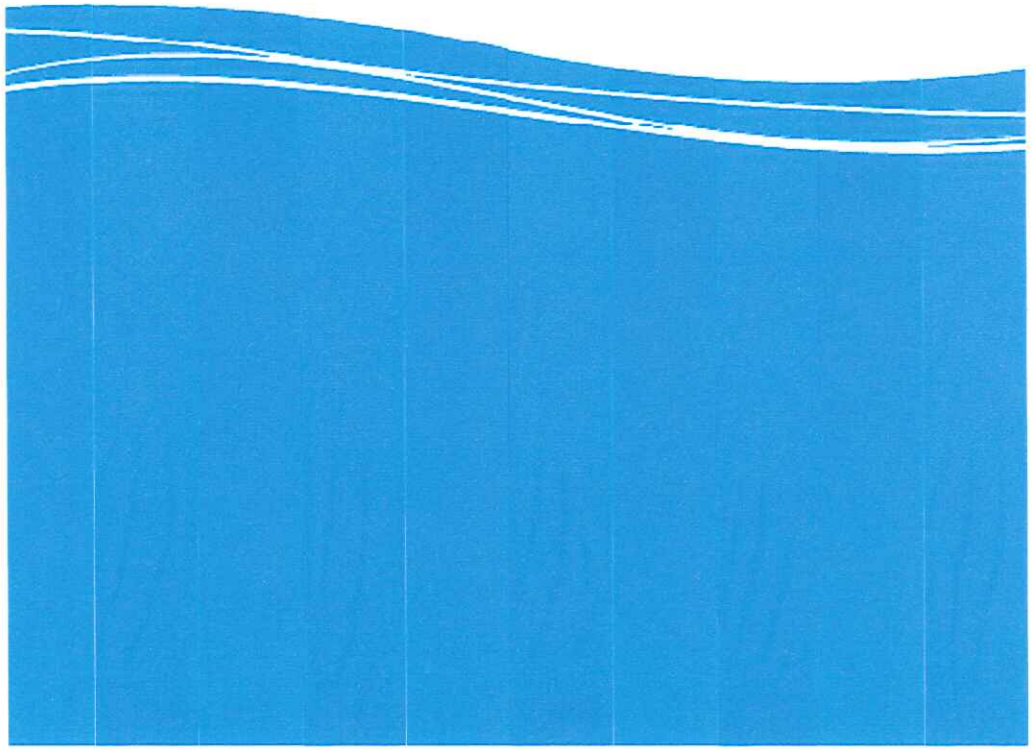
North Cumbria University Hospitals NHS
NHS Trust

NHS Cumbria

North Cumbria Clinical Strategy

NHS Cumbria & North Cumbria University Hospitals NHS Trust

March 2011



Foreword

This document describes a clinical strategy for North Cumbria. Significantly the clinical engagement process has been strengthened across the whole of North Cumbria. This process included with two significant clinical workshops attended by over 50 people at each event, to discuss and agree the models of care. The workshops were structured to review the key clinical workstreams which need to be developed to ensure there is an integrated sustainable and financially viable clinical strategy.

We recognise the importance of this clinical strategy to address a number of challenges facing the health economy.

- Long term sustainability
- A revised Full Business Case for the redevelopment of West Cumberland Hospital which shows how the reconfigured models will be delivered within an affordable capital scheme and thus how the hospital will play its part in the sustainability of the health economy in North Cumbria
- The need to ensure that the secondary care model is clinically and financially viable
- The need to align secondary care capital investment and resources with specific community developments in West Cumbria and similarly how these will play their part in the sustainability of the health economy within agreed time frames
- The need to contribute to efficiency savings set for the NHS

The clinical strategy will need to be supported in the PCTs commissioning intentions for 2011/12 and subsequent years. Required now is assurance on the affordability of service models described in the strategy as our clinicians have framed it. To ensure future sustainability we need to be assured that what we are setting out shifts how health care is provided in North Cumbria *and that* we are efficient in how we deliver our models of care and implement our new ways of working.

This document sets out our clinical strategy and the process that is in place to confirm its safety, sustainability and affordability and to plan for its implementation.

Section:

Section 1:

Reconfiguration Background & the Closer to Home Vision and Strategy

Purpose of this section

This section provides a background to the reconfiguration work in North Cumbria. It also includes a reiteration of the Closer to Home strategy's overall vision and objectives; a reminder of the agreement process; and a summary of progress to date.

Reconfiguration Background

A process of clinical engagement and leadership in North Cumbria, across GP commissioners, senior hospital consultants and other clinicians across secondary, community and primary care, have been working together to agree clinically sustainable models of care over the past six months. These are described in subsequent sections of this document.

The overall strategic direction remains that set out in the Closer to Home Strategy (developed and consulted on in 2007/08) and the models will provide the key foundations for separate but linked challenges which we face in North Cumbria:

- Long term sustainability
- A revised Full Business Case for the redevelopment of West Cumberland Hospital which shows how the reconfigured models will be delivered within an affordable capital scheme and thus how the hospital will play its part in sustainability of the health economy in North Cumbria
- The need to align secondary care capital investment and resources with specific community developments in West Cumbria and how these play their part in the sustainability of the health economy
- The need to contribute to efficiency savings set for the NHS

Closer to Home Strategy

NHS Cumbria (the PCT) developed and publically consulted on a strategy in 2007/08 to provide more health services closer to people's homes. We worked together with our key health and social care partners – North Cumbria University Hospitals NHS Trust, North West Ambulance Service NHS Trust and Cumbria County Council – in preparing proposals for how to do this across the north of Cumbria.

The vision and aims of Closer to Home were:

- We want to help more people keep fit and well for longer.
- We want greater involvement of patients and citizens in shaping the delivery of services and managing their own care and conditions.
- We want to provide more services in the community by strengthening the capacity of community and primary care services, including providing local beds where necessary.
- We want to complement these local services with acute hospitals providing the specialist services that they are uniquely able to provide and to the standards of the best in the country.
- We want services to reflect local priorities, with local doctors, nurses and other professionals playing a greater role in setting local priorities.
- We want services which are more responsive to what patients and their families need, such as fewer and shorter admissions to hospital
- We want to repatriate and re-provide as much secondary care as possible within Cumbria

Section 1
Closer to Home Vision and Strategy

The benefits are:

- Services will be designed to meet the circumstances of each local area, making them more responsive to the needs of patients and local communities.
- People will be involved in managing their own care, ensuring it meets their individual needs and thereby providing better outcomes
- Promoting good health will help improve the quality of people's lives now and ensure healthier lives for future generations.
- People with long-term conditions will have more control over their lives and will spend less time in hospital.
- Waiting times for hospital treatment will be shorter as more beds are available for planned treatment, reducing anxiety and improving patient outcomes.
- Patients with serious illnesses will receive the treatment they need in an acute hospital and will be able to receive further care closer to home.
- Families and friends will have to make fewer long journeys and it will be easier for them to visit and care for relatives who are treated closer to home.
- People's lives and social networks will be less disrupted as a result of responsive local services.
- We will be able to invest in improving our hospitals, clinics and other facilities to make them better places to be treated in and to work in.
- We will provide a consistently high standard of care across Cumbria.
- People working in health and social care will be able to develop their skills and to use them in satisfying ways, improving recruitment and retention of staff

The proposals went through a rigorous Gateway process and we consulted extensively on our proposals between September 2007 to February 2008. The consultation process set out how our new model of care would operate and how our proposals might be developed and implemented. Importantly, it explained how hospital services in north and west Cumbria would need to change and reduce capacity as we move certain services into the community. We asked for comments on our proposals from the public, staff in the NHS, partners such as the other NHS Trusts and local authorities, and other stakeholders, such as community and voluntary groups. Following consultation, joint agreement was reached by the PCT, NCUHT and SHA Boards on the proposals and the key actions to implement the Strategy.

What we have achieved so far

We have implemented many of the components of the community models:

- We have established 6 GP-led localities. The success of these has recently been recognised as Cumbria has been accepted as a Pathfinder for GP commissioning
- We have breathed new life in to the county's community hospitals and have developed new Step Up/Step Down units in Carlisle, Whitehaven, Kendal and Barrow where there was no provision before
- Across the 9 community hospitals and 4 Step Up/Step Down units there have been major improvements in activity, efficiency and quality. Since 2007 admission numbers have more than doubled and the number of admissions for each bed across all the community facilities (spells per bed) has increased by 82%. This is coupled with major improvements in quality.
- New models of care have been introduced, such as short term intervention nursing service (STINT) and a new model for diabetes as the fore-runner to new approaches to managing long term conditions

- We have established Primary Care Assessment Services (PCAS) in Carlisle, Whitehaven, Penrith, Kendal and Barrow; but we recognise that these would benefit from further integration with A&E services in to integrated Emergency Floor arrangements.

There have been significant achievements in the delivery of primary and secondary care provided by both NHS Cumbria and NCUHT. These include;

- Secondary care capacity has been reduced across West Cumberland Hospital and the Cumberland Infirmary
- Hospital acquired infection rates in secondary care have dramatically reduced.
- A&E services have achieved key targets and are one of the best performing services in the North West
- 18 week referral to treatment time targets and cancer waiting time targets have been consistently met enabling local patients to get one of the best access times to secondary care in the region
- Excess bed days have been reduced and performance exceeds upper quartile benchmarks
- Excellent and Good ratings for the quality of secondary care over the last 2 years from the Healthcare Commission/CQC
- Design of new integrated service models for emergency care and a new rapid assessment model for older people
- Nationally recognised leader in developing real time patient experience measures in secondary care to support the overall Quality Improvement strategy
- Implementing the NHS North West Advancing Quality programme with the 3rd highest ranking in service improvement in 2009/10
- Development of an extended clinical network to provide stroke telemedicine out of hours (thrombolysis)
- Establishing a clinical leaders forum involving GP Locality Leads and Associate Medical Directors in developing demand management models and improving the quality and efficiency of patient pathways across primary and secondary care
- The level of non-elective admissions in north Cumbria fell by 8.13% compared to a 3.7% increase for the North West SHA providers and 4.9% increase nationally
- The level of GP referrals increased by just 0.95% in north Cumbria compared to an increase of 3.95% in the North West and 4.1% in England
- The level of first outpatient attendances fell by 0.35% in north Cumbria compared to an increase of 3.5% in the North West and 6.1% in England
- Total electives in north Cumbria rose by 0.1% compared to an increase 4% in England.
- Achievement of a cost improvement programme of £22m over the last two years with the cost base being further reduced by £12m in 2010/11.

Section 2:

Clinical Leadership

Purpose of this section

This section sets out our commitment to a sustainable Clinical Strategy that is developed, led and implemented through strong clinical leadership across primary, community and secondary care and the key assumptions that we share in the development of that strategy.

Clinical Leadership

At the beginning of September 2010 a new process of senior clinical engagement for West Cumbria was embarked upon, which had as its purpose the agreement of a common clinical understanding of the development of integrated health services for West Cumbria. This common understanding would then provide the underlying principles and shared understanding for the development of healthcare services and facilities across community and secondary care in West Cumbria, a common basis from which commissioners and providers of healthcare would work. This process has been built upon to produce an agreed Clinical Strategy for North Cumbria, where our models of working across primary, community and secondary care are common and owned by senior clinicians. They are rooted in an integrated approach to patient care pathways- integrated across primary, community and secondary care- and form part of an integrated secondary care network within North Cumbria and beyond. The clinical strategy for North Cumbria must be set within a Cumbria-wide context, ensuring fair distribution of resources across the County (to address inequity in Barrow) and excellence of care irrespective of location.

Clinical Leadership is vital to ensuring that the strategy that we adopt is the right one. The common principles shared by all are;

- We need high quality sustainable services.
- We need clinicians working together not separated through organisational barriers formed by competing or conflicting imperatives.
- We need to be able to recruit high quality staff.
- We need to ensure that we plan to provide services within the funds available to us and that we get the very best out of every NHS pound spent.
- We need to communicate properly so that we are efficient and effective in all that we do. We owe this to our population.
- It needs to be clinically led, jointly owned and with an emphasis on effective implementation

This clinical strategy is a part of a paradigm shift in how we work together and the delivery of integrated care pathways for patients. It is about new models of care provision that require clinicians to organise differently, develop new relationships *and* for individual clinicians and clinical teams to work differently in the future. It is a considerable change process that without clinical leadership and collaboration will not be implemented effectively. It is imperative that when the provision of clinical services to a local population changes that the clinicians have led the development and can articulate the rationale for change to the public.

The development of this strategy has led to new agreements on how, as senior clinicians, GP commissioners and providers of care, we will work together in the future to ensure that the models of care are properly developed, based on best practice and evidence and that strong clinical governance arrangements are in place across whole pathways of care.

Section 2
Clinical Leadership

Clinical Responsibility: Affordability and Sustainability

The models have been agreed by senior clinicians from primary, community and secondary care. We know that these models of care need to be provided within an agreed financial envelope, at a cost that is sustainable for the health community.

This clinical strategy aims to reduce costs in two main ways. Firstly, the models of care are based on patient pathways using the 'right person, right skills right time right place' principles, not reflecting the often competing organisational imperatives of different organisations. Secondly, we are ensuring that delivery of the models is as efficient as it possibly can be. The models for acute hospital services have been developed based on a philosophy of integrated delivery of clinical services. The next step is to understand the cost base of the acute hospital services component of these models.

Clinicians are taking the responsibility for ensuring that we design the models of care for sustainability - if the costs prove not to be affordable we will jointly review the models to ensure that they can be delivered within an affordable cost base which continue to emphasise safety and quality.

Key Notions

As we have developed our clinical strategy we have built upon key assumptions and our strategy is:

- designed and delivered for Cumbria - not around organisational boundaries
- built upon the foundations, and implementation of the Closer to Home strategy
- designed to enhance the integration of services and delivery of seamless care for patients
- to actively facilitate and promote learning between clinicians
- enhance recruitment through the development of innovative working practices, new roles and relationships across primary and secondary care
- Designed and delivered to ensure that the health resources available are used to maximum effect and efficiency- the shared health pound, rather than for organisational gain or need.

Where we:

- consider our workforce as a shared resource, delivering across locations and facilities
- Consider buildings as facilities to operate from rather than the sole property of individual institutions- we will do away with the notion that consultant medical staff only work in acute hospitals and GPs only work in primary care premises.

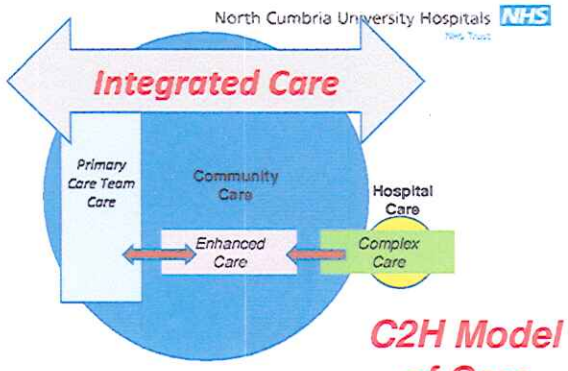
Community Orientated Primary and Secondary Care

The redesign of all of our services will build on the considerable assets within our local communities and ensure that all our services focus on our communities - developing pathways of care which are built to reflect the patient in their community, focusing on prevention and supporting self management of care.

Integrated Working and Clinical Networks across Primary and Secondary Care

Clinicians in secondary and primary care have different skills and understanding. One is not inherently better than the other. Together they can provide clinical networks that support good care for patients. Our examples of integrated working include:

- Integrating skills within a team: Forming integrated teams of secondary and primary care clinicians working alongside each other- not as part of a hierarchy. This could be in our emergency services or in the provision of ambulatory care through one stop shops.
- Supportive clinical networks: An example is the development of a network of community surgery, with primary care clinicians providing care actively supported by secondary care clinicians for training, equipment and shared audits
- Clear pathways: clear pathways across services such as the Copeland Unit (community step up step down unit at the West Cumberland Hospital) and Community Hospitals and for pre and post operative care between GP services and elective care
- Co-consultation and advice: Different relationships between GPs and Consultants that allow proactive discussions of patient needs at different stages of the pathway, sharing expertise to agree the treatment and care
- Professional networks: Examples include physiotherapists who follow a patient during a hospital episode and continue rehabilitative care into the home and community.
- Equal emphasis on in-reach and out-reach by all providers irrespective of sector or organisation – to ensure the continuity and consistency of patient care



C2H Model of Care

Section 2
Clinical Leadership

High Quality Care

Planning and development for the future should not be limited by the aspiration of keeping what we have now. Future clinical models need to aspire at least to best UK practice available for the people of North Cumbria. Our clinical pathways need to be built to deliver best UK care and practice- challenging all clinicians to continually seek out and develop new techniques and approaches and build local clinical pathways and networks to deliver them. Good enough is not good enough and more of the same only done more efficiently is not good enough.

Sustainability- Workforce Development and Recruitment

We can't keep doing what we have always done because clinicians of the future will not have the skills to continue with our existing ways of working- nor will we be able to attract new clinicians or afford to run the clinical rotas in the same way. We are actively considering developing new roles that cross secondary and primary care, linked to new training opportunities, whilst at the same time restructuring our rotas to increase senior clinical input from Consultants and GP's. We need to extend this thinking to all clinical professionals. Clarity of what is provided where in the future needs also to take into account the availability of key professions, such as anaesthetists, to support service models.

Education and Shared Learning

The clinical community is currently fractured. We don't share our expertise, learn from each other or communicate effectively (individually or as groups). For example Consultant clinics held in a community setting or GPs working alongside Consultants in hospital settings may appear to be inefficient at a superficial level but this will be more than offset from the potential for shared learning, We must plan for this in the design of future services and systems as we are not realising these benefits at the moment. We will develop a range of approaches to release this potential and ensure that we have an integrated approach in the future.

Efficient Ways of Working

There is everything to gain from working more efficiently, reducing length of stay, increasing the amount of planned/scheduled care, organising service delivery so that a patients needs can be met on one visit to a clinical service not multiple visits to different places, reducing the number of 'handovers' in a patients pathway, predicting at an early stage the tests that will be needed, the aftercare that will be required, improving communication. We envisage our new models of care may require more senior clinical staff in the future, clinicians who can make decisions quickly about patient care and at an early stage in the care pathway

Location

We are clear that our 'buildings' provide physical facilities from which health care can be delivered but that they will not be constrained by the traditional definitions of primary care or acute care. Community services for the people of Whitehaven and surrounding areas may be best provided on the West Cumberland Hospital site - the same services for the people of Seascale or Cockermouth may be best provided in local community facilities.

Ambulatory Care

We want to provide as much care as possible on a planned or scheduled basis. This directly impacts on both the emergency care pathways and pathways for elective care. Three levels of ambulatory care have been agreed. A key priority is that all services should focus on the opportunity for one stop services.

- Level 1: Defined as a simple consultation that could be performed in any consulting room and where, with efficient organisation the visit could be completed by the patient in under an hour/half hour.
  In principle in the future all such consultations could be undertaken in any community or secondary care facility. The preference is for a community setting, offsetting potential inefficiencies for consultant/specialist time with the opportunity for education between primary/community care and reduced costs e.g. for NWAS/ambulance transport.

- Level 2: Defined as 'one stop shop' services, where a patient visit would be expected to take 2/3 hours and a range of diagnostic facilities may be required.
  In principle for the future many services could be provided from community facilities such as Community Hospitals or some GP premises that already have an extended range of facilities. Some one stop services would only be able to be provided on acute hospital sites due to the nature of clinical facilities required.

- Level 3: Defined as minor procedures, possibly requiring a patient stay of 3 or 4 hours, e.g. endoscopy. *This group needed to be specifically considered with facilities for some minor procedures already existing in the community but for others, where expensive equipment is required best suited to a small number of sites/acute*

Repatriation of Out of County Patient Flows

The development of local service models must support the repatriation of out of county patient flows to hospitals in the north east and south to Lancashire. This will be achieved through commissioning priorities, closer collaboration across primary and secondary care and an improved use of existing secondary care capacity. Clinicians will also identify key service developments which will enhance local access, improve outcomes and reduce the need for high cost tertiary services e.g. the development of PCI (angioplasty) in Carlisle and AMD (age related macular degeneration) in ophthalmology.

Section 3: Acute Hospital Services Strategy

Purpose of this section. This section describes the agreed models of care for acute hospital services as part of the overall clinical strategy for North Cumbria. It describes the future provision of services based on the notion of 'one hospital- two sites', setting out common models of care for the whole population and identifying what this means for the two hospital sites at Whitehaven and Carlisle.

The Closer to Home Strategy explicitly recognises the need for high quality and sustainable acute services with "acute hospitals providing the specialist services that they are uniquely able to provide and to the standards that are the best in the country". In 2010, after the delivery of a successful cost improvement programme of £22m over two years coupled with sustained performance improvements and high quality ratings from the HCC/CQC, the NCUHT Trust Board recognised the need to go further in terms of its clinical strategy. A new programme was established to deliver £21m in the first year (2010/11) along with a commitment to also redefine a clinical strategy for north Cumbria that would significantly benefit the Trust and the whole health economy from 2011/12 onwards.

During the summer of 2010 the Trust has undertaken a robust and systematic process led by the executive and medical management team. This process commenced with a focussed workshop event to discuss the strategic development of the new West Cumberland Hospital. The outputs of this workshop formed the basis of a full service review at an away day for the NCUHT Trust Management Committee (TMC). The context was to build the framework for the new clinical strategy using a systematic development of clinical options taking account of how the new hospital build in West Cumbria would input into a new strategy and how the Trust could provide a configuration of services that would be safe and clinically and financially sustainable.

Key strategy sessions have been held with senior clinical leaders within the organisation to look firstly at the critical matter of clinical sustainability. These sessions covered recruitment difficulties, sustainability of clinical rotas across two hospital sites and potential solutions to fragile rotas. All emerging themes were then brought together by the TMC to form a set of clinical strategy options in November 2010 with further refinement and quality assurance of options taking place with senior clinical leaders during December 2010.

This work, undertaken by the Trust has now been brought together through a facilitated approach, with the commissioning intentions of the PCT, to ensure that our acute services strategy is properly and effectively integrated with the broader Closer to Home Strategy, aligning pathways of care and developing integrated working models across primary, community and secondary care.

What does this mean for Acute Hospitals in North Cumbria?

We have two Acute Hospitals in North Cumbria. Whilst part of the same NHS Trust, clinical services have historically, largely been provided separately on each hospital site. The clinical strategy for the future is built upon the notion of 'one hospital- two sites'. This is more than just a slogan; it describes how clinical services will be developed that offer the best health care common across North Cumbria, efficient ways of working and secures the future of both hospital sites in North Cumbria. The clinical models proposed have all been previously consulted upon as part of the Closer to Home strategy. This clinical model takes that strategy and operationalises how to deliver it effectively.

Section 3
NCUHT operational right sizing plan

What does it mean for West Cumberland Hospital?

The hospital is a key facility to enable us to provide clinical services. We will have a redeveloped hospital in the near future that is being designed to support our new models of care. We will use this vehicle to change the models of clinical care and take the opportunity that a modern, well designed hospital offers to secure services for West Cumbria. Services will be sustainable for the future because they reflect a common clinical model with strong integration with primary care and because we will exploit the opportunity to attract patients to WCH for designated elective care procedures from beyond its 'usual' catchment area, either because it is planned for example that certain elective procedures for the whole of North Cumbria will be concentrated on this site only or because it develops the reputation as the best place in the North of England to go to if you need a particular type of care.

Clinical services will be provided through: secondary care specialists based at the hospital, working in the hospital and into the community, integrated teams of primary care and secondary care specialists working together in the hospital and by North Cumbria specialist teams, for example in Cardiology, radiology, ENT, ophthalmology and respiratory medicine working across both Hospital sites. There will be an emphasis on rapid senior clinical assessment through an integrated emergency floor staffed by a range of clinical professionals to ensure rapid assessment and care planning for patients, be it back to the patient's own homes with appropriate on-going support, hospital care at West Cumberland or Carlisle, or outwith the county for specialist services. This model will be for both children and adults. Integrated working across primary, community and secondary care will mean well managed and coordinated care pathways for patients at all times in their care.

What does it mean for the Cumberland Infirmary?

The hospital is a key facility to enable us to provide clinical services. It is a PFI hospital which needs to be used to deliver activity volumes which enable it to achieve financial stability. We will use this opportunity to change the models of clinical care and to make the Cumberland Infirmary the main hospital site for complex and emergency care and more specialised procedures. For example, the development of PCI services for Cumbria will be developed at this site and it will be the hospital that provides all unscheduled emergency surgery in north Cumbria. Services will be sustainable for the future because they reflect a common clinical model and because we will exploit the opportunity to attract patients who currently travel out of the county for their care back to north Cumbria- through the better organisation of clinical services that we already provide and through the development of new services such as PCI.

There are significant opportunities for treating north Cumbrian residents locally who currently travel for their care to hospitals in Newcastle, Northumberland, Middlesborough and Wrightington. Some of the opportunity involves reclaiming secondary care activity that, as evidenced by comparable HRGs and procedures, is taking place out of county to those currently provided locally. For some specialties this work is sent directly from primary care and represents either patient or GP choice; in other specialties there is a high level of referral from NCUHT doctors to distant specialists. In addition there are opportunities to develop what might be called "sub-specialty development" where additional services are offered that can be delivered safely and appropriately away from a Tertiary Centre.

Subspecialty developments
Cardiology Procedures – PCI, PPCI, Pacemakers, ICDs etc
Spinal procedures
Pain procedures
Some mouth procedures

Secondary Care
Elective Orthopaedics
Urology
Skin

Clinical services will be provided through; secondary care specialists based at the hospital, working in the hospital and into the community, integrated teams of primary care and secondary care specialists working together in the hospital and by north Cumbria specialist teams, for example in Cardiology radiology, ENT, ophthalmology and respiratory medicine, working across both Hospital sites. There will be an emphasis on rapid senior clinical assessment through an integrated emergency floor staffed by a range of clinical professionals to ensure rapid assessment and care planning for patients, be it back to the patient's home with appropriate on going support, hospital care, or outwith the county for specialist services. Integrated working across primary, community and secondary care will mean well managed and coordinated care pathways for patients at all times in their care.

Clinical Service Models

The Emergency Floor

There will be an Emergency Floor and integrated assessment service on both hospital sites which has three key components:

- Single call handling and triage
- Integrated assessment and treatment services
- Community based urgent care service

The Emergency Floor will integrate all the services currently delivered by CHoC, PCAS, A&E Departments, Nurse Practitioners and some of those delivered on paediatric wards. Community Hospital based minor injury services will continue to be integrated with Community Teams however the new service will provide clinical leadership, common standards, outcome measures and common pathways as part of a single governance framework.

The model provides appropriate senior clinical assessment using facilities for imaging, assessment and treatment. There will be rapid access to diagnostics and specialist support which may at times be provided at distance (e.g. by phone and telemedicine, most usually to WCH from CIC). This must be available 24/7 in order to support the Hospital at Night team.

The Emergency Floor will be staffed to provide an appropriate senior assessment from a mix of consultant, primary care and middle grade doctors working shifts and sharing skills. The

Section 3
NCUHT operational right sizing plan

team will include A&E consultants, acute physicians, surgeons, GPs and nurse practitioners. Out of hours services should consider any doctors in training at F2 level as trainees.

Non Elective Care

There will be a range of skills and facilities available 24/7 to provide stabilisation, initial treatment and ongoing care in the place most appropriate to the clinical needs of the patient. This will involve transferring patients from West Cumberland Hospital to the Cumberland Infirmary and from both hospitals to other specialist units when and if required due to the severity and complexity of their problems. There should be no out-of-hours operating or complex surgery at West Cumberland Hospital.

Elective Care

Elective care will be provided at both hospital sites. The aim will be to develop West Cumberland Hospital as a site which provides sophisticated operating techniques in relatively fit patients requiring brief or day case admission, such as orthopaedic care. This model could be very attractive to medical trainees in the future. Sustainability of services will be reliant on the local services offered and attracting patient flows from a wider catchment area.

An ambulatory care model for elective care will increase the work undertaken in primary care for pre-operative assessment and follow up as well as the development of 'one stop shop' services. Networks of community surgery will also work in an integrated way with hospital specialists and 'community surgeons' will require training supported by secondary care clinicians. GPs trained in surgical techniques could reduce the need for junior doctors.

Hospital at Night

A Hospital at Night system will be implemented on both hospital sites. The evidence is that it is efficient and can improve outcomes. A team led by Nurse Practitioners with senior medical support which could include primary care doctors who are working on-site at night in the Emergency Floor.

Acute Medicine

Both sites will have a team of consultants operating as Acute Physicians working in the A&E and the assessment areas as part of the Emergency Floor. Acutely ill adults will be assessed either from a GP call or an A&E attendance. The Acute Physician will have no other commitments. A key role will be close liaison with the community STINT and other admission avoidance services and ensuring patients requiring admission are placed on the most appropriate pathway with access to sub-specialty services, not all of which may be on-site. There may be support from middle-grade, primary care and some juniors in training but the early senior assessment is crucial. This service will require shift based rotas for senior clinical staff which will represent a significantly different way of working.

It is expected that all admitted patients will be reviewed the following morning by a senior physician (consultant or middle-grade) from the team for that ward to confirm the ongoing care pathway and to ensure a predicted length of stay is established prompt intervention or discharge.

Elderly Care

The model of integrated working is expected to include a rapid assessment service, led by Elderly Care Physicians as part of the development of the Emergency floor. The Physician will work as the clinical lead of an integrated secondary and primary care assessment pathway for elderly care patients. This will ensure that GPs and community teams have access to rapid advice for the ongoing care of older people at home (reducing hospital admissions) as well as agreed care plans for patients at the earliest stage.

Elderly Care Physicians will also support primary care teams in General Practice, Community Hospitals and other community services.

Critical Care

This is the outstanding aspect of the overall model which has to be finalised including CCU, HDU and ITU. Options range from:

1. Current configuration – HDU, CCU and ITU beds on both sites

2. A "treat and transfer" model from West Cumberland Hospital to the Cumberland Infirmary Carlisle for patients needing more than short-term ventilation, with a combined HDU / CCU facility for sick patients needing more intensive nursing and physiological support e.g. severe sepsis, cardiac dysrhythmia

General Surgery – Non elective

For non elective patients the decision on the right clinical pathway will be made by the senior emergency medicine clinician and surgeon working as part of the emergency floor.

Patients at WCH requiring more straight forward non elective procedures, depending on the urgency of need, will usually be discharged to attend the next day for operating or admitted overnight for operation on a planned list. Within the model it is assumed that consultant rotas at CIC for emergency surgery, theatre utilisation and bed management will reflect this arrangement, within existing capacity.

Trauma & Orthopaedics

Standard orthopaedic trauma will be operated on in-hours on both sites particularly for elderly patients with a fractured neck of femur. As elective surgery is carried out on-site these patients will be scheduled onto theatre lists according to anticipated numbers. Patients should be discharged for rehabilitation in the community setting within 2-5 days but this will require unbundling of PbR tariffs to make this a cost effective proposition across network providers.

Gynaecology

The vast majority of Gynaecology emergencies are not severely ill and relate to early pregnancy bleeding. The numbers are small and they could be sent home after an assessment to return for a procedure on the following day. More severe episodes e.g. ectopic pregnancy should follow the complex surgery principles.

Section 3
NCUHT operational right sizing plan

Acute Specialist Medicine

The full range of Acute General Medical Services will be available 24/7 and will be delivered in the most cost effective and clinically appropriate setting. Specialist rotas, for cardiology, gastroenterology, respiratory medicine, GI bleeding and stroke will be established on a single north Cumbria basis but serving both hospital sites.

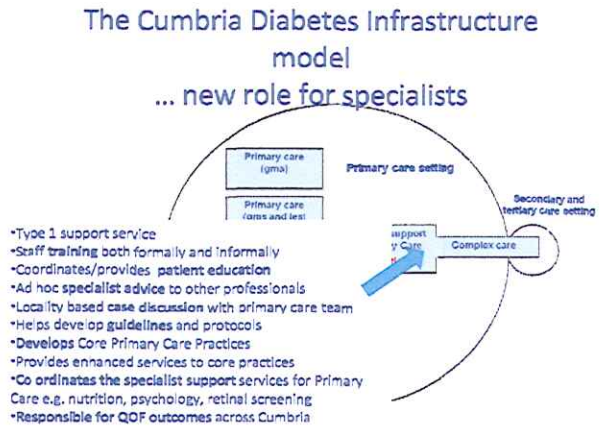
In particular the model for cardiology will concentrate expertise on the Cumberland Infirmary site in order to facilitate the development and delivery of PCI and other interventions. In relation to stroke services the Telestroke initiative will provide local scanning, remote reading and assessment followed by thrombolysis as appropriate. Of equal or greater importance is the ability to ensure that patients with acute stroke are triaged rapidly to an acute stroke bed where there is a concentration of skills and to develop further the rehabilitation phase in community settings including community hospitals. Acute stroke services will be provided on both sites.

In relation to GI bleeding a scoring system is used to identify patients at risk and those which will benefit from early endoscopy with possible injection therapy. The same principle applies to patients with liver disease with (suspected) bleeding varices. The evidence that a concentration of skills leads to better outcomes plus the need for surgical back-up etc. means that this service will be at CIC. The majority of endoscopic intervention can be done within hours as night-time endoscopy is not a common occurrence. Access to night-time advice is however needed and the ability to scope at the weekend will be required. Trust-wide rotas of all skilled staff, including surgeons will therefore be required taking into consideration as the GI physicians will be required to support acute medicine.

Long Term Conditions

The future model of care for people with long term conditions will be based on a community based model similar to the one established in Cumbria for diabetes care. Extending this model to other long term condition groups will be based on Consultant Physicians for common long term conditions working in the community with designated capacity for in-patient admissions, at both hospital sites. Outpatient clinics which do not require fixed or complex diagnostics will also be delivered in community settings, in line with the ambulatory care model. Where applicable Consultant Physicians will be included in the acute medicine rotas.

For less common long term conditions, for example aspects of neurology, Consultant Physicians may need to work as a network across sites and potentially across other Trusts.



Palliative Care

The specialist palliative care service is a community based service that will contribute to, and in some areas of Cumbria provide clinical leadership for the delivery of a fully integrated service. The service will provide specialist palliative care support and advice to patients with complex needs and their personal and professional carers.

The service will:

- Provide holistic specialist assessment and person-centred treatment planning
- Co-ordinate weekly multi-disciplinary team meetings to review the care of each patient referred to the service
- Provide specialist palliative care medical and nursing input for complex patients in collaboration with other organisations
- Provide specialist palliative care advice to a range of professionals including consultants
- Prevent inappropriate hospital admissions (24/7) by mobilising support from the most appropriate agencies

Patients needs will normally be met in the community. Where a patient has needs that require inpatient care this will be provided in community hospitals or within community step up step down wards at Carlisle West Cumberland Hospital (Copeland Unit) with the support of the specialist team.

Major Trauma

The North West Strategic Health Authority is currently undergoing an exercise to determine the configuration for trauma services that delivers best care and supports the national initiative/criteria. Clearly all severe major trauma will go to a Trauma Centre which has 24/7

Section 3
NCUHT operational right sizing plan

specialist neurosurgery, cardiothoracic services. In north Cumbria we wish to ensure that there is a Trauma Unit based in Carlisle which will be linked to the North East Trauma Network with a Trauma Centre in Newcastle.

Maternity

There should be one consultant-led service delivered across two sites with a dedicated anaesthetist in support such to ensure emergencies can be responded to within 30 minutes. The implementation of cross-site rotas, to maintain standards, given the small number of deliveries at both sites will be required.

SCBU services will be at both sites, with increased use of nurse practitioners particularly at WCH.

Anaesthetic cover at WCH should also be utilised to support other on site anaesthetic needs, prioritising obstetric care but not constrained only to obstetric care given the low levels of anaesthetic obstetric activity.

The models of care for obstetrics in North Cumbria have been the subject of a number of external reviews. This future model has been based on the conclusions of these reviews and additional clinical enquiry by local GP commissioners, Public Health consultants and secondary care consultants.

Children

Most children and young people will experience illness at some time. Most of their health needs will be met in the home and only a small number should need rapid access to a full hospital admission. In Cumbria 17% of all attendances are by 10 to 19 year olds compared with 14% nationally. Of those attending A&E, 10% (almost 3500) were admitted for treatment. Hospital services contain some of the most critical skills and the model is therefore based on deploying these skills more widely within local community based services. The aim of this service is to contribute to the health and well being of all children in Cumbria, and particularly where they relate to acute and severe health need. Acute illness or injury will be managed outside hospital where safe and efficient to do so.

The hospital element of an integrated local service will be provided at both hospital sites. It will include robust assessment, rapid response and hospital at home services supported by the paediatricians working in the community, in-reaching into the hospital assessment services and working as part of the Emergency Floor. Senior A&E practitioners will have advanced paediatric life support skills.

The Cumberland Infirmary will provide a full range of inpatient, outpatient and paediatric assessment and treatment services. Further modelling of paediatric inpatient beds needs to be undertaken. At West Cumberland Hospital there will be a senior paediatrician presence as part of the Emergency floor team at peak times to reduce the need for hospital admissions. There will be a paediatric assessment and treatment service (PATS) acting as the front end of the hospital, supported by 5-8 paediatric beds. The purpose of the beds is to support the assessment area.

Section 3

NCUHT operational right sizing plan

Compliance with Closer to Home Strategy and Consultation

The clinicians have considered the new models of care within this strategy against the Closer to Home Strategy and consultation exercise outcomes. We can confirm that the proposals are in line with the decisions jointly agreed by both organisations following the consultation, with the following provisos:

- The agreement on obstetrics following the Closer to Home consultation was "to recognise the concern about maternity services and agreed to delegate work on developing new service models which take account of concerns raised in the consultation to the children and maternity care stream". At present the intention is to retain obstetric services on both sites (albeit with a different model of delivery, as described above) and thus proposals do not represent a material change from the current service.
- The current Strategy outlines two options for ITU: option 2 could potentially be construed as being materially different from the Closer to Home consultation outcome, depending on the detailed operational arrangements put in place. However, until further work is done on costing, a decision on which option is preferred cannot be made. Further work on detailed operational arrangements will be required to support the costing process which will allow for further consideration of the extent to which option 2 is beyond Closer to Home.

NHS Cumbria