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NHS
University Hospitals of Morecambe Bay
NHS Foundation Trust

Managing demand in the community enabling reduction in beds at the Royal Lancaster Infirmary

Case for Change
V0.2 (revised February 2026)

CONTENTS

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REVISION HISTORY

Version	Date	Description of changes
V0.1	22/12/25	First collation of case for change information
V0.2	27/02/2026	• Inclusion of proposed closure of second ward on Castle View (Phase 2) at a future date • Further information on discharge delays added • Addition of equality and health inequalities date / narrative • Addition of detailed performance metrics and actions being taken

	• Added narrative regarding communications and engagement actions and plans • Inclusion of approved QIA and EIA for Phase 1 of the proposal (closure of 24 beds) • Added in detail regarding further related improvement work within place

PURPOSE

The purpose of this document is to outline the drivers for our focused work to improve patient flow and inpatient pathways and therefore the rationale for the need to reduce the general and acute (G&A) bed base at the Royal Lancaster Infirmary (RLI) by closing 48 beds - a total of two recently repurposed rehabilitation wards in the Castle View Unit. This will be done in a phased approach with one ward (24 beds) closing in late 2026 and the second ward (24 beds) closing at a future date when further improvements have been sustained.

Framed within the current NHS operating environment, it will articulate clinical, and operational detail underpinning the bed reduction proposal presenting a clear and evidence-based justification for action.

The aim of undertaking this work is to ensure that patients receive the right care in the right setting in a timely way that improves their outcomes and maximises their independence.

The NHS Lancashire and South Cumbria Integrated Care Board (ICB) is focused on delivering with partners the Government's direction in the 10 Year Health Plan of shifting from acute to community. The ICB's commissioning intentions, along with partnership working on the urgent and emergency care system across Morecambe Bay, aim to invest in demand management initiatives and community services which reduce demands on inpatient services and creates the rationale for reviewing the G&A bed base.

Closing the two wards on Castle View in a phased manner ensures that the Trust's financial resources are allocated where they can deliver the greatest impact for patients and communities. By ensuring right care in the right place, the Trust avoids unnecessary expenditure on services that are not aligned with the primary role of an acute hospital.

Given the current NHS operating and financial climate, the Trust must reach breakeven in each financial year and is required to accelerate plans and make difficult decisions in relation to shortfalls in commission service provision.

VISION AND AIM

The vision of this Case for Change is to:

- Increase both the options and utilisation of alternatives to admission for attendees who should be managed on more appropriate pathways of care
- Improve the number of simple discharges where patients can return home with no additional support (called P0 discharges)
- Reduce the numbers of patients who no longer require hospital care (patients Not Meeting the Criteria to Reside or NMC2R)

- Increase the number of patients cared for in the Virtual ward
- Free up bed capacity within the Trust's hospitals and improve patient flow to maintain patient safety
- Reduce the deconditioning that patients experience due to discharge delays and maximise their independence earlier in their pathway affording them the best opportunity to return to their own home or home of choice as soon as they are medically fit

The aim is to achieve this by:

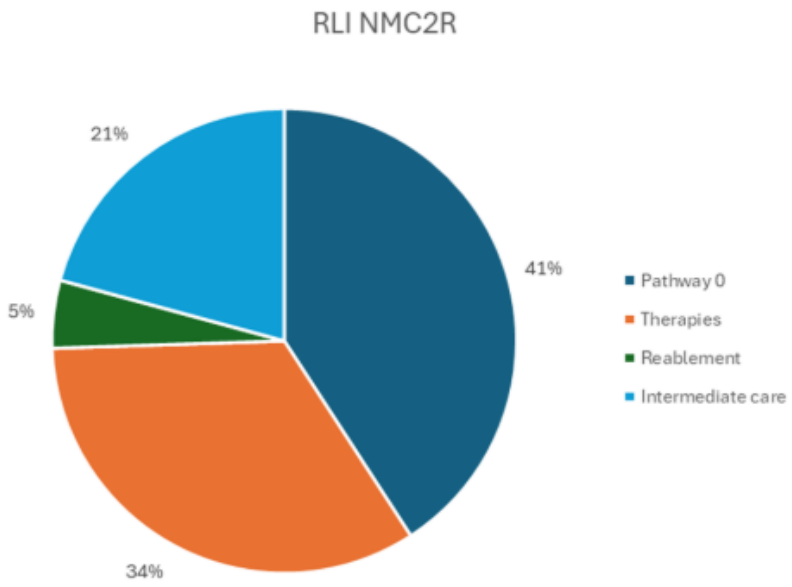
- Focus on three agreed Alternatives to Admission (A-tA) with system partners - including primary care, North West Ambulance Service NHS Foundation Trust (NWAS), Lancashire County Council (LCC), Westmorland and Furness (W&F) Council, local hospices, Lancashire and South Cumbria Integrated Care Board (L&SC ICB), Place and the Voluntary, Community, Faith and Social Enterprise Sector (VCFSE)
- An increased focus on criteria to admit and admission avoidance opportunities in the Trust's Urgent and Emergency Care (UEC) plan
- Continuing to drive forward the delivery of the improvement actions already being taken
- Maintain the focused interventions with system partners to reduce discharge delays and the time patients spend away from home
- Continuing to foster this collaborative improvement approach with partners and community assets, seeking further opportunities to support residents to stay independent, improving their health and wellbeing and ability to engage support closer to, or in their home
- Continue to appropriately escalate delays in discharge for patients who require temporary, short-term rehabilitation or assessment in a non-acute bed before returning home (called P2 patients) - where there is insufficient care capacity to meet the demand

This vision and aim reflect the Trust's commitment to delivering high-quality care that meets the clinical needs of patients requiring inpatient care and improves their outcomes whilst maximising independence, improving patient flow and colleague experience and aligning to the system care partners deliverables both now and into the future.

KEY DRIVERS FOR CHANGE AND OUTLINE OF PROPOSAL

As of 20 February 2026, 32.41% of beds at the RLI are occupied by patients who do not have a need for ongoing medical care - they do not meet the criteria to reside. This means patients are having prolonged lengths of stay in an acute setting where they decondition and cognitive function deteriorates when they are more likely to be happier and recover better and quicker in their own home or in a more appropriate setting.

A breakdown of the key causes of delays in discharge at the RLI is noted in the below graph:



The secondary and intrinsically linked driver is the impact of the Trust's financial position. The Trust cannot sustain the costs of caring for this volume of NMC2R patients and therefore improvement actions must be taken to remove these costs as a result of delivering a better service. The cost of running each of the identified wards is £1.77m per ward each year.

The Trust is proposing reducing the bed base in Castle View at the RLI by a total of 48 beds (14.8% of the G&A bed base) in a phased manner as below:

- Phase 1: Close 24 beds (one full ward) by late 2026
- Phase 2: Close a further 24 beds (the second ward) at a future time when improvements are sustained and the beds can be removed safely

The beds will be removed from recently repurposed rehabilitation wards (previously medical wards) that are occupied by NMC2R patients who are either waiting for intermediate care beds or who have ongoing therapy needs. These patients should have their needs met in an appropriate setting which is not a hospital bed and there is focused work both internally and with system partners to reduce the NMC2R numbers to support this which commenced in July 2024 with aligned trajectories.

When the beds were repurposed to rehabilitation beds, the ambition was that Local Authorities would develop these beds as intermediate care beds, but this plan did not materialise as Local Authorities are trying to reduce bedded intermediate care facilities with a real focus of increasing home-based intermediate care and improving patient's outcomes. This means that more patients will step onto a reablement pathway earlier in their discharge journey and is reliant on reducing delays in discharge for patients returning home with interim support, such as reablement, rehabilitation, or increased home care (called P1 patients).

It is important to recognise that the closure of beds is not about a removal or reduction in service. It is the output of delivering several high impact improvement initiatives. By making these improvements, there will be a decrease in unnecessary admissions, a reduction in the time patients are away from home, and less NMC2R

patients in hospital - all quality improvements that deliver better outcomes and experience for patients.

OVERVIEW OF IMPROVEMENT PLANS FOR PHASE ONE

Our plans to enable the closure of 24 inpatient beds (Phase 1) by late 2026 are structured around an agreed set of high impact improvement interventions, which are summarised below:

Virtual wards

In November 2025, the Trust changed its Virtual Wards to a generalist model and since then, has increased the capacity from 46 to 66 with an occupancy target of 85%. This will further increase to 73 by March 2026. Occupancy for Virtual Wards has increased from 50-60% to regularly over 80% - including an increase in the use of Virtual Wards for patients requiring IV antibiotics. Occupancy and the types of patients using the service are reviewed daily to maximise usage.

There are no additional staffing requirements to achieve the 85% occupancy target as this was in the workforce modelling for the 73 beds.

Internal process improvements

Several changes have been made internally to strengthen internal processes with an aim to improve admission avoidance and reduce delays in discharge, including:

- Launch of a structured improvement programme (based on Getting It Right First Time - GIRFT) to improve Board rounds and criteria-led discharge. The aim of this programme is to improve flow whilst discharging patients when they are medically fit and before they decondition and /or lose their confidence and /or their cognitive impairment deteriorates that results in an increased reliance on additional social care support or enhanced care needs
- Increased therapy capacity by working much more efficiently across the RLI to reduce the delays for therapy and maximise patients' independence in parallel to the care they receive on our mainstream wards
- Focus on risk aversion and increasing confidence of therapists by safety netting patients discharged into the community with the wider community teams
- Daily reviews of all therapy delays by therapy leads providing check and challenge
- Increased Step Down into the Virtual Wards (resulting in increased occupancy as capacity increases)
- Continued streaming from the Emergency Department to alternative services
- Maximising commissioned discharge support provided by VCFSE partners

Partnership working with Local Authority partners

The Trust has been working effectively with partners in W&F Council (who also have residents from South Cumbria as inpatients at the RLI) and LCC to significantly reduce delays for patients requiring reablement and reduce the overall NMC2R numbers.

Actions taken include:

- Establishment of a weekly strategic meeting between both Local Authorities, place and the Trust chaired by the Interim Chief Operating Officer for escalations and identification of different ways of working
- Opening of eight intermediate care beds at Maude's Meadow in Kendal. These are additional beds with therapy provision and a primary care medical model. W&F Council is currently seeking recurrent funding for the beds from the ICB
- Two weekly written escalations to the ICB regarding the un-commissioned shortfall in the number of patients waiting for Pathway 2 beds (general nursing, specialist care, dementia beds and residential care beds). The ICB reviews these delays with the relevant Trust teams to identify solutions at pace
- Reduction of the five-day referral times to three days for both W&F Council and LCC
- LCC is actively reviewing its reablement / intermediate care offers to streamline processes and release community capacity in a timely manner which will reduce reablement and intermediate care home-based discharge delays for relevant patients

Beyond the addition of the eight intermediate care beds by W&F Council and the requests for Pathway 2 delays to the ICB, there is no additional bed base in the community anticipated.

IMPROVEMENT TRAJECTORIES

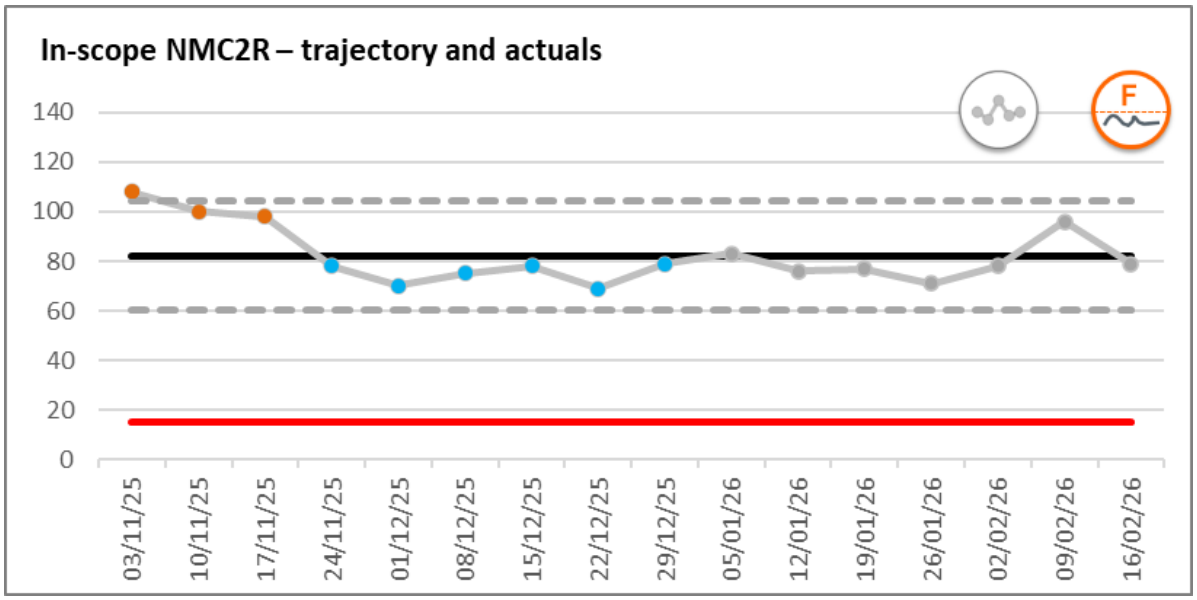
Improvement trajectories - informed by data and evidence - against all high impact improvement interventions (HII) have been agreed with accountable leads. An overview of the improvement to bed capacity that each intervention is modelled to deliver is summarised below:

Increased bed capacity trajectories

High Impact Intervention:	**Nov-25**		**Dec-25**		**Jan-26**		**Feb-26**		**Mar-26**	
	RLI	**FGH**	**RLI**	**FGH**	**RLI**	**FGH**	**RLI**	**FGH**	**RLI**	**FGH**
HII 1: Pathway 0 - Board Rounds, etc	3	3	6	6	9	9	9	9	9	9
HII 2: Virtual Wards	6	4	9	6	10	7	13	9	16	11
HII 3: Therapies Integration	3	2	6	4	9	6	12	8	12	8
HII 4: Early notification to Local Authorities of complex discharges	4	2	4	2	4	2	4	2	4	2
HII 5: Reablement service reshaping	9	21	9	21	9	21	9	21	9	21
Total:	**RLI**	**FGH**	**RLI**	**FGH**	**RLI**	**FGH**	**RLI**	**FGH**	**RLI**	**FGH**
	25	32	34	39	41	45	47	49	50	51

**As of 22 February 2026*

In-scope NMC2R - trajectory and actual



**As of 22 February 2026*

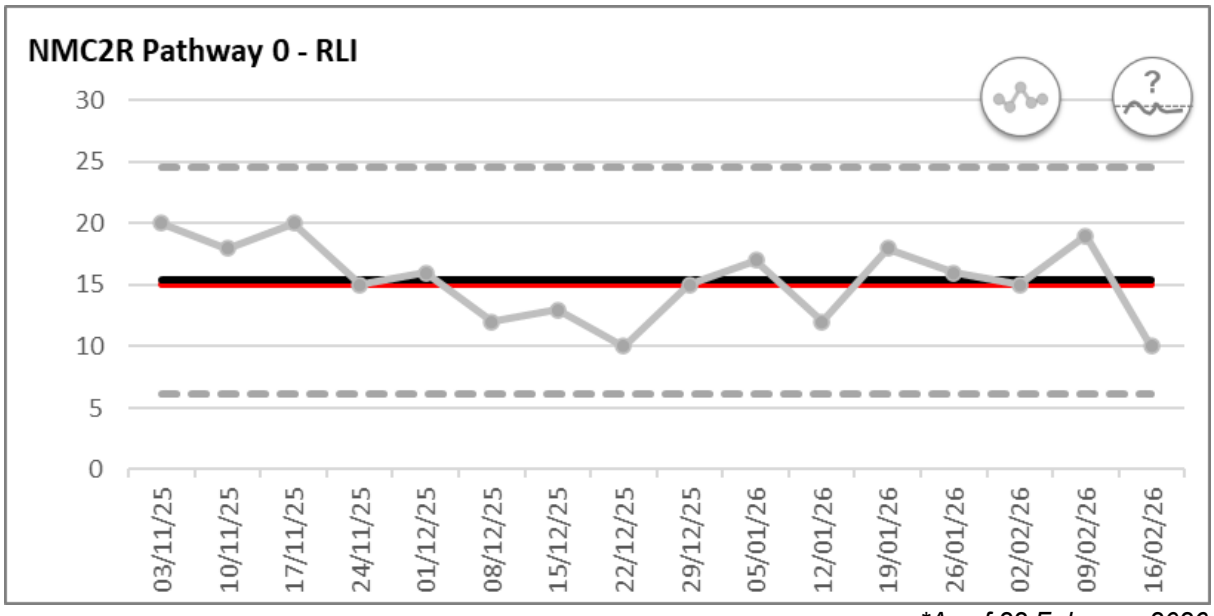
Metric summary

- In-scope NMC2R average of 84 for February 2026 to date- significantly higher than the planned trajectory of 15
- In-scope NMC2R metric is in common cause variation.

Actions undertaken to improve postion

- Following a review of the commissioned stroke pathway, patients recieving stroke specific rehabilitation will be classified as meeting criteria to reside
- Continue to work on the high impact interventions to drive improvements across whole patient pathways.

Pathway 0



**As of 22 February 2026*

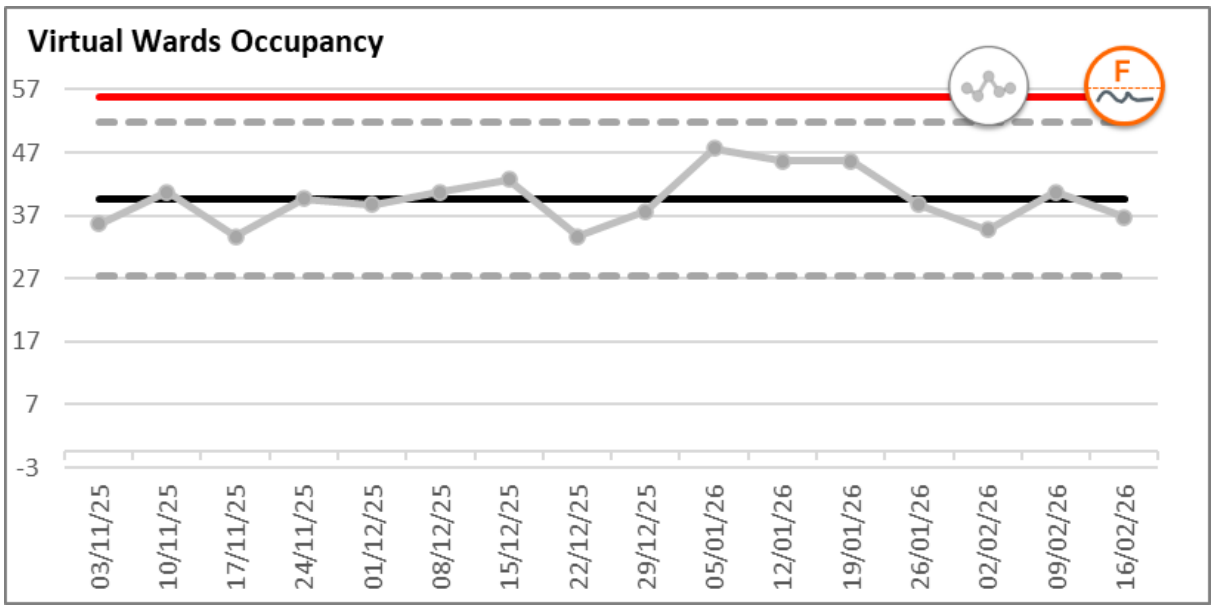
Metric summary

- Metric is in common cause variation, but the process will not consistently hit the target suggesting further improvements are required to the processes on wards to enable consistent achievement against the target

Actions taken to improve position

- Clinical Operating Standards implemented on 9 February 2026 which will drive a change in the management of patients across emergency admission pathways
- Board Rounds and Criteria Led Discharge are now live on all wards across the RLI, apart from ward 16 (Gynaecology) where a roll out plan is being finalised
- Refreshing the use of Active Ward across the RLI wards which supports patients to stay physically and mentally active during hospital stays - reducing harmful deconditioning and promoting faster, more independent recovery

Virtual Ward occupancy



**As of 22 February 2026*

Metric summary

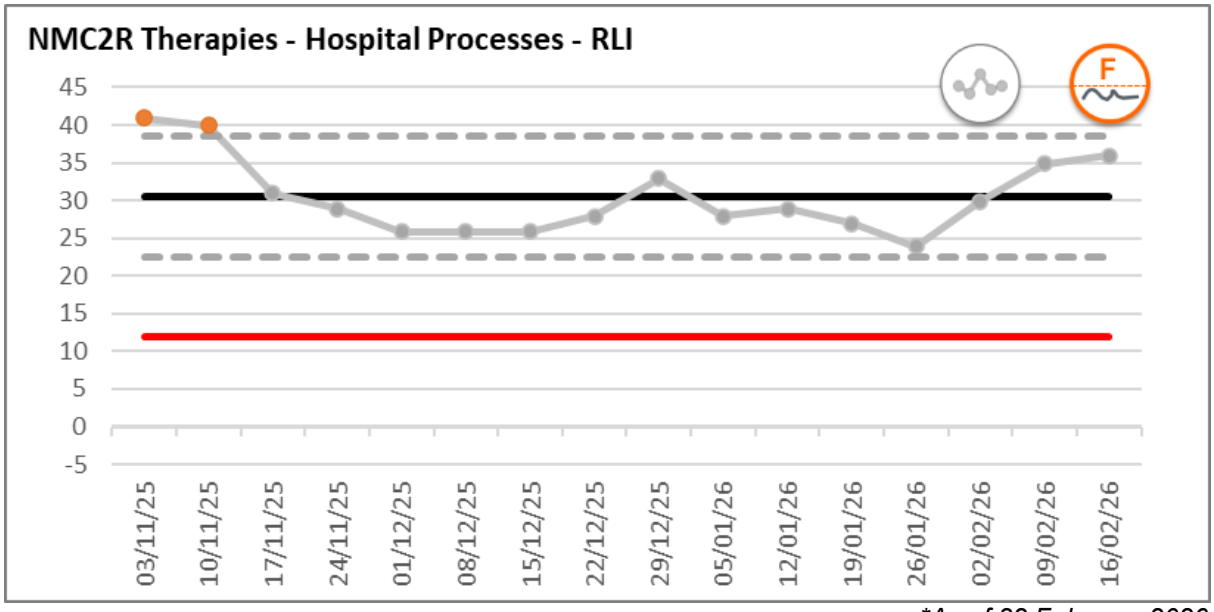
- Virtual Wards bed capacity increased to 60 beds on 16 January 2026
- Metric is deteriorating because of a reduction in referrals due to the acuity of patients - reducing opportunities for appropriate step downs
- Flow in terms of Virtual Ward admissions and discharges remain good. During February 2025, there have been 111 admissions and 107 discharges which is in common cause variation with the admissions and discharges in January for the comparable period (1-22 January 2026)

Actions undertaken to improve position

- Engaging with residential care to encourage step up referrals to Virtual Wards to reduce conveyance via ambulance to the Emergency Department
- Working with teams across the Trust to promote the use of Virtual Wards

- Testing out a redesigned referral process with Emergency Department at RLI to increase the numbers of patients able to access Virtual Ward.

Therapies - hospital processes



**As of 22 February 2026*

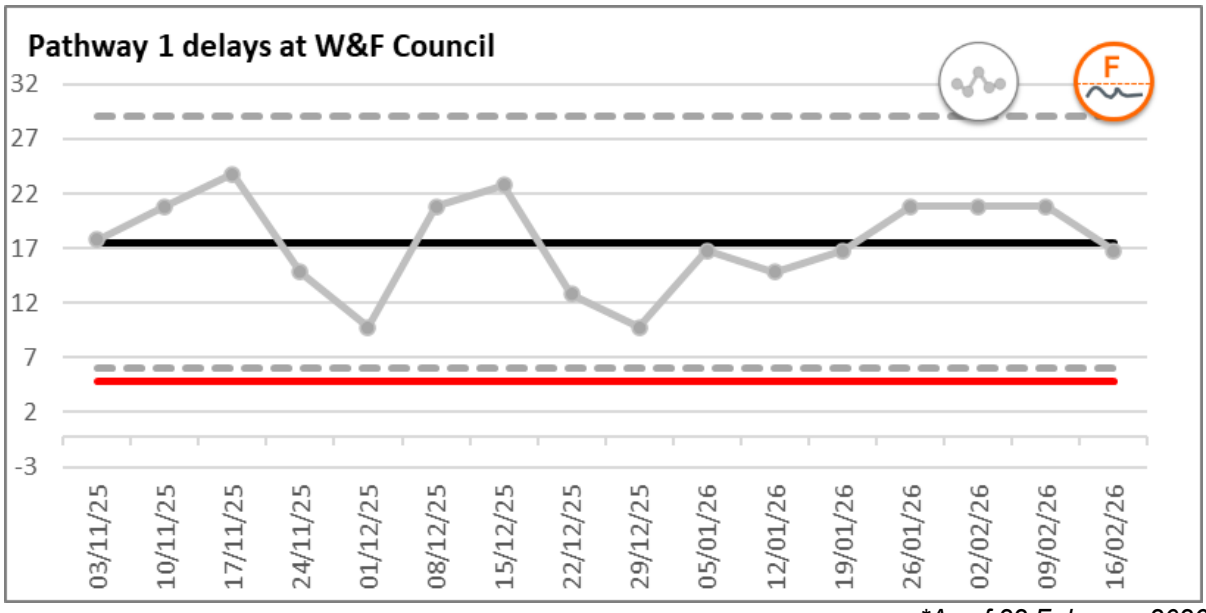
Metric summary

- Metric is in a deterioriating position and failing to meet the target

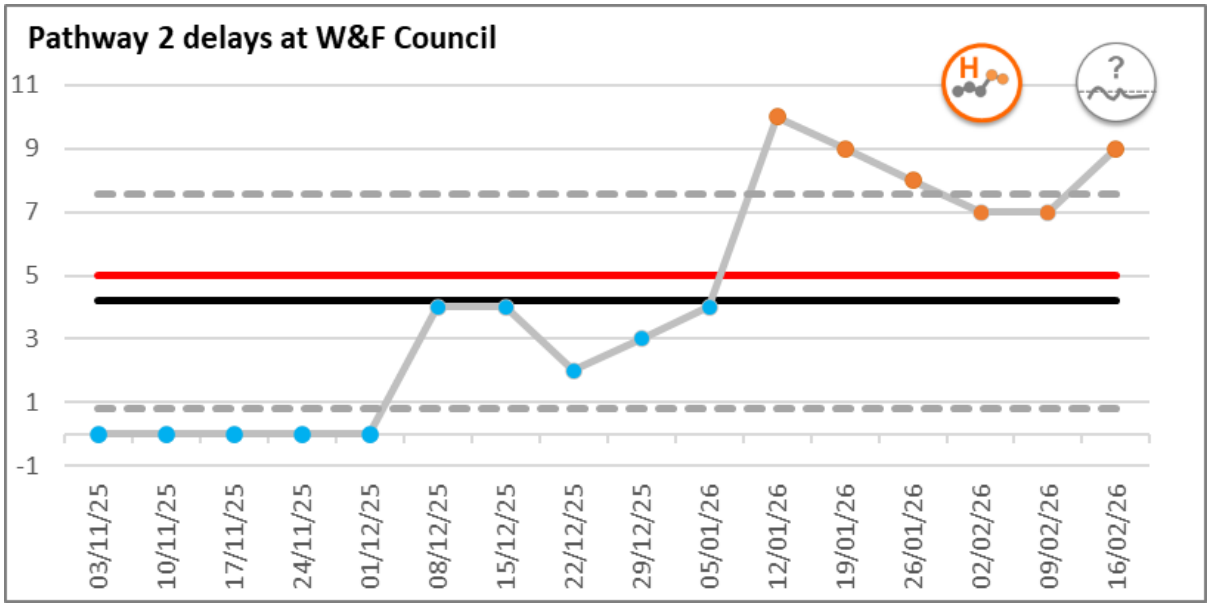
Actions taken to improve position

- Allied Helath Professional contribution to Board Rounds and Active Wards.
- Daily senior-led caseload reviews.
- Leadership for Active Ward.
- Capacity and demand and workforce planning review underway.

Reablement Delays at Westmorland and Furness Council



**As of 22 February 2026*



**As of 22 February 2026*

Metric summary

- Pathway 1 performance has deteriorated from an improved position in December 2025 / beginning of January 2026 due to a surge in referrals recently, rising from 2-3 per day to 12-13 per day. Despite higher volume, W&F Council is managing to maintain waits at 48-72 hours in contrast to historic 2-3-week waits.
- Workforce pressures remain a factor, with around one third of the Pathway 1 workforce still to be recruited. Once recruitment is complete and the capacity and demand modelling is finalised, improvements are expected not only in discharge performance but also in the system's ability to prevent unnecessary admissions
- Pathway 2 metric is deteriorating due to issues with flow into temporary, individual care home placements commissioned outside of standard contracts to meet immediate, high-priority, or complex patient needs (called spot purchased beds)

Actions taken to improve position

- Discussions are ongoing to explore how the internal referral process can be more consistent through the week to allow W&F Council to manage capacity and demand more effectively.
- W&F Council to implement revised referral process for spot purchased beds, running referrals in parallel and removing requirements for repeated referrals with the aim of reducing waits for discharges to these beds

PATIENT OUTCOMES

Long lengths of stay have negative impacts on the outcomes of patients through deconditioning, deterioration in mental impairment and self-confidence resulting in higher levels of need on discharge and poor experience. By driving forward the improvement actions, the number of NMC2R patients in hospital which in turn leads to improvements in flow, quality and safety and patient experience.

Quality and Equality Impact Assessments for Phase 1 have been approved by the Trust's Interim Chief Nursing Officer and Chief Medical Officer and are included as Appendix 1. Whilst these were approved with the caveat of two-weekly reviews of the impact and effectiveness of the mitigations, as the scheme has been paused whilst the Trust follows the Service Change process, these reviews have not taken place and therefore the review date shows as overdue.

Quality and Equality Impact Assessments for Phase 2 will be completed at a future date when implementation plans and timings are developed.

Whilst the Trust is clear that there are risks in making the changes, several measures have been put in place to keep patients and colleagues safe, including:

- Fortnightly review of all changes by the Chief Medical Officer and Interim Chief Nursing Officer - both of whom have the right to reopen beds should they believe there is evidence of an impact on patient safety
- Full commitment to review and change decisions if pressures put the safety of patients or colleagues at risk at any point

EQUALITY AND HEALTH INEQUALITIES

Approximately 20% of patients admitted to RLI are Core20 population patients. Within the hospital catchment, Core20 patients are generally younger than average. As such, the proportion of patients discharged from Castle View who live in a Core20 area is only 14%. In line with this, only 12% of NMC2R bed days for discharges from Castle View are for patients living in Core 20 areas.

The average Length of Stay for Core20 patients discharged from Castle View is lower than that for non Core20 patients. 87% of discharges from Castle View are for patients with a recorded white ethnicity, and similarly 87% of NMC2R bed days for Castle View discharges are for patients with this ethnicity. The vast majority of the remaining patient episodes have no recorded ethnicity. Only 0.61% of Castle View discharges have recorded Black, Asian and Minority Ethnic categories, in line with the local population profile that would be likely to use the unit. This group has a similar NMC2R ratio, showing no adverse experience specifically in this group.

54% of patients discharged from Castle View are female, and they have 55% of the attributable NMC2R bed days for discharges from the unit. This slight female bias is to be expected given the population pyramid for older patients, who are more likely to be users of the unit (only 4% of Castle View discharges are aged under 65, with 69% aged 80 or over).

Five inclusion health principles from 'A National Framework for NHS - Action on Inclusion Health'

The Trust has a stated commitment to the inclusion health principles (Principle 1) and available in-house resources via the health inequalities hub for workforce development (Principle 3). The Trust has some data on inclusion health groups via recorded patient passports on its Lorenzo e-record system which showed that the vast majority of patients had no flag (95%), and of the remaining that had any flag (such as a learning disability, veteran status etc), average length of stay and NMC2R days were not statistically different. There were no patients identified in the records who were homeless at discharge. As this relates to a shift to a model of care closer

to home, it is assumed that the need to provide integrated and accessible services (Principle 4 and 5) will be achieved through the planning of the alternative service and is therefore not considered here.

The Trust is continuing to develop its response to patient safety healthcare inequalities. There is no suggested reason why this reconfiguration would be differentiated from any other Trust provision.

The Trust has a health inequalities action plan overseen by the Trust's Health Equity Committee. This year, it is focusing on improving ethnicity coding, which will strengthen baseline data reporting for these groups

As highlighted above, no variation in outcomes can be attributed to the current care model or proposed change. If such measures were to be identified, the Trust has past evidence of incorporating equity targets into its Integrated Performance Report, and a similar approach could be taken here. Care closer to home is highlighted in national health inequalities strategies as being advantageous for reducing inequalities, and the alternatives to inpatient admission would therefore be aligned to this policy direction.

IMPACT ON COLLEAGUES

The colleagues affected by the totality of Phase 1 and 2 of the bed reduction plans are detailed below. It is expected that half of the colleagues would be affected in Phase 1 with the remaining half affected in Phase 2.

Role	Current FTE	Headcount
Band 2 Admin & Clerical	2.11	3
Band 2 Support Staff	2.57	4
Band 3 CSW	25.17	29
Band 5 Registered Nurse	24.83	26
Band 6 Registered Nurse	5.60	6
Band 7 Registered Nurse	2.00	2
Total	**62.28**	**70**

The Trust is committed to ensuring that all affected colleagues are redeployed safely and fairly into suitable alternative roles. A structured matching process will be implemented, using ringfenced vacancies identified across relevant services. Colleagues will be matched based on their skills, experience and expressed preferences, with a clear and transparent selection framework applied where multiple candidates meet the criteria.

All colleagues will receive individual support throughout the process, including access to information, 1:1 conversations, and guidance from People Services. Where required, supernumerary periods, induction and training will be provided to

ensure a safe transition into new roles. Individual circumstances, including existing flexible working arrangements, will be carefully considered.

Supporting colleague wellbeing, morale and psychological safety will be a central priority throughout this process. The Trust will provide clear, regular communication to ensure colleagues remain fully informed about timelines, redeployment processes and the rationale for change.

Comprehensive wellbeing support will be available, including access to Occupational Health, psychological services, and on-ward wellbeing outreach. Leaders will continue to engage with colleagues to ensure that concerns are heard and that staff remain valued and supported throughout the transition.

PHASE 2 - CLOSURE OF A FURTHER 24 BEDS

Phase 2 of the plans would see the second ward on Castle View (a further 24 beds) close at a time where the improvements detailed in this Case for Change have been sustained with a continued reduction in patients NMC2R and avoidable admissions.

Phase 1 of the plan to close 24 beds is predicated on the five high impact interventions described in this case and the forecast impact of each of these as set out on page 8. The collective impact is modelled to realise capacity equivalent to 50 beds at RLI when embedded. This modelling therefore confirming that once embedded, the equivalent bed capacity to be released will allow Phase 2 to be taken forward.

It is, however, pertinent to highlight though that many of the improvements referenced in this paper go beyond the high impact interventions which are quantified in the table on page 8; such as the focus on alternatives to admission. The Trust and its partners across the Bay have also committed to introducing an Integrated Wellness Service in Lancaster in 2026/27 as part of the National Neighbourhood Improvement Programme. This will replicate the service in place in Barrow, which is evidenced to reduce non-elective admissions for those accepted into the service by 51%. This integrated service supports patients who have the highest number of both emergency department and non-elective admissions and therefore are the highest users of our urgent and emergency care services.

The Wellness Service model was developed and works because of the strength of collaboration and partnership working across Morecambe Bay. It recognises that the factors that enable independence, or risks that lead to a hospital admission are wide ranging, requiring a holistic response from a range of community-based organisations, that is coordinated around the patient.

Delivery plans for all the improvements noted with improvement trajectories to note the consequent impact on acute bed capacity are currently being created and will be finalised in April 2026. At that time, the Trust will have clarity on when the full benefits of the improvements will be realised and therefore, when Phase 2 can be enacted.

As is described for Phase 1, the same oversight and controls around patient safety will be taken to Phase 2 with beds only closed when the Trust is assured that improvements are evidenced and it is safe to do so.

ENGAGEMENT WITH COLLEAGUES, STAKEHOLDERS AND COMMUNITIES

Colleagues

The Trust recognises that the proposed closure of beds and the associated service redesign may create uncertainty and concern for colleagues. Supporting colleague wellbeing, morale and psychological safety will remain a priority throughout the process.

Affected colleagues continue to be supported and engaged with directly by local and Divisional leaders. Wider colleagues across the Trust are kept up to date via formal Trust communications channels, including Executive-led briefings, colleague newsletters, intranet and on-site briefing sessions.

Key stakeholders

Before the plans to reduce the number of beds at both the RLI and FGH were announced at the end of December 2025, the Trust engaged directly with key stakeholders, including local MPs, Local Authorities and the two Overview and Scrutiny Committees that cover the Trust's catchment area to inform them of the plans and allow them to ask any questions.

In addition, there has been direct written and verbal communications and engagement with stakeholders and the local media.

At the end of February 2026, the Trust's Interim Chief Executive met with the Deputy Chair of Lancashire Health Overview and Scrutiny Committee to verbally update on the plans and seek guidance on the most appropriate way to engage with the Committee. The Deputy Chair of the Committee asked the Trust to formally present the plans at a public meeting of the Committee on Tuesday 3 February 2026 which was delivered by the Chief Medical Officer.

At the meeting, the concerns raised by the Committee included the Trust's ability to safely deliver care during. operational pressures with less beds, the impact of the change on social care, and the levels of capacity to support patients in the community - including virtual wards. The recommendation from the Committee was that the plans should follow the full-service change process, including public consultation.

Local communities

Given that the reduction in beds does not change the services offered to patients at the RLI, the Trust does not believe this triggers the need for formal public engagement or consultation. However, it remains committed to engaging meaningfully with key stakeholders wherever possible.

The Trust has shared the plans to reduce beds at FGH and the RLI across all available internal and external communication channels and responded to comments

and questions from local communities - received directly, or via MPs, social media or Governors.

The ICB will lead some targeted patient insight and engagement to support the case for change during March 2026 - supported by the Trust. This will include:

- Targeted engagement with current patients, families and carers on the affected wards
- Direct engagement with relevant community groups - including patients with long-term conditions and frailty
- Desktop review of previous feedback / insight - including previous ICB-led engagement activities, patient and public insights from partners, patient comment and complaints, and data and performance metrics

A further programme of wider engagement will be created to inform the development of the Pre-Consultation Business Case, should that be required.

CONCLUSION

The actions described and evidenced in this Case for Change are delivering improvements and incrementally are all contributing to a reduction of patents NMC2R which will offset the impact of the proposed 24 bed reduction (Phase 1) by late 2026.

In addition, the close working with Local Authority partners is yielding results and incremental improvements that will reduce the amount of time patients spend away from home and the number of patients NMC2R. These patients should be in their own home or home of choice. The principle of collaborative improvement engaging system partners underpins our approach.

The proposal has been through appropriate governance including Board and is being monitored in Quality Impact Assessment meetings by the Chief Medical Officer and Interim Chief Nursing Officer - with regular reporting to the Chair of the Quality Assurance Committee.