

We are  
**UHM**BT

*Together*, we are creating a great place  
to be cared for and a great place to work



University Hospitals of  
Morecambe Bay  
NHS Foundation Trust

# Clinical Strategy

## 2023 - 2028



"Creating a great place to be cared for and a great place to work"



supporting  
life's journey  
*together*

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“Creating a great place to work and a great place to be cared for”





# Section 1: Introduction & context

# Foreword

During 2021/22 we spent time developing our overarching Trust Strategy, this was approved by the Board in April 2022.



At this time we committed to the development of a refreshed clinical strategy which we commenced in July 2022.

The strategy has been developed in line with our overarching Strategy commitment of being:

- **Patient First** – focused on you, the community we serve
- **Clinically Led** – development has been through our clinical and operational teams
- **Quality / Safety Driven** – ensuring we seek to deliver outstanding care & experience in line with best practice

Along with this commitment is the requirement for the clinical strategy to address and support resolution of our clinical, financial and workforce sustainability issues.

We recognise more than ever that collaboration is critical; over the last two years we have seen the scale and power of what can be achieved when the NHS comes together as one. We will therefore continue to work closely with our system partners to provide the best services for the population of Lancashire and South Cumbria.

Since our last strategy the Royal Lancaster Hospital & the Royal Preston Hospital sites have been confirmed as part of the governments New Hospitals Programme, meaning that by 2030 we will have new hospitals in the Lancashire & South Cumbria system.

Working in collaboration with our Provider Collaborative partners we are also about to procure a single EPR; giving us great opportunity to maximise collaboration enabled through convergence of systems and processes.

We recognise that the NHS is constantly changing and with change comes opportunities; we continue to be immensely proud of how our staff continue to adapt to new ideas and ways of working.

Together we aim to provide outstanding care an experience for those we are looking after now and those who will need our services in the future.

## Our Strategy - Patients First 2022-2027



## What our vision & strategic priorities mean for our clinical strategy

Our Trusts vision to ‘deliver compassionate care and the best results for the people of Morecambe Bay’ is central to and at the heart of this clinical strategy.

The Trusts Strategic priorities were developed through wide engagement with staff and stakeholders and are intended to provide a framework to help the organisation meet the needs of our community and address the challenges faced by the local health and care system over the next five years. The overriding narrative for the strategy is one that is:

- **Patient First** – focused on you, the community we serve
- **Clinically Led** – development has been through our clinical and operational teams
- **Quality / Safety Driven** – ensuring we seek to deliver outstanding care & experience in line with best practice

Development of the clinical strategy following the principles outlined above has been through wide clinical and operational engagement, informed by an assessment on the current performance and delivery of our services in relation to a range of internal and external factors including: quality & safety outcomes, demographic and disease burden forecasts, patient experience, workforce and financial and clinical sustainability. And assessment against best practice through Getting it Right First Time and Model Health System data.

As a provider of acute and community care from ‘cradle to grave’ the strategy commits to integrated care where appropriate and to the delivery of age-appropriate care.

Our clinical strategy recognises the imperative to consistently provide high quality services which are clinically and

financially sustainable building on the opportunities that exist to transform and integrate pathways and service models from emergency to planned care. Therefore supporting the local health system to effectively and efficiently meet the health care needs of the community the Trust serves. On delivery of the clinical strategy we set an ambition to perform at upper decile against a range of metrics which will drive improved outcomes and financially sustainable service provision.

Improving outcomes in the health of the population in Morecambe Bay is an essential success measure of an integrated clinical strategy. Population health and reducing health inequalities are important themes that have been considered during the development of this clinical strategy.

We recognise now more than ever the requirement to work in the ‘system’ space, developing systems thinking is integral to the delivery plan for this clinical strategy as we encourage our clinicians to play active and leading roles across the system to co-design and deliver sustainable services at scale.

In recognising that healthcare is an ever-changing environment this strategy is a live document and will be subject to regular review and iteration as will the identified enabling strategies and delivery plans.

Alignment to and with our strategic financial improvement plan is critical as is the developing workforce and estates strategies.

# Why a new clinical strategy now?



## What are the drivers for change....



We serve a growing and ageing population requiring us to better coordinate and join up care



We know we need to improve the quality of our services. Access to care varies depending on where people live and people are waiting too long to access care



Patients expectations are changing and their experience of care varies



There are significant differences in healthy life expectancy and quality of life across different areas within the Bay, with recent data suggesting this gap is widening



Attracting, training, supporting and retaining the right workforce is one of our biggest challenges and a key challenge across the NHS



Not all our services are configured in the right way to deliver high quality sustainable care. And the cost of delivering these services means we are spending more than we receive



Advances in digital technology, innovation and AI are creating opportunities to radically transform how we deliver our services



System reform is giving us growing opportunities to collaborate beyond UHMB

## Strategic context

### National context

The Long Term Plan (published in January 2019) remains the main driver for change across the NHS and outlines a clear strategic commitment to the delivery of truly integrated services across the ensure health and social care system in order to provide a single, connected episode of care supported by a reformed workforce model and greater use of digital and new technology.

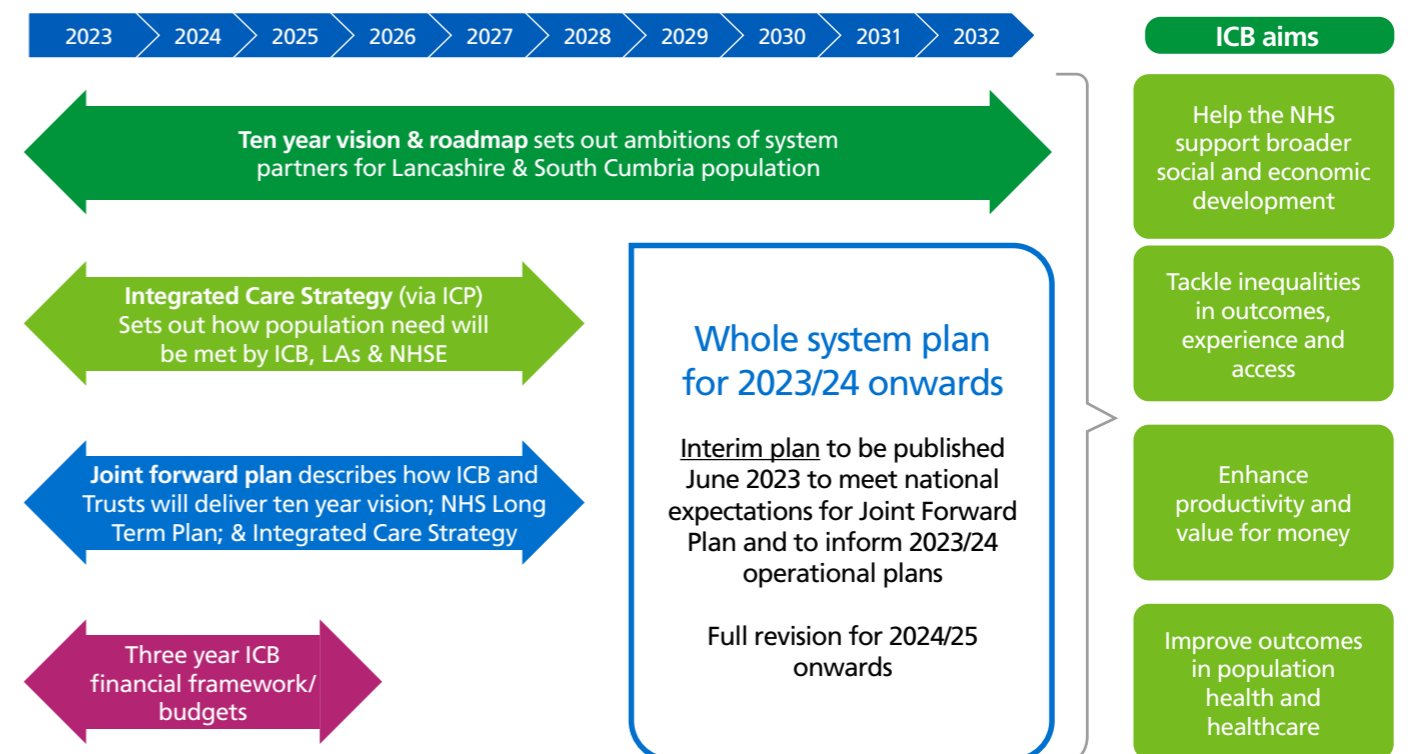
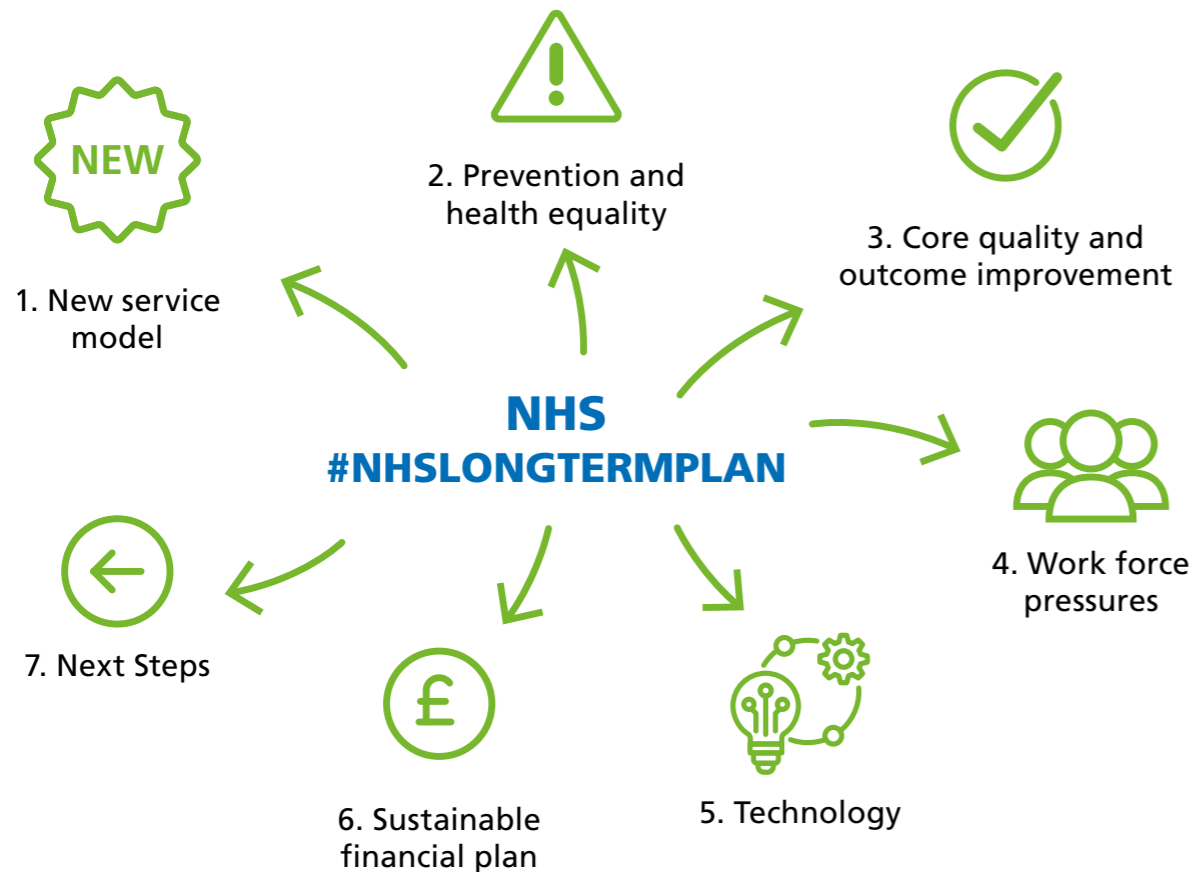
Whilst the LTP will continue to set the direction for the NHS into the future, as a result of the COVID-19 pandemic there are also a number of emerging areas of focus at a national level to ensure health systems can recover from the pandemic and implement lessons learnt, to ensure the resilience of the NHS for the future. This includes addressing waiting lists for elective surgery and access to mental health support for NHS staff.

### Lancashire & South Cumbria ICB

Whilst the system architecture is still embedding; Lancashire and South Cumbria have been working as an ICS with an effective Provider Collaborative programme board for a number of years. As a partner we are working closely with health, care and voluntary sector partners across Lancashire and South Cumbria to empower and support the 1.8 million people in our communities to have the best

start in life, so that they can live longer, healthier lives.

The development of a ten-year vision and road map setting out the ambitions of system partners will be in place from 2023; the infographic below sets out the ICB aims and the programmes of work that are in development.



## Provider Collaborative (PCB)

The PCB consists of five provider NHS trusts in Lancashire and South Cumbria, the five trusts are:

- Blackpool Teaching Hospitals NHS FT
- East Lancashire Hospital NHS Trust
- Lancashire and South Cumbria NHS FT
- Lancashire Teaching Hospitals NHS FT
- And University Hospitals Morecambe Bay NHS FT

The PCB clinical vision is **“Together we aim to ensure clinically and financially sustainable services that improve health outcomes, reduce health inequalities and offer a great place to work”**. Work has commenced on the development of a joint clinical strategy, central to that is to ensure that services are as close to people’s homes as possible whenever they can be, whilst making sure that people have the same access to high quality care no matter where they live in Lancashire and South Cumbria).

Given the challenges we face, we believe that the only way to do this if for us to work collaboratively together as a connected network of service providers. We know from the feedback from our communities on the New Hospitals programme joining up health and care services is a top priority for many people who live in Lancashire and South Cumbria.

Working as a joined-up network we will be able to share best practice, pool resources and standardise services – improving reliability, access and quality across the whole of LSC.

Focus will remain on the delivery of care close to home; we will work collaboratively on standardising care; improving access and outcomes across our services and where necessary we will work in collaboration as a group of providers to deliver networked services.

**Examples of networked services currently in action across the ICB are:**

- Stroke
- Diagnostic Imaging
- Critical care
- Cancer
- Children and Young People
- Maternity

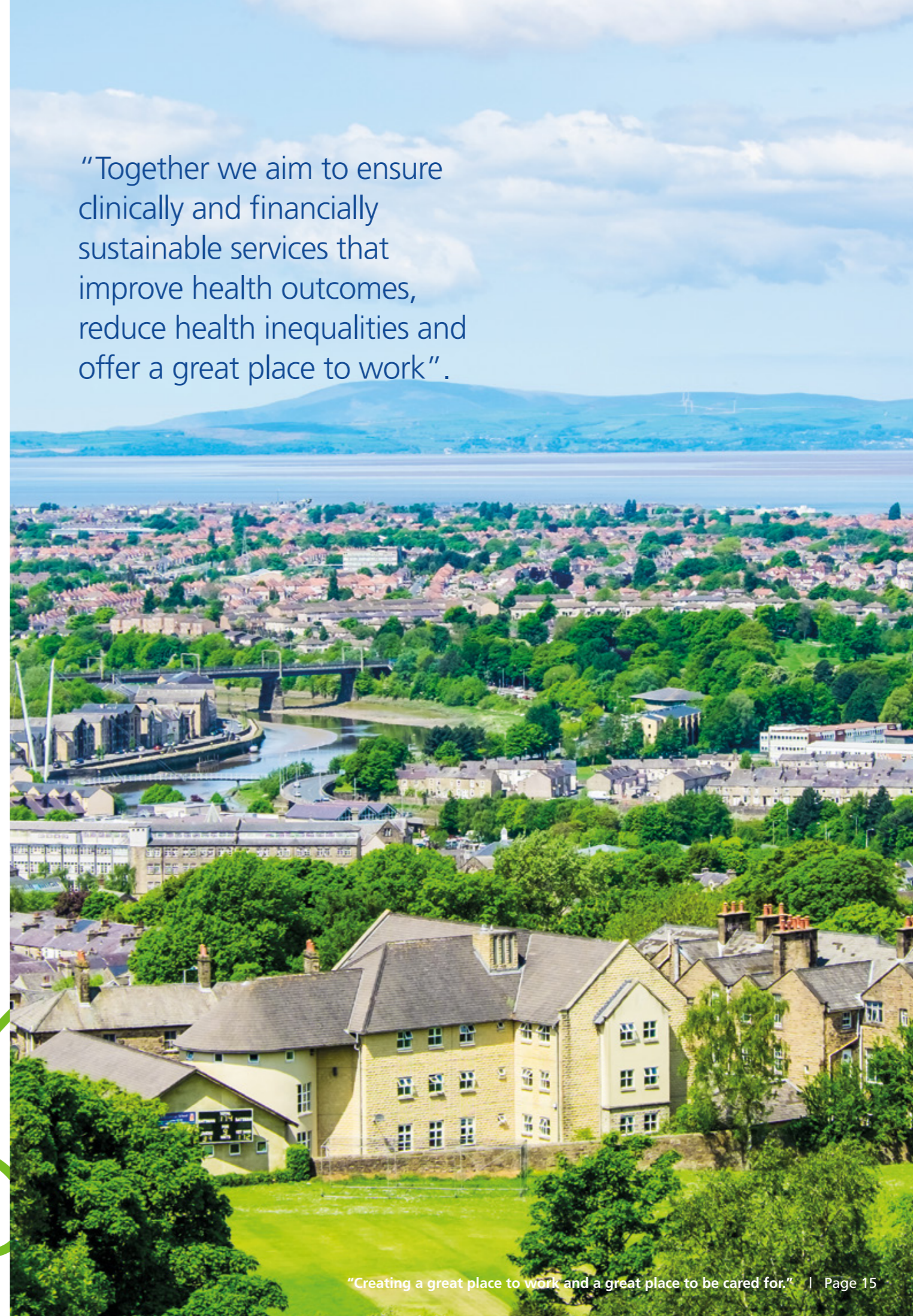
This approach supports individual trust clinical strategies which will continue to describe how service are run locally and it will also support the continuing development of the New Hospitals Programme.

## New Hospitals Programme (NHP)

We have a once in a generation opportunity to transform our regions hospitals by 2030. By creating a network of brand new and refurbished facilities we will help local people live longer, healthier lives.

The New Hospitals Programme is currently in development, the case for change has been created and a framework for the Model of care. Our clinical strategy has taken account of the work underway and is fully aligned to the NHP Model of Care.

“Together we aim to ensure clinically and financially sustainable services that improve health outcomes, reduce health inequalities and offer a great place to work”.

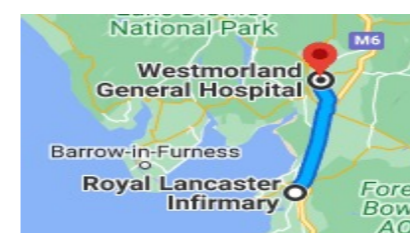


## About us

The geography & demographics of Morecambe Bay is a significant factor in the consideration of this clinical strategy. The Trust serves a population of 350,00 spread over a thousand square miles.



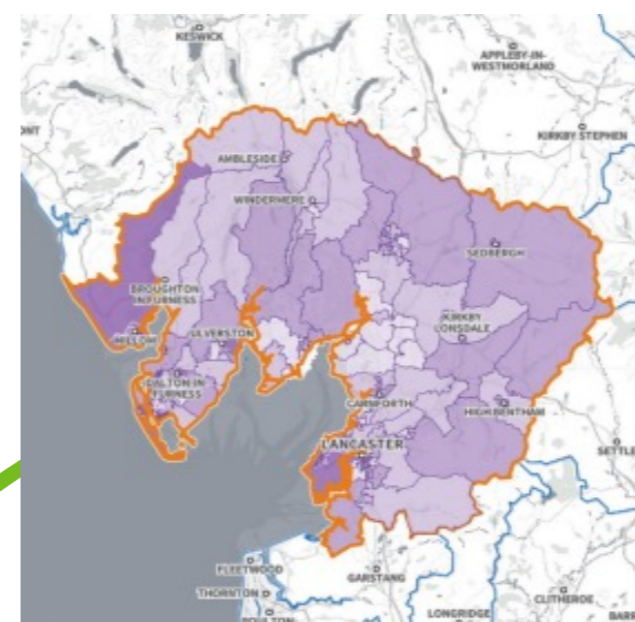
Distance – 45.4 miles  
Travel time – 1 hour



Distance – 20 miles  
Travel time – 29 minutes



Distance – 31.6 miles  
Travel time – 47 minutes



Higher deprivation areas are denoted by darker shades of purple.

- The map shows that there is variation in deprivation across the area with:
- Significant high deprivation levels located in Barrow-in-Furness and
- Pockets within Morecambe and Lancaster district

Source: SHAPE Crown copyright & database rights 2018 Ordnance Survey



**Royal Lancaster Infirmary**

District General Hospital

- A&E; Critical Care
- Obstetric led maternity care
- Neonates & Paediatrics
- Urgent & Emergency Care
- Planned Care services
- Outpatients & diagnostics



**Furness General**

District General Hospital

- A&E; Critical Care
- Obstetric led maternity care
- Neonates & Paediatrics
- Urgent & Emergency Care
- Planned Care services
- Outpatients & diagnostics



**Westmorland General**

Elective Centre

- UTC
- Midwifery led service
- Planned Care services
- Diagnostics
- Outpatients



**Community Care**

Adult community services

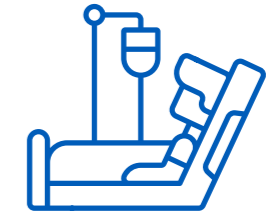
- Community beds
- Nursing and therapy services delivering planned & unplanned interventions



UTC attendances  
**14,000**



Births  
**2,694**



>0 LoS non elective admissions  
**29,500**

**48,000**  
Antenatal clinic attendances



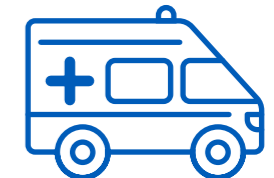
>zero-day non elective admissions  
**16,000**



**510,000+**  
Adult OP attendances



Overnight elective admissions  
**5,000**



ED attendances  
**102,000**



Community contacts  
**430,000**

Children OP attendances

**46,000**



Day case admissions

**42,000**



**8,500**  
Colleagues employed by the Trust



Income to the Trust  
**457m**

## Trust context and ambition of the Clinical Strategy

The performance of this strategy will be reported to the Quality committee quarterly and annually via the trust annual report.

	Challenge	Ambition and opportunity
<b>Safety &amp; Quality</b>	<p>CQC – rated as requires improvement</p> <p>Stroke Section 31</p> <p>Maternity – MSSP</p> <p>Sustained improvement journey to support SOF 3 to 2 being achieved</p> <p>Urology - Niche actions</p> <p>T&amp;O – Royal College action plan</p>	<p><b>Our ambition is to provide outstanding care &amp; experience to our patients.</b></p> <p>Through the clinical strategy we have an opportunity to:</p> <ul style="list-style-type: none"> <li>• Improve the quality of our service provision and improve the care &amp; outcomes for our patients.</li> <li>• We will do this by applying best practice &amp; utilising benchmark information.</li> <li>• We will align and improve to the recommended GIRFT standards</li> <li>• We will continue to share learning across services</li> </ul>
<b>Performance</b>	<p>Performance against national standards is challenged across emergency, planned, cancer and diagnostics</p>	<p><b>Our ambition is to consistently achieve the national performance indicators.</b></p> <p>Through the clinical strategy we have an opportunity to:</p> <ul style="list-style-type: none"> <li>• Alignment of capacity to demand. Configuration of services / pathways to support delivery.</li> <li>• Whole system view of delivery for urgent / emergency care to support delivery of national standards</li> </ul>
<b>Finance</b>	<p>Financial sustainability</p> <p>As an organisation we have an underlying deficit of £60m (assuming receipt of £67.4m system funding at 22/23 levels)</p> <p>Model Health / Patient level information costing data demonstrates we have a significant opportunity to improve this position</p>	<p><b>Our ambition is to move to financial sustainability</b></p> <p>Our financial sustainability plan identifies the opportunities for our clinical services to improve financial sustainability through improved: productivity; configuration; workforce utilisation.</p> <p>Development of the clinical strategy has triangulated the data and assumptions within the financial improvement plan and applied to the work being undertaken in the clinical service workshops - to support implementation of delivery plans that drive delivery of financial improvement with a particular focus on the services with the largest drivers of deficit (see page 13).</p>

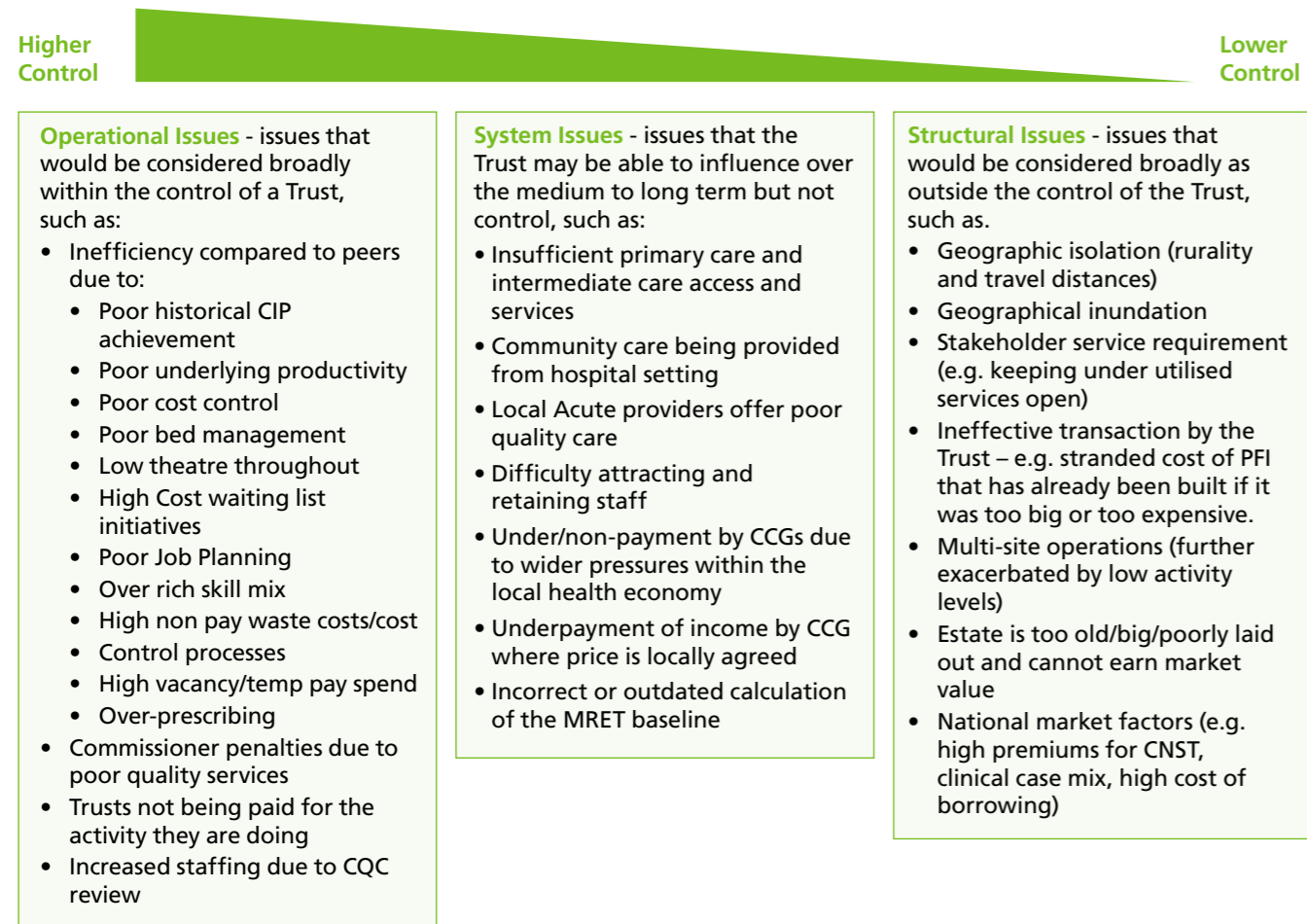
	Challenge	Ambition and opportunity
<b>Workforce</b>	<p>Workforce sustainability</p> <p>Areas of recruitment concerns – Consultants in Medicine circa 30% vacancy rate</p> <p>High reliance on AAS; locums and agency</p> <p>Poor application of job planning</p>	<p><b>Our ambition is to have a sustainable workforce</b></p> <p>Through the clinical strategy we have an opportunity to:</p> <ul style="list-style-type: none"> <li>• Focus within the models of care and the clinical service delivery plans is on aligning the right workforce to deliver the model / service.</li> <li>• Using and applying the Health Education England (HEE) STAR workforce transformation model</li> <li>• Implement robust job planning – delivery of productive 42 weeks</li> </ul>
<b>Culture</b>	<p>Clinical engagement</p> <p>Clinical leadership</p>	<p><b>Our ambition is to be a clinically led organisation with high levels of clinical engagement across all services</b></p> <p>Through the clinical strategy we have an opportunity to:</p> <ul style="list-style-type: none"> <li>• Ensure that the development is clinically led</li> <li>• Ensure there is significant engagement with clinical &amp; operational teams</li> <li>• As the overarching models of care are agreed, work at a clinical service level will support further involvement &amp; engagement</li> </ul>

## Making services sustainable

A key focus in the development of this clinical strategy is to ensure we can deliver and maintain clinical and financially sustainable services.

We know from the work on our 'Sustainable Financial Improvement Plan' that we have many opportunities to improve the sustainability of our services. We have considered and reviewed this data along with Model Health; GIRFT; PLiCs and other benchmark data.

The reasons for this and therefore the solutions are multifaceted as identified in the table below:

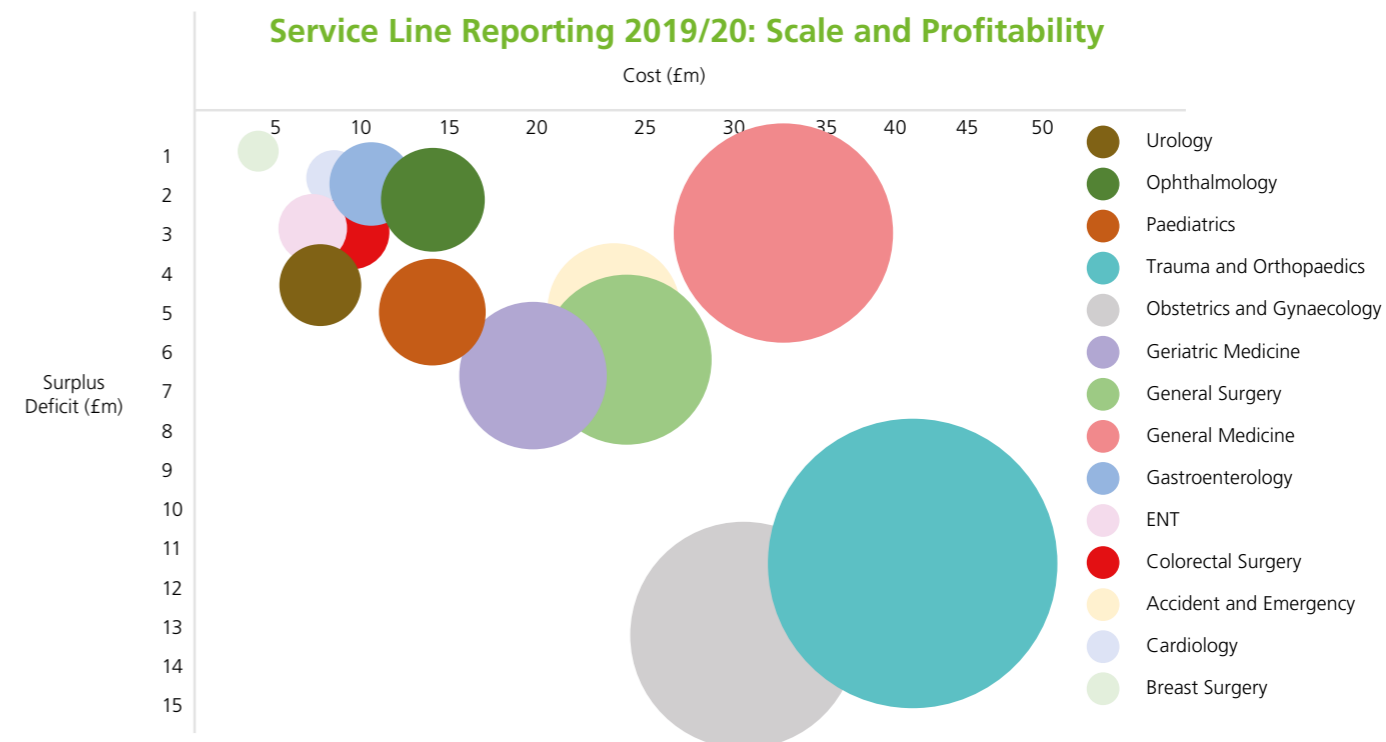


\*Inefficiency may be a symptom rather than cause with the underlying driver being either a system or structural issue

The models of care and the developing clinical service delivery plans acknowledge these issues and look to address through:

- Workforce redesign
- Improved productivity
- Site configuration / consolidation / collaboration
- Introduction of a refreshed continuous quality improvement approach

We remain committed to balance the safety and efficiency advantages of centralising services against the access and responsiveness advantages of localising services. We recognise that there are a number of clinical services where our clinicians are clear that a one site option would be the safest most efficient approach. Therefore consolidation of some of our smaller specialties will be inevitable as will the continued work for the more specialised services to be provided as a networked model across Lancashire and South Cumbria.



## Development through engagement

Fundamental to the development of this clinical strategy was that it was clinically led; ensuring we had a strong clinical voice underpinning the development was critical.

Overall leadership has been provided by Jane McNicholas, Chief Medical Officer and engagement with clinicians from all professional groups has been extensive.

### Who have we engaged with and how?

Our initial workshop held in July 2022 brought together over 150 colleagues from across the Trust; clinicians, operational managers and executives.

We have engaged with: acute; community; primary; social care; Health Watch and voluntary sector colleagues.

**We have used many different forums and modes of communication to develop, share and test the principles of the clinical strategy. Since the initial workshop we have held:**

- 15 x Model of care workshops
- 16 x engagement sessions
- 14 x Virtual 'all colleague' engagement sessions
- 3 x Governor constituency meetings
- 3 x Awareness sessions in the dining rooms across sites
- 2 x Integrated care workshops
- 18 x Clinical service delivery workshops

We have listened to feedback from our patients and families and used the extensive feedback sought during the engagement sessions on the New Hospitals Programme to guide our thinking. As we move into developing our programmes of work we are committed to ensure we engage and co-design in partnership with our patients.



## What our patients say is important to them

The infographic features three groups of human silhouettes in the center, colored blue, green, and teal. Surrounding these silhouettes are 12 speech bubbles of various colors (blue, green, teal) containing patient testimonials. The testimonials are as follows:

- "I can plan my care with people who work together to understand me and my carer(s), allow me control and brings services to achieve the outcomes important to me"
- "S4S has transformed my and my families' eating habits, so much so I no longer need surgery and am symptom free."
- "I have information & support that will help me manage my condition"
- "The more I know about myself, my body and the choices and the consequences I make, the more confident I will be in managing my health and wellbeing"
- "When Patricia has been in hospital overnight in the past it's been very, very stressful, but when she's at home she's relaxed and comfortable"
- "The Virtual Ward works. I wholeheartedly agree with this kind of home care. It's the best thing that could have happened to us. I've got my wife back, and I can't thank them enough for that."
- "When I move between settings & service there is a plan in place so I know what to expect"
- "Much better waiting for a call at home than going to the hospital"
- "The start of a more patient-centred approach to care of frail people in a safe environment"
- "By working together we have an opportunity to better use resources to improve health outcomes for people in our region".
- "Keeping patients informed every step of the way".
- "It feels like I am in control if I can book a follow up appointment as I need rather than when one is due whether or not I need it"
- "I can tell my story once and I have one point of contact"

## Population health – why is this important?

Improving outcomes in the health of the population in Morecambe Bay is an essential success measure of an integrated clinical strategy.

Population health and reducing health inequalities are important themes that have been considered during the development of this clinical strategy.

Population health approaches enable the delivery of evidence-based interventions and ensures the effective distribution of resources, enabling measurement of cost effectiveness against population outcomes. This will improve care and quality, whilst also reducing demand, saving money and making our services more sustainable in the long term.

The ambition of a population health system is to reduce the differences in health outcomes within populations whilst improving health for all. Delivering a range of evidence-based interventions across populations can ensure that all citizens benefit with improved health and reduced risk of disease. Targeted support and services reduce the proportion of the population at high risk of morbidity and mortality and, also maintains the health of people not yet accessing healthcare.

The role of population health in an integrated clinical strategy is to ensure that the needs of the populations are understood, the impact of preventable disease is mitigated, and health inequalities are reduced. This requires a truly integrated model of care to respond to the multiple causes of ill-health.

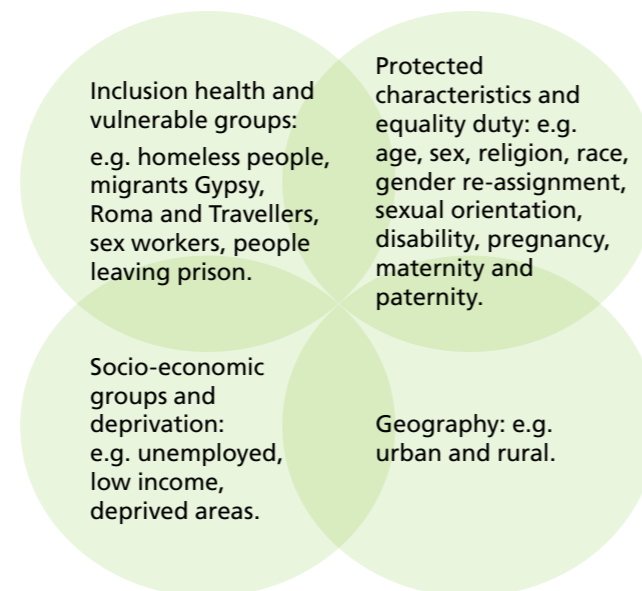
The Four Pillars of population health:

- The wider determinants of health
- Our health behaviours and lifestyles
- The places and communities we live in and with
- An integrated health and care system

The breadth of factors influencing health and ill-health require a multi-faceted approach to improve outcomes. Working as an integrated health and care system provides the bedrock for a population health approach, facilitating action in partnership to ensure that healthcare services are integrated to provide accessible, seamless preventative and treatment services.

### Health inequalities.

Health inequalities are the avoidable, unfair and systemic differences in health between different groups of people. The populations that are at a higher risk of experiencing health inequalities are described below. Service design, resourcing and delivery should reflect the differential access, experience and outcomes that these populations experience. Services should be delivered in an equitable manner to ensure that support and provision is enhanced for these groups to achieve equal access, experience and outcomes.



## Population Health Management

Population Health Management enables a data driven approach to system and service design, highlighting outcomes across different populations to identify inequalities and target action. Population health management uses risk stratification to identify patients and populations that will benefit from targeted interventions. It is the basis upon which action can be taken to improve outcomes and reduce inequalities.

A focus on child health is essential in improving population health and reducing health inequalities. Health inequalities are often inter-generational, so providing equitable support and care for children and young people can help break the cycle and improve outcomes across the life-course. Inequalities in child health can lead to poorer life outcomes, so it is essential that child healthcare is both equitable and integrated.

## Why is our population health data important?

Our population health data tells us a lot about where we need to refocus, to ensure we deliver the right services it is here that we need to start. Improving outcomes in the health of the population in Morecambe Bay is an essential success measure of an integrated clinical strategy. Population health and reducing health inequalities are important themes that have been considered during the development of this clinical strategy.

**Aligned to the Long Term Plan our Integrated Care Boards have 4 key aims relating to population health that we have considered in the development of our clinical strategy:**

- Improve outcomes in population health and health care

- Tackle inequalities in outcomes, experience and access
- Enhance productivity and value for money
- Help the NHS to support broader social and economic development.

## Why is this important across Morecambe Bay?

### Improve outcomes in population health and health care

- The rate of premature mortality is 250% higher in the most deprived wards

**The data tells us that Barrow-in-Furness is ranked:**

- 2nd highest in the country for suicide in women aged over 10 yrs
- 3rd highest for admissions caused by unintentional and deliberate self harm
- 4th for deaths from drug misuse
- 4th highest for smoking prevalence
- 5th highest for premature mortality from liver disease in over 75yrs

South Lakeland has no rankings higher than 57 – which relates to estimated diabetes diagnostic rate.

**Lancaster & Morecambe is ranked:**

- 5th nationally for premature mortality rate in women over age of 75 yrs from preventable respiratory diseases.
- 8th nationally for breast cancer screening coverage
- 16th highest for suicide rate in people over age of 10
- 18th highest for premature mortality from liver disease.

**The population of Morecambe Bay is characterised by high levels of:**

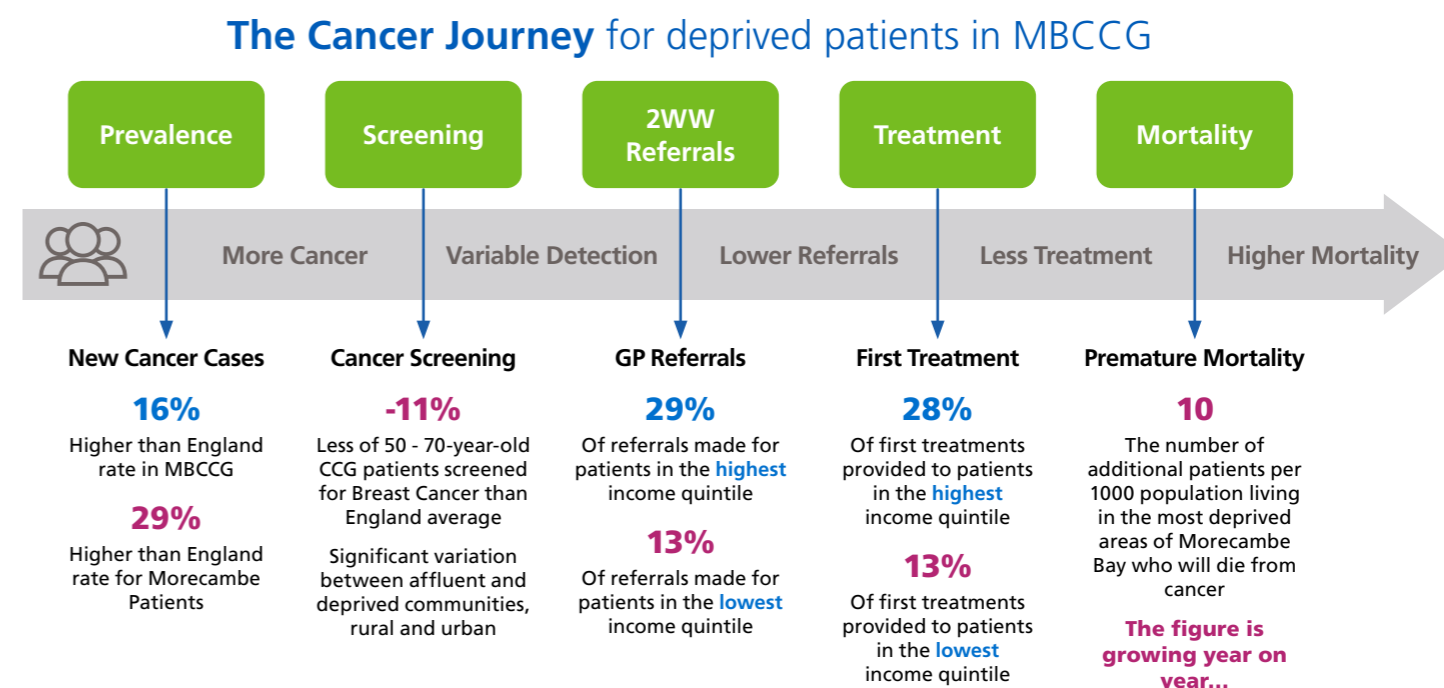
- Cardiovascular disease
- Admissions for alcohol related & alcohol specific conditions
- High incidence of self-harm and suicide

## Tackle inequalities in outcomes, experience and access

- Since the pandemic we know access to elective care has decreased in the most deprived communities faster
- In Morecambe Bay emergency admissions are over 50% higher in the most deprived communities compared to the least deprived and access to A&E over twice as high.
- DNA's are 40% higher in our most deprived communities

- When we drill down specifically into DNA's we can see nuances across areas – for example Maternity DNA's we see high levels in Barrow but our highest area that is ranked 2nd highest nationally are two areas in Morecambe
- The rate of premature mortality for people living in the most deprived decile in Morecambe Bay is 2.5 times higher than that for people living in the least deprived decile

**The differences in access and outcomes of cancer care across Morecambe Bay is outlined below:**



## Enhance productivity and value for money

- Elective care is better for patients and is 25% less expensive than emergency care and uses 7 x fewer bed days
- Targeted approaches to DNA rates in deprived areas will improve productivity and improve value for money

- Using our population health data enables the targeted delivery of evidence-based interventions and ensures the effective distribution of resources, enabling measurement of cost effectiveness against population outcomes. This will improve care and quality, whilst also reducing demand, saving money and making our services more sustainable in the long term.

## Help the NHS to support broader social and economic development

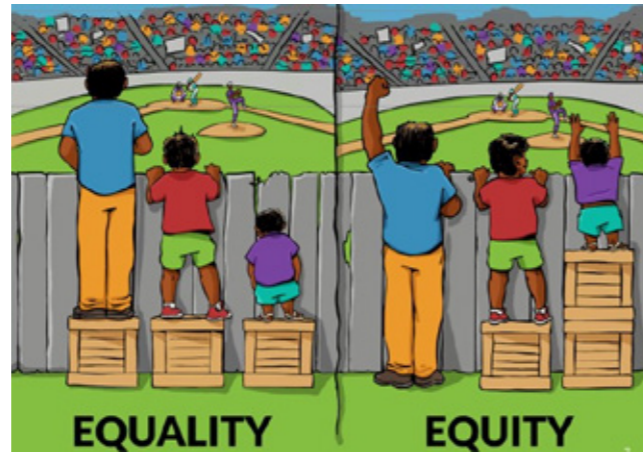
The ambition of a population health system is to reduce the differences in health outcomes within populations whilst improving health for all. Delivering a range of evidence-based interventions across populations can ensure that all citizens benefit with improved health and reduced risk of disease.

Across Morecambe Bay we see high levels of:

- Teenage conception
- Low breast-feeding initiation

Targeted support and services to reduce teenage conception and increased breast feeding rates will have a direct positive impact on or populations health and well-being.

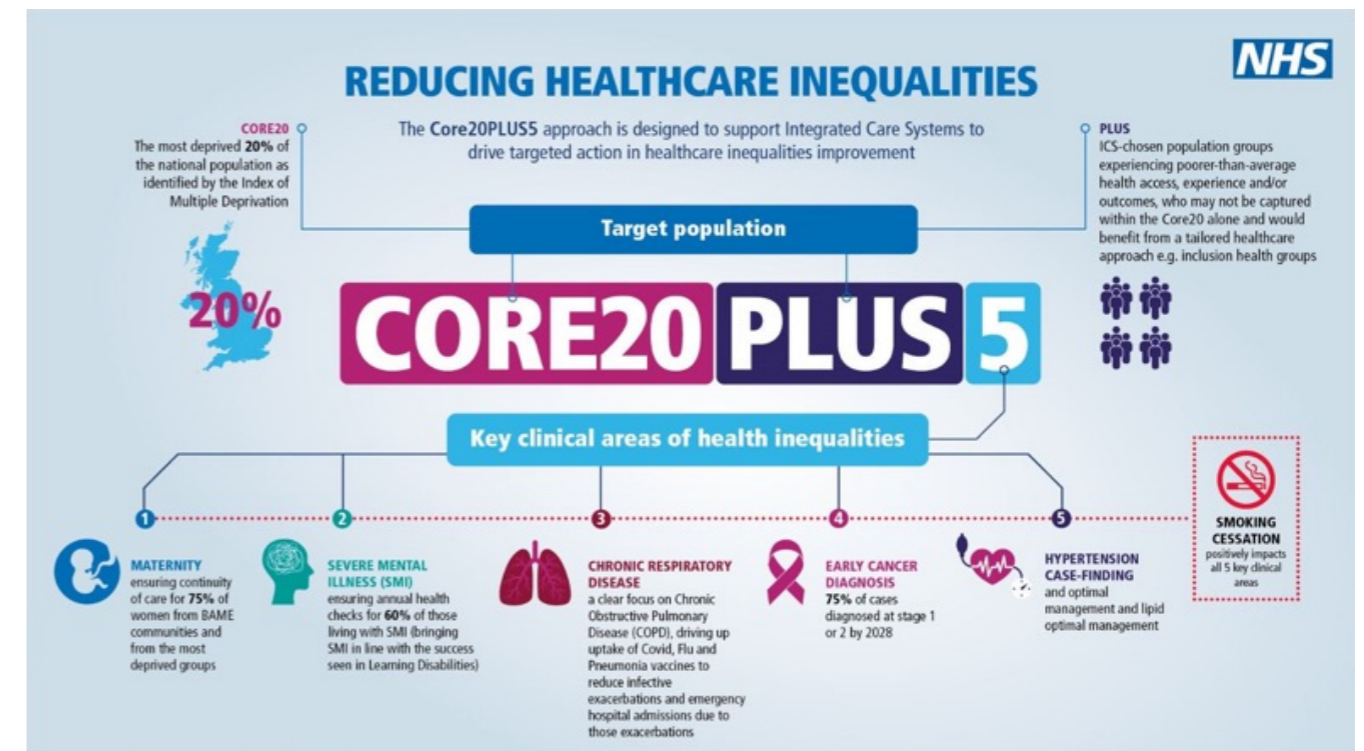
The role of population health in an integrated clinical strategy is to ensure that the needs of the populations are understood, the impact of preventable disease is mitigated, and health inequalities are reduced. This requires a truly integrated model of care to respond to the multiple causes of ill-health.



It has therefore been important that in development of the strategy and our service delivery plans we:

- Understand any difference in access, experience and outcomes when designing models of care
- Ensure that the models of care ensure equity and can demonstrate that impact through performance and outcome measures
- Include preventative pathways to prevent new conditions and exacerbation of current conditions

Our clinical strategy and the clinical service delivery plan have taken note & aligned to the Reducing Healthcare Inequalities Core20Plus5 programmes.





# Section 2: Clinical Strategy

## Overview of the clinical strategy

This clinical strategy has been developed to be

- **Patient First** – focused on you, the community we serve
- **Clinically Led** – developed by clinical and operational teams
- **Quality / Safety Driven** – ensuring we seek to deliver outstanding care & experience in line with best practice

Along with this commitment is the requirement for the clinical strategy to address and support resolution of our clinical, financial and workforce sustainability issues.

We will continue to provide acute and planned care services to local people but we will do this more increasingly in partnership with local providers across community, primary, mental health, social care and voluntary sector to ensure we provide more integrated services.

In developing this strategy, we are committed to delivering age-appropriate care for our community and the Trusts legal duty to make reasonable adjustments in line with the Equality Act (2010) and aims to provide outstanding patient safety, quality and experience.

Our future model of care will include a material shift from being hospital centric to a whole system approach with care integrated across providers and locations. Many of our services will be provided in a community or home setting, pathways will be joined up both in terms of information and care delivery; we will focus on improving the health and wellbeing of our communities and preventing deterioration in health and where escalation of health needs does occur we respond quickly to ensure timely access to the right level of care and treatment. This will mean that





patients will only come into the acute hospital when it is clinically appropriate to do so and time spent in hospital will be reduced due to timely discharge and ongoing support in the community.

As work commenced on developing the overarching models of care, it became very clear to our clinical leads that specific work was required to develop a robust approach to integrating care; working in partnership with Place and system colleagues; optimising out of hospital pathways; delivery of responsive, effective personalised care as close to home as possible; keeping our communities well; promoting self-care and preventing deterioration.

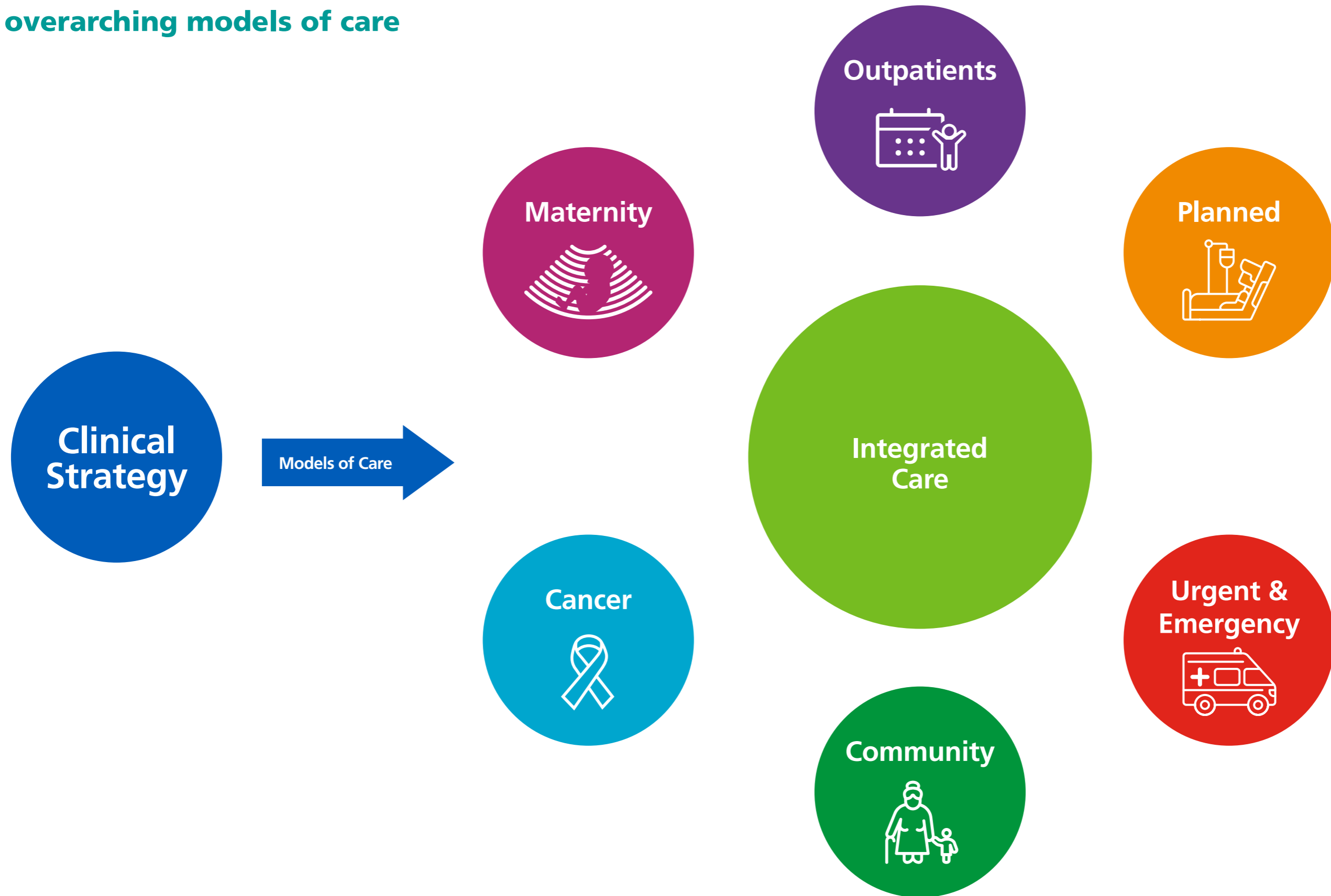
As the models of care developed, work commenced with each clinical service to identify the ambition for the service and the priorities needed to deliver against the trust strategic priorities. This work to develop the clinical strategy recognises the imperative to consistently provide high quality, easy to use services which are clinically and financially sustainable, building on the opportunities that exist to transform and integrate pathways and service models from emergency to planned care using the correct mix of skilled people to deliver them.

Implementation of this clinical strategy will begin April 2023 and a range of enabling strategies on quality improvement, workforce, finance, estates and digital will support delivery.

During this time period further work will take place with each clinical specialty to refine the five-year plans setting out how each specialty will respond to the challenges and opportunities.

Trust Priorities	
<b>Deliver outstanding care and experience</b> 	<p><b>We will:</b></p> <ul style="list-style-type: none"> <li>✓ Provide safe and sustainable services</li> <li>✓ Our focus will be to keep our communities living well &amp; maximising independence</li> <li>✓ A focus on integrated care</li> <li>✓ Through collaboration &amp; integration we will provide evidence-based care</li> <li>✓ Ensure best practice is incorporated into our service models</li> <li>✓ Embrace and engage in digital technology to improve pathways of care</li> <li>✓ Reduce waits for care</li> <li>✓ Ensure population health data is used to plan delivery of services across our community</li> <li>✓ Embed shared decision-making principles</li> </ul>
<b>Create the culture and conditions for our colleagues to be the very best they can be</b> 	<p><b>We will:</b></p> <ul style="list-style-type: none"> <li>✓ Ensure our workforce are engaged in the delivery of our clinical strategy</li> <li>✓ Develop workforce models that meet the needs of our community</li> <li>✓ Provide relevant training and equipment to ensure we can support our workforce to adapt to any service model changes</li> <li>✓ Develop our clinical leadership capability along with 'systems thinking'</li> </ul>
<b>Make the best use of our financial and physical resource</b> 	<p><b>We will:</b></p> <ul style="list-style-type: none"> <li>✓ Support delivery of effective &amp; efficient models &amp; pathways of care to reduce duplication; improve coordination and to ensure sustainability for the future</li> <li>✓ Monitor, audit and review changes to ensure improved outcomes and efficiency</li> <li>✓ Outcomes and operational delivery at upper decile performance levels</li> <li>✓ Ensure effective use of our workforce – by having a strategic workforce plan; effective job planning</li> </ul>
<b>Working in partnership</b> 	<p><b>We will:</b></p> <ul style="list-style-type: none"> <li>✓ Work with partners across Morecambe Bay, PCB &amp; LSC ICB to develop standardised high quality sustainable services &amp; pathways</li> <li>✓ Work collaboratively with our GP's ensuring the delivery of safe and sustainable community services</li> <li>✓ Focus on Place based care</li> <li>✓ Support integration with ICC's &amp; PCN's</li> <li>✓ Listen and Engage with our communities</li> <li>✓ Work with partners on workforce planning to enable the development of innovative pathways to care and hospital-based career pathways to meet the rising challenges of Health and Care workforce planning.</li> </ul>

## Our overarching models of care



## The foundations underpinning the models of care

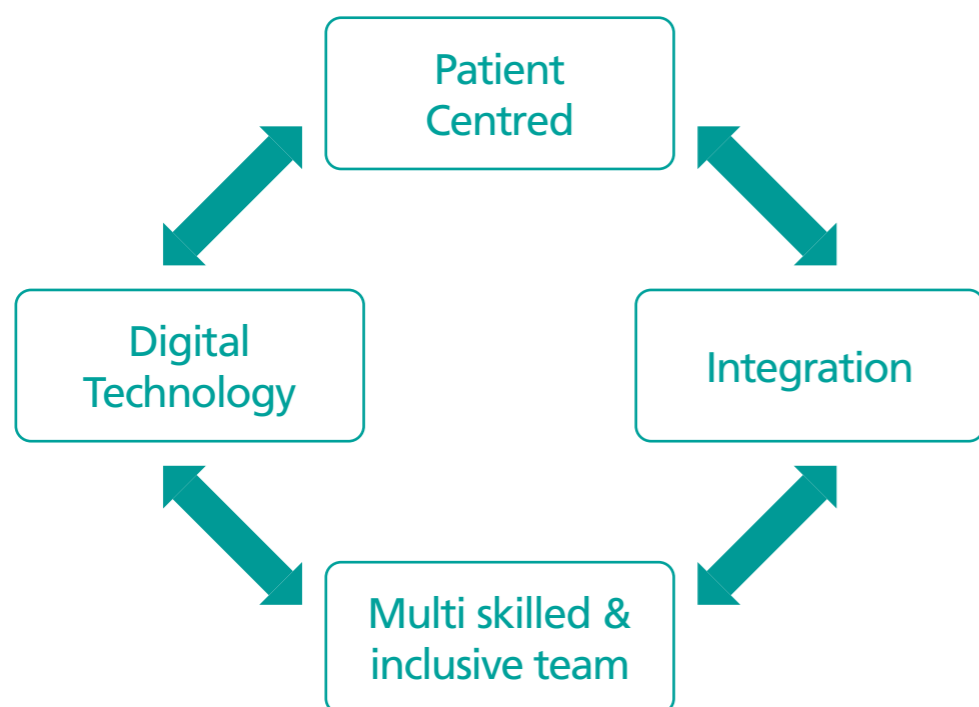
In development of our clinical strategy we heard very strongly a commitment to the following foundations which should be implicit within our models of care and service delivery plans:

**Patient Centred** care will be at the heart of everything we do. Our services will be designed to fit with patients needs and lives, giving them much more control over their health, with Shared Decision Making across the whole pathway.

We will plan and deliver in an **integrated** way to maximise the opportunities to improve the health & wellbeing of our communities and deliver the best access to care and outcomes.

We will achieve this by investing and developing our colleagues to be a **multi-skilled & inclusive team** developing new roles to support effective delivery.

Supported and enabled through the use of **digital technology** - maximising the use of data intelligence; robotics and digital systems to drive effective service delivery.



The following test questions aligned to the drivers for change were agreed to support development of the models of care and the clinical service delivery plans:

## Testing our Clinical Strategy do our models...



Take into consideration our growing and ageing population & provide a more coordinated & integrated model of care?



Improve our ability to attract; retain; train and support our workforce and improve colleague experience?



Improve the quality & outcomes of our services?



Deliver clinical and financial sustainability?



Meet our patients expectations & provide an improved patient experience?



Adopt digital technology, innovation and AI to radically transform how we deliver our services?



Meet and improve life expectancy and quality of life across different areas within the Bay?



Maximise the opportunity to collaborate with our partners across Place and System?

## Integrated Care

Central to the development of this strategy is the commitment to work in an integrated way to improve the care & outcomes of our communities.

This strategy recognises the part we play towards integration: across pathways; workforce; services; Place and System.

### What is integrated care?

'It is care that is planned with people who work together to understand the service user and their carer(s), puts them in control and coordinates and delivers services to achieve the best outcomes'.

### Why is Integrated Care more important than ever?

Nationally there is a commitment to integrated care and the 'new' architecture of the NHS is fundamentally based on integration. The passage of the Health and Care Act (2022), saw 42 Integrated Care Systems (ICSs) established across England on a statutory basis on 1 July 2022. In the context of ICSs, 'place' refers to a smaller geographic footprint within a system which often aligns with a local authority area or patient flows for acute care.

These collaborative arrangements are called place-based partnerships. They bring together a range of organisations responsible for planning and delivering

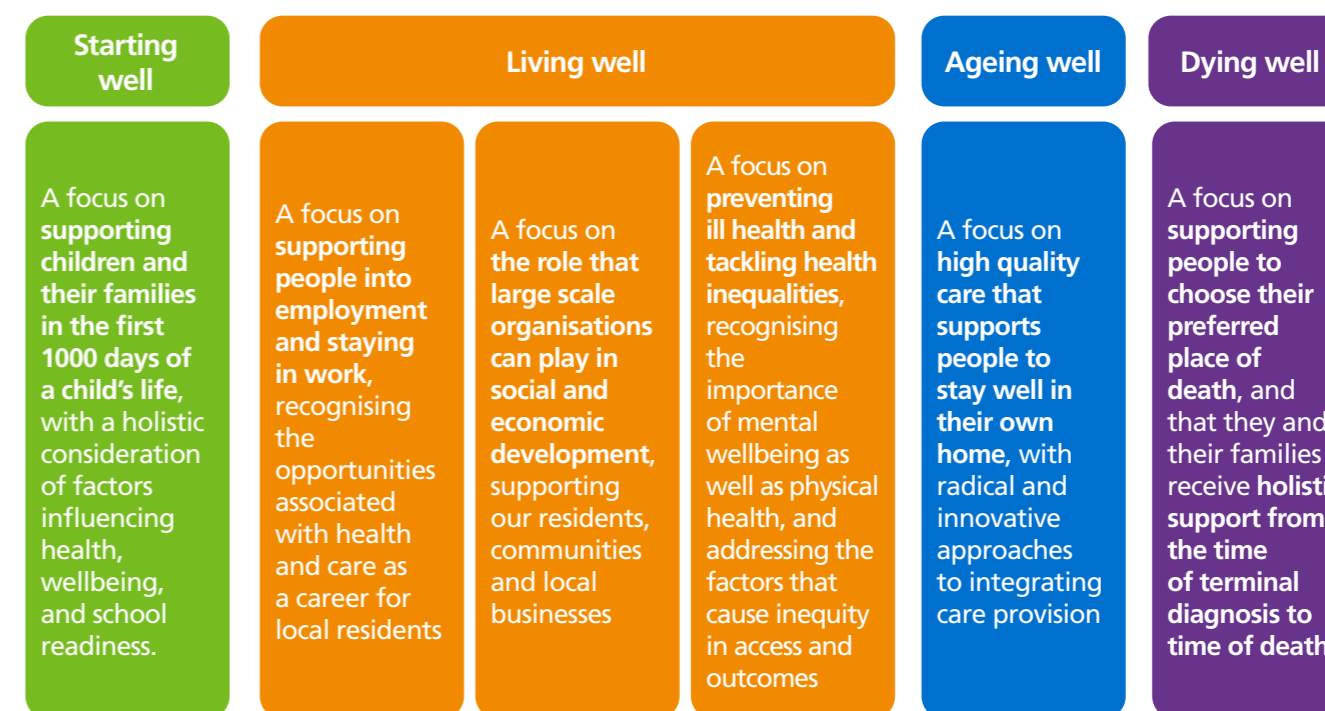
health and care services. These include trusts, commissioners, local authorities, primary care services, voluntary and community sector organisations, local residents and service users, and wider partners such as housing or education providers.

Through this strategy we identify integration as a foundation with integration featuring across all our models of care.

In development of this strategy and through collaboration across our Place Base Partnership we agreed an aim **'to deliver the best place to be cared for with empowered citizens and staff'**.

In delivery of this strategy, we will work with Place Based Partners to deliver a coordinated, integrated, responsive health and care services, helping people to stay well longer and receive proactive support, preventative interventions or primary treatment before it becomes urgent or an emergency

## NHS commitments to Local Authority partners made within the (National) Integrated Care Strategy (currently under consultation)



## Community



### Our successful model of care means:

Our focus is to support the population to live well at home, avoiding unnecessary hospital attendances and admissions. We will therefore deliver age-appropriate person-centered coordinated care that is focused on adopting wellness rather than illness as a perspective. We will have engaged and informed individuals and carers with health care professionals committed to partnership working.

Wherever care is received we want it to be a positive experience and to be centered around our patients and their loved ones. Our pathways and models of care are fully integrated across the health community – reducing duplication and improving patient experience.

We will work with Place Based Partnerships to deliver a coordinated, integrated, responsive health and care services, helping people to stay well longer and receive proactive support, preventative interventions or primary treatment before it becomes urgent or an emergency.

We will effectively use digital solutions, to deploy resources to support patients with long-term conditions within their own homes or in home-like settings by providing alternatives to on-site referral assessment and on-site case management.

Should an admission to hospital care be required we want our patients to be able to return home, to their community as quickly as possible with support to recover and live well. When patients are at end of life we will work in partnership with the patient, family and other relevant partners to be supported to die peacefully in their preferred place.



### To support delivery we will:

- Utilise our population health data to deliver appropriate and targeted service provision in order to deliver equitable access to care
- Widen the scope of our community teams working with our ICP partners, in order to deliver as much care as is safely permissible in non-hospital settings, fostering and supporting seamless clinical management protocols provided as close to home as is practicable
- Ensure that all such pathways are backed by rigorous, shared and agreed governance processes that can be enacted across and between care providers – learning lessons from stroke and MBRN services
- Support, develop and implement anticipatory care planning for all frail and vulnerable patients
- Support people to live well & die well in their preferred place
- Embed and enhance digital monitoring
- Agree models of shared care and risk via A&G - advice and guidance pathways to enable community teams to manage patients with secondary input, whilst avoiding secondary care attendance
- Develop a patient involvement and volunteer strategy
- Contribute and support the development & delivery of an intermediate model for health and social care
- Embrace a user perspective, seeking feedback and working with patients, families and colleagues to co-design processes to support development of high-quality services for our community
- We will develop our workforce with new skills and roles to support a sustainable workforce both now and in the future.

### Measures of success:

- Improved patient experience
- Improving colleague engagement scores from the NSS and pulse surveys
- Deliver the virtual ward capacity per 100,000 population & exceed national benchmark for utilisation
- Maintain top decile performance for 2 hour urgent response community care
- 100% frail / vulnerable patients have anticipatory care plan in place by 2025
- Increase the number of patients who have died within their preferred place
- We will have maximised current & created new alternatives to hospital admissions
- We will have implemented an intermediate model for health & social care
- Reduced inequalities in access, experience and outcomes

## Outpatients



### Our successful model of care means:

First and foremost, our focus will be on established self-management models as a core component of age-appropriate person-centered care, providing information and education to support and empower people to understand and manage their own health and wellbeing effectively.

Working in partnership with general practice and wider primary care we will move away from the traditional structure of outpatients which has been in place for many years, to a modern, digitally optimised service with the right workforce with the right skills built around the needs of the population we serve.

We will ensure every patient is booked into the correct clinic by specialty, clinician

and timescale and we will engage with our population to define solutions around maximising attendance, engagement and preparation for clinic.

Whilst the patient-level value of a face-to-face consultation with the clinician is, in some circumstances, of critical importance, many clinical scenarios are now better served by alternative approaches; we will embrace these alternatives in every available circumstance and develop mechanisms to provide them. As innovative ways of delivering services are embedded, where clinically appropriate it is intended that discharge will become the default position following first OP appointment.



### To support delivery we will:

- Use digital technology to redesign the way we book and schedule our outpatient services
- Ensure access to outpatient services will be straightforward and by using our population health data we will work to break down barriers which exist for those with unequal access to healthcare.
- Increase the range of appointment times in the day and week – making access more equitable
- Improve referral optimisation, standardise pathways and then digitise
- Move to a default model that specialty-provided follow-up is not required unless by exception
- Develop and widen the scope of pre-clinic test protocols and patient-completed assessment proforma, so that all patients who do require assessment and care within our specialist services are seen efficiently and swiftly, with their face-to-face contact time spent in actual dialogue with a clinician, rather than collation of information and data
- Ensure that our on-site clinic capabilities focus upon core clinical services that cannot be provided in alternative settings – including procedures and one stop where clinically best practice
- Embrace a user perspective, seeking feedback and working with patients and colleagues to co-design processes to support development of high quality outpatient services for our community
- Review current workforce models for OP and implement new ways of working, providing and supporting the most efficient use of resources to improve patient experience and outcomes.

### Measures of success:

- Improved patient experience
- Improving colleague engagement scores from the NSS and pulse surveys
- A minimum of 25% of all outpatient consultations being undertaken remotely
- Maintain number of patients discharged to PIFU at 5% and increasing
- New to Follow up ratios within best practice for all specialties by 2025
- Full digital technology will be in place to support effective patient booking and cancellation of appointments
- 100% (response rate/specialty) on Advice & Guidance
- A reduction to 5% DNA rates for all specialties
- Reduction of fallow clinic slots to less than 5%
- Reduced inequalities in access, experience and outcomes

## Planned



### Our successful model of care means:

We will provide a wide range of responsive planned / elective services to meet the clinical needs of our patient population. Working in partnership with colleagues across Lancashire & South Cumbria we will reduce the long waits for elective care caused by the COVID pandemic.

We will engage meaningfully with our patients, beginning our approach to optimised planned care at the point of referral, managing patient's expectations and ensuring their active contribution to their health journey.

Working with our partners across health, care and the voluntary sector we will further develop our #setforsurgery programme, to maximise everybody's fitness for planned care to ensure the best outcomes are achieved.

We will create dedicated elective facilities; day case provision will be our default for elective services, ensuring that patients spend as little time as possible in hospital and only when clinically justified. Our planned care pathways will align to best practice guidance and peer review evidence from GIRFT and other bodies.

We have the right workforce with the right skills to deliver our model of care. We will continue the development of our acute care team and enhanced care areas reducing the demand for critical care capacity and ensuring those patients who do require critical care are able to access without delay.



### To support delivery we will:

- Utilise our population health data to deliver appropriate and targeted service provision in order to deliver equitable access to care
- Ensure restoration and recovery of elective capacity; reducing waiting times for our local communities
- Further develop WGH as our centre of excellence for elective care – ensuring protection of elective capacity
- Find definitive solutions for our fragile services
- Increase use of social prescribing, health coaching and wellbeing programmes in pre op period
- Implement fully supported administrative process with digital technology
- Develop and widen the scope of pre-op test protocols and patient-completed assessment proforma, so that all patients who require elective care are seen efficiently and swiftly, with their face-to-face contact time spent in actual dialogue with a clinician, rather than collation of information and data
- Standardise pathways based on best practice to deliver upper decile performance
- We will develop our workforce with new skills and roles to support a sustainable workforce both now and in the future
- Embrace a user perspective, seeking feedback and working with patients and colleagues to co-design processes to support development of high-quality planned care services for our community

### Measures of success:

- Improved patient experience
- Improving colleague engagement scores from the NSS and pulse surveys
- Year on year improvement to deliver of the RTT standard
- Achieve next quartile day case rates by specialty
- Optimal use of theatre capacity
- Reduction in the numbers of patients cancelled on the day
- Reduction in the reliance on additional capacity sessions to near zero
- Full digital technology for patients booking and cancellation of their TCI dates
- Achieve next quartile performance for length of stay
- Reduced costs per procedures & service line
- Accreditation of WGH within the national surgical hub programme
- Reduced inequalities in access, experience and outcomes

## Urgent & Emergency



### Our successful model of care means:

We are committed to improving experience and outcome through greater coordination, support and planning for those who are at most risk of needing urgent & emergency care. We will work with our Place Based Partnerships to prevent escalation of care for these populations. We will have effective information, signposting and advice that support people and their families to self-care or care for their dependents.

We will provide responsive, effective and personalised age-appropriate care delivered in or as close as possible to our patient's homes, for those with non-life threatening but urgent physical or mental health needs.

Where assessment within an acute hospital setting is required our urgent & emergency care services will be fully integrated & operational 24 hours a day every day.

For those with more serious or life-threatening emergency needs, we will work in partnership with our provider colleagues across Lancashire & South Cumbria to provide timely access to expert clinical assessment and treatment with an aim to maximise the chances of survival and a good recovery.

Where admission to hospital is clinically justified, we will ensure, early decision making with senior decision maker(s), putting patient needs, not service at the centre and where necessary involving multi-specialty inputs early.

There will be a focus on maintaining independence to prevent deconditioning ensuring that all patients return to their home wherever possible.



### To support delivery we will:

- Utilise our population health data to deliver prevention & population health management to improve demand management
- Optimise current and create new out of hospital pathways to prevent attendance to hospital
- Optimise streaming and single point of access arrangements for ambulatory care
- Change our approach to care provision such that each patient episode is approached as one suited to ambulatory, assessment-unit or same-day care, unless by exception
- Where an inpatient bed is clinically necessary, this exception decision will be based upon assessment of that patient by a senior, experienced clinician
- Our ambulatory care areas will be expanded and managed operationally, in collaboration with community care colleagues, such that they are able to function seven days per week
- Support the use of anticipatory care planning
- Prevent deconditioning by promoting independence and self care
- Align the 10 point plan for improving mental health responsiveness and compliance with quality standards in UEC settings
- Embrace a user perspective, seeking feedback and working with patients, families and colleagues to co-design processes to support development of high-quality services for our community
- We will develop our workforce with new skills and roles to support a sustainable workforce both now and in the future

### Measures of success:

- Improved patient experience
- Improving colleague engagement scores from the NSS and pulse surveys
- Increase in use of ambulatory / same day emergency care
- Consistently be in the upper quartile for delivery against the emergency care 4 hour standard
- Ambulance handovers within 15 mins of arrival
- Reduction in harms (falls /PU)
- Reduce the number of times a patient moves for a non-clinical reason
- Reduced average length of stay for any acute admission staying >24 hrs across all specialties
- Reduce the number of patients who have been assessed as no reason to reside in an acute hospital bed.
- Reduced inequalities in access, experience and outcomes

## Cancer



### Our successful model of care means:

Working with partners across health, care and voluntary sector we will proactively manage and support people through their cancer pathway. We will maximise early presentation, diagnosis, treatment and ongoing support which will be enabled by a robust administration and MDT structure.

Our pathways will be person centred to ensure that people are well informed, supported and receive holistic and personalised care.

We will focus on getting the first contact appointment as early as possible, with rapid diagnostics to support early detection and diagnosis – services will be one stop / straight to test where possible.

We have the appropriate amount of capacity to meet demand at each point of the patient pathway ; Outpatients, Diagnostics and inpatient treatment and these are aligned into one seamless patient journey.



### To support delivery we will:

- Utilise our population health data to deliver appropriate and targeted service provision in order to deliver equitable access to care
- Work with Primary Care on referral criteria and ensuring that patients understand that they are on a suspected cancer pathway ; supporting them through their patient journey with patient navigators
- Implement national best practice timed pathways
- Maximise the use of new digital technologies eg. Tele-dermatology and A.I. in Skin
- Increase and prioritise diagnostic and treatment capacity, including ensuring that new diagnostic capacity, particularly via community diagnostic centres (CDCs) for urgent suspected cancer
- Provide a sustainable 'Personalised Stratified Follow Up' (PSFU) pathways for current services
- Strengthen the delivery of Personalised Care to support patients from point of diagnosis and including the transition from hospital to community support; using holistic needs assessment, care plans, end of treatment summaries and health and wellbeing information
- Embrace a user perspective, seeking feedback and working with patients, families and colleagues to co-design processes to support development of high-quality services for our community
- We will develop our workforce with new skills and roles to support a sustainable workforce both now and in the future

### Measures of success:

- Consistently score at or above the national average for the overall patient experience measure in the National Cancer Patient Experience Survey.
- Improving colleague engagement scores from the NSS and pulse surveys
- Reduce the number of patients waiting over 62 days for Treatment
- Achieve the faster diagnosis standard (FDS) so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days
- Compliance with milestones from National best practice timed pathways that facilitate the 28 Day FDS standard.
- Compliance with Quality Surveillance Programme
- Achieve PSFU patient recruitment at or above national targets
- Reduced inequalities in access, experience and outcomes

# Maternity



## Our successful model of care means:

We will ensure safer care based on a relationship of mutual trust and respect between women and their midwives.

Maternity services are safer, more personalised, kinder, professional and more family friendly; where every woman has access to information to enable her to make decisions about her care; and where she and her baby can access support that is centered around their individual needs and circumstances.

All staff to be supported to deliver care which is women centered, working in high performing teams, in organisations which are well led and in cultures which promote innovation, continuous learning, and break down organisational and professional boundaries.

### **\*\*Awaiting publication of National Maternity Strategy**

At the time of finalising this clinical strategy we were awaiting the publication of the National Maternity Strategy – therefore this chapter will be subject to review once publication is made.



## To support delivery we will:

- Focus on personalised care – centred on the woman, her baby and her family
- Develop community hubs – to deliver proactive education & support
- Use population health data to target care in deprived areas
- Develop continuity of carer – to ensure safe care based on a relationship of mutual trust
- Ensure our maternity workforce is skilled & supported to meet the needs of our community
- Ensure delivery of safer care – with professionals working together to ensure access to right care in the right place
- Deliver against the 10 LMNS workstreams

## Measures of success:

- Improved patient experience
- Improving colleague engagement scores from the NSS and pulse surveys
- Delivery against the 10 LMNS workstream programme deliverables
- Continuity of Carer standards achieved
- 5% PIFU for ante natal care pathway
- Reduce DNAs
- Reduced inequalities in access, experience and outcomes



# Section 3: Supporting Delivery

## Building a sustainable workforce

Development of an enabling workforce strategy and delivery plan is critical to the delivery of this clinical strategy.

During the development of the models of care and the clinical service delivery plans we have spent time understanding and exploring the workforce requirements and opportunities.

The workforce challenges we face are not unique to UHMB, many of the recruitment and retention challenges are experienced by the NHS as a whole.

In order to deliver our clinical strategy we will develop a skilled and committed workforce that connects with the Trust vision, values and strategic priorities, whilst

directly supporting the ambitions of the clinical strategy. This will mean, growing our substantive workforce; innovating with new roles to address significant workforce constraints; investing in education and training to develop our colleagues and support new ways of working. Our challenge will be doing this whilst we develop, pilot and test our new models of care without de-stabilising existing provision.

**We will deliver this through our commitment to the NHS People Plan:**



The NHS People Plan includes specific commitments around:

- **Looking after our people** – with quality health and wellbeing support for everyone.
- **Belonging in the NHS** – with a particular focus on tackling the discrimination that some staff face.
- **New ways of working and delivering care** – making effective use of the full range of our people’s skills and experience.
- **Growing for the future** – how we recruit and keep our people, and welcome back colleagues who want to return.

We commit to co-designing our approach to this development and our improvement priorities with our colleagues, staff side, senior management teams and the Trust board.

We have been explicit in the development of our models of care, of our commitment to delivery of integration; delivery of this will only be achieved by moving towards a one team philosophy; having a skilled and committed workforce that connects with the Trust vision and values and responds positively to the quality, safety, operational and financial obligations of the Trust.

We recognise the significant change that our teams have committed to in endorsing this clinical strategy and we will ensure that in line with our trust values we will support our colleagues through complex organisational change, transition and integration where it is required.




## Oversight & assurance

Oversight and assurance of delivery of the clinical strategy will be sought through the following mechanisms:



- The Board signed off an **effectiveness review** process for the overarching trust strategy; this committed to a formal annual review of the strategy to assess delivery against the strategic priorities. The clinical strategy will now form a part of that review process.

A clinical strategy delivery programme will be put in place with a strategic governance and oversight structure that will support our assurance of progress along our sustained improvement journey.



**We are UHMBT**  
Together, we are creating a great place to be cared for and a great place to work

**Effectiveness Review Process - Trust Strategy**  
2022 - 27



“Creating a great place to be cared for and a great place to work”



## Next steps

- On approval, the Trust will implement a robust communications and engagement exercise
- Define the overarching programmes of work; define the clear measure of success and develop a programme delivery plan
- Implement the revised continuous improvement model
- Continue to adapt and refine considering any emerging changes from the development of the ICB / PCB clinical strategy
- Ensure meaningful engagement with our patient and communities to ensure participation in co-design of service and pathway changes.





# Appendix



## Clinical service delivery workshops

### Workshops have commenced – schedule in place

- Data packs developed for each service & shared two weeks pre workshop
- Attendance at a full day facilitated 'interactive' workshop
  - Clinical and Operational at a minimum with support from Finance and Workforce business partners
- **Step 6** – Implement, monitor & refresh  
Within a week the teams receive a typed up version of outputs of the day and the start of a Service Delivery Plan with an offer of continued support

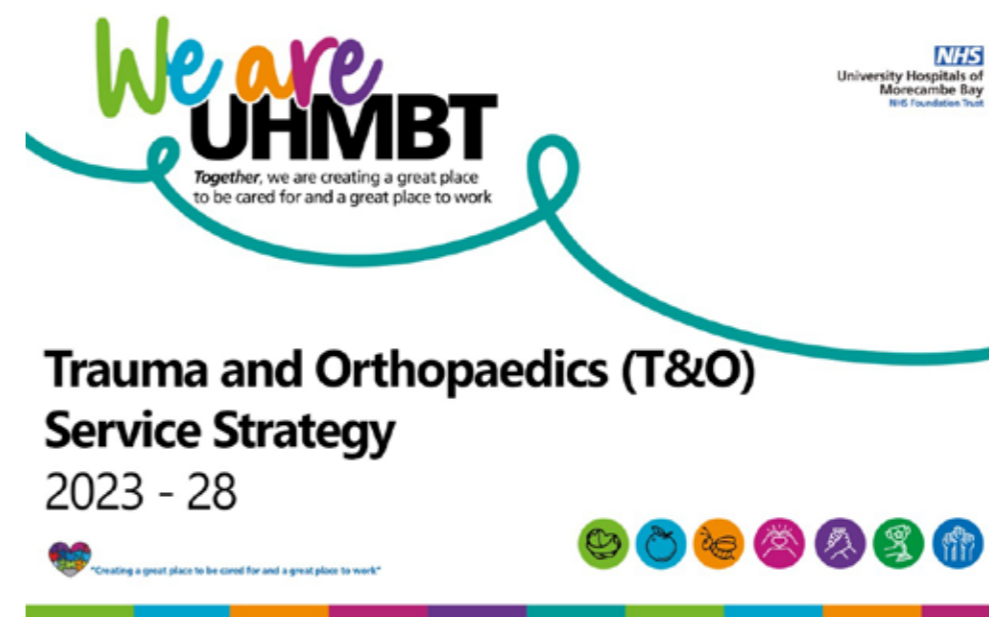
### Agenda

- Context
- Overarching models of care
- **Step 1** – Defining Current service – what does the data tell us
  - SWOT
  - Fragility Matrix
  - PESTLE
- **Step 2** – Creative thinking - Wouldn't it be amazing if...
- **Step 3** – Amazing & Ambitious – what are our requirements in the context of safety / quality, workforce and finance
- **Step 4** - Understanding resource availability
  - HEE STAR model
  - Key enablers of workforce transformation
- **Step 5** – Developing an action plan
  - Align key actions to strategic priorities
  - Develop a plan on a page for each strategic priority
  - Alignment of workstreams to a 5 year delivery plan



Each service receives a diagnostic data pack ahead of the workshop

The outputs of the workshop are inserted into a service strategy / delivery plan document



**Introduction and Contents**

This diagnostic pack gives you a detailed overview of key information related to your service and highlights key messages for each area to support with future service planning.

Diagnostic Information	Workforce Information	External Information
<ul style="list-style-type: none"> <li>Consolidated summary</li> <li>Model Health/ PLICS data</li> <li>HED data</li> <li>Mortality data</li> <li>Performance Metrics</li> <li>Service data – waiting lists, activity plans, theatres, referrals, outpatients</li> <li>SWOT and Pestle</li> <li>Budget/ Expenditure</li> <li>Efficiency Opportunities including SFIP Plan, CIP</li> <li>Business Cases</li> <li>Patient feedback</li> </ul>	<ul style="list-style-type: none"> <li>Current staff in post/ staffing budget</li> <li>Vacancies - Difficult to recruit to roles/ agency and bank usage</li> <li>Workforce age profile</li> <li>Job plan/ %DCC</li> <li>42 Productive weeks</li> <li>Recruitment/ retention/ sickness rates</li> <li>AAS spend and extra duty payments</li> <li>Staff experience/ staff survey</li> </ul>	<ul style="list-style-type: none"> <li>National Policy/ Guidance/ Recommendations /GIRFT</li> <li>External priorities – CQC, RSP etc</li> <li>ICS/ Clinical network priorities</li> <li>New hospital programme</li> <li>Models of Care</li> </ul>

# We are UHMBT

*Together*, we are creating a great place  
to be cared for and a great place to work

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Please do not hesitate to contact us should you require this document in an alternative format.

The information in this report is correct to the best of our knowledge as of April 2023.

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supporting  
life's journey  
*together*