APPENDIX 9

Cumbria Clinical Commissioning Group

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Summary of the Documents

The Governing Body should consider the views of the relevant NHS Trusts in relation to the deliverability of the options included in the Public Consultation to inform its decision making.

In February 2017 NHS Cumbria Clinical Commissioning Group wrote to each of Cumbria Partnership NHS Foundation Trust, North Cumbria University Hospitals NHS Trust, and North West Ambulance Service NHS Trust seeking a formal position statement in relation to the options.

In considering the deliverability of each of the options, the Trusts were requested to address each of the following:

- Workforce sustainability, i.e. the ability of the Trust to retain, recruit and train the required workforce to deliver each Option
- Operational Management and Clinical leadership, i.e. the ability of the Trust to deploy the appropriate leadership to enable the delivery of the option, and any relevant practical operational management implications
- Estates and Infrastructure, i.e. the ability of the Trust to ensure a fit for purpose physical infrastructure for delivering each Option
- Any other material consideration

The response from each Trust is included as part of Appendix 9.
Attention: Dr David Rogers Accountable Officer Cumbria CCG

Dear David,

**Re: Community Hospitals and the Success Regime Consultation**

In response to the request from the CCG, we are pleased to attach CPFT’s appraisal of the alternative proposals for Alston, Wigton and Maryport that were submitted during the consultation process. This includes a quality impact assessment for Maryport and the original community led alternative proposal.

In submitting this appraisal, it is important to note that this is the opinion of CPFT. We recognise that two of the alternative proposals include suggestions that would have major implications for services provided by other organisations, including the Local Authority. To determine whether these have merit and are feasible or indeed whether there are any other alternative service models, there is a need for all partners to work jointly in determining the most appropriate future configuration. Recognition of this has been taken on board in coming to our conclusions.

The position of Cumbria Partnership Foundation Trust is as follows:

- We confirm our support for the preferred option in the Success Regime (Option 1). This will mean a reduction of medical community hospital beds from 133 to 104 with the remaining community hospital wards having a minimum size of 16 which brings operational resilience and more efficient staffing models.

- We support the implementation of the preferred option though progressing alternative option 2 in Maryport and a further time limited piece of work in Alston and Wigton building on the ideas put forward by the local communities and local clinical teams, and in full partnership with our colleagues in the County Council. We anticipate this piece of work will be jointly commissioned and led by the CCG and CCC with our engagement and support; and in full collaboration with the local community and other stakeholders.

- We are committed to continuing to operate the beds in Alston and Wigton during this period of further work. However, it should be noted that this is likely to pose significant operational challenges and we would highlight there may be occasions when we need to close beds on a temporary basis where quality and safety would otherwise be compromised. Given this challenge, we would recommend any further work is concluded as rapidly as possible and should last no longer than 12 months at the latest.

The work we have done with the local community groups, Hospital Leagues of Friends, local clinical teams and local general practices has been extremely positive and constructive. We should continue this co-production approach as we move forwards.
We have submitted this report early to help your preparations for your governing body meeting in March. It should be noted that our board is not formally considering our appraisal until 28th Feb 2017. If there is any change to our position after this we will inform you immediately.

Yours sincerely,

Claire Molloy

Chief Executive

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Statement of Deliverability for Community Hospital Proposals

Workforce Sustainability

The underpinning principle which allowed for each of the proposals to be made was the recognition that a minimum bed number of 16 in each unit would provide:

- Greater resilience and safety of staffing establishments in these isolated units
- Improved development opportunities and career paths in our community hospitals
- More stability and certainty in these units should enhance opportunities for recruitment and retention of staff
- Further enhancement and standardisation of the operating model creating more skills development across all units.

Through the evaluation process, CPFT consider the preferred option described in the consultation document to have the best opportunities to maximise workforce sustainability as set out above.

Operational Management and Clinical Leadership

The capacity and skills needed to transition to a new model has been developed and put into place as part of the Governance structure of CPFT supported by short term investment in project capacity offered at system level. Existing leadership arrangements would continue with supporting staff enabled to act under the leadership of the current management team. The development of ICC leadership will further enhance the opportunities to strengthen local clinical leadership in each community over a planned period of transition.

Estates and Infrastructure

The planned development of additional beds in each of the options will require additional capital investment as described in the pre consultation business case.

Statement of Deliverability of Conclusions from the Critical Option Appraisal

There was consensus that we should keep to the 104 ‘medical’ community hospital beds number proposed in the Success Regime consultation.

Draft implementation plans have been developed which would enable us to move towards a consolidated and reduced hospital bed base but over a period of years.

The timeline for implementation of this model is directly affected by a longstanding staffing fragility issue which is at high risk of deteriorating should a decision be reached to close hospital beds in any of the communities. It is important to note therefore that any period of planned implementation may be curtailed as a result of prolonged uncertainty for staff and that we may need to close facilities sooner than planned.

Whether planned or reactive we can deliver a reduction in sites and beds in line with the proposal made. There may be some shorter term impact on patient flow but plans to provide enhanced community services and in particular offer 7 day services in ICC’s will absorb much of this over time.

There was agreement that we should aim to optimise the ward sizes in the other community hospitals as proposed in the consultation to a minimum of 16 to give future resilience and more cost effective staffing models.

Draft implementation plans have been established for a number of scenarios based on the options within the consultation. As stated above, the timeline would be affected by the impact on staff at any units affected by a decision.

Maryport alternative option 2 achieves the proposed bed reduction (-13 beds) but invests more in Maryport for admission avoidance and population health.

The development of the options for the services in Maryport has included Service Managers and staff within CPFT. From a staff perspective there is broad agreement with the proposal to provide a service aimed to support people in
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the community to avoid admission to acute or community beds. Resources have been quantified as part of the modelling and this has now been expanded to include a fuller implementation plan to enable any transition. It is proposed that we would achieve deliverability of the model if resources were protected through this proposal thus enabling staff to practice in Maryport within a new service.

It would be delivered using the principles and approach to the implementation of the Hospital at Home Service in Carlisle where transition was achieved through a 3 month process focusing on the reorientation and re-training of staff.

It should be noted that as yet no plans have been made to deliver an integrated service with Social Care staff aimed at admission avoidance. The design and delivery of this model would be progressed as part of the ICC agenda. Without protected investment in line with the proposal this would be an undeliverable option.

The Wigton and Alston proposals require further work subject to discussions and agreement with the county council.

It is not possible at this stage to assess deliverability of this proposal without the active involvement of other providers and commissioners.
Dear Peter

WNE Cumbria Health Consultation – Option Deliverability Statement from NCUHT

This letter provides a concise assessment of the deliverability of the service configuration options set out in the W,N,E Cumbria Public Consultation. As requested, NCUHT has considered option deliverability against the following key criteria:

- Workforce sustainability
- Operational management & clinical leadership
- Estates & infrastructure and associated capital costs.

Our assessment of Public Consultation option viability against these criteria is set out below.

Emergency and Acute Care

The Trust Board supports the continuation of 24/7 emergency and acute care at both WCH and CIC in line with the clearly articulated wishes of W,N,E, Cumbria population. This is underpinned by a high level of confidence in the Composite Work force model at WCH, where increasing numbers of appropriate trained and experienced non-medical clinicians will progressively reduce our reliance upon locum middle grade staff and will improve our ability to recruit Consultant Physicians. The Trust therefore prefers option one; the continued provision of 24/7 A&E and acute inpatient care at both WCH and CIC, recognising that some more seriously ill patients will be transferred from WCH to CIC.

Emergency & Acute Care Option 1 – Maintaining A&E, acute medicine and ITU at WCH & CIC: This option is assessed as deliverable. Workforce sustainability issues are being addressed through the Composite Workforce Strategy and joint clinical / academic appointments with UCLan. There are no significant operational or clinical leadership concerns. Estate and infrastructure are well founded at WCH with the new build, and the impending reconfiguration of the Emergency floor at CIC will further support this option.
Emergency & Acute Care Option 2 – Daytime A&E at WCH, ITU at CIC only: This option is assessed as not presently deliverable; although, should the impact of Integrated Care Communities (ICCs) deliver the anticipated reduction in need for acute beds, it may be in the future. The removal of ITU and overnight A&E from WCH will result increased transfers to, and admissions at, CIC. This option will only marginally improve workforce sustainability and in some respects worsen staff productivity as core clinical cover will be retained for fewer patient numbers. It is operationally the most complex option and may to some extent confuse service users. The key challenge will be the transfer of clinical activity from WCH to CIC equating to appx 30 beds; current service configuration and the existing estate at CIC, at present, preclude this option.

Emergency & Acute Care Option 3 – Consolidation at CIC: This option is assessed as not deliverable. This option would improve workforce sustainability. However, the current configuration of services based at CIC and the existing estate will not permit the transfer of appx 80 beds from WCH to CIC. Future modifications to the estate, combined with further redistribution of clinical services across the W,N,E Cumbria health system may make this option viable in the future.

Hyper Acute Stroke Care

The Hyper Acute Stroke Unit (HASU) model is recognised best practice for the care of patients experiencing an acute stroke. Both the National ‘Stroke Tsar’ and the Stroke Association have been clear in their advice that a single stroke unit based at Carlisle is the optimal clinical model to adopt. The Trust Board therefore supports option 2; the creation of a new Hyper Acute Stroke Unit at CIC with subsequent acute care & rehabilitation provided at WCH and CIC.

HASU Option 1 – Acute model status quo: This option is deliverable, but with significant reservations. It fails to deliver recognised improvements to patient care. Continuation with the current model exacerbates our difficulties in sustainably staffing the service, as it duplicates staffing requirements (especially for Consultant and Specialist Stroke staff) in the context of a national Stroke Clinician shortage across the UK.

HASU Option 2 – Single HASU at CIC: This option is assessed as deliverable. It better supports a sustainable workforce, not least because the adoption of a best practice stroke model will improve our competitive position in respect of recruitment. Recruitment will, however, remain a challenge and innovative approaches to staffing (composite model & network relationships with adjacent Trusts) will be necessary. There are no operational or clinical leadership concerns, nor any estate or infrastructure concerns.
Emergency Surgery and Trauma & Orthopaedics at WCH

The Trust Board supports the proposal to maintain changes to service provision at WCH already made on grounds of safety, but additionally to; conduct further minor trauma surgery at WCH, return more non-complex day surgery to WCH, provide additional fracture clinics at WCH, and improve communication channels between GPs and Surgeons. This proposal will increase the range and capacity of surgical services provided in West Cumbria.

*Adoption of proposal:* The proposal is assessed as deliverable; there are no specific workforce concerns, or concerns relating to operational or clinical leadership. The proposal has the benefit of transferring surgical activity to WCH, releasing bed capacity (apx 16 beds) at CIC – which will enable the transfer of clinical activity proposed in other consultation options to CIC.

*Non-adoption:* This option is assessed as not deliverable; as it will compromise clinical safety and unravel the improvements to surgical outcomes achieved. Non-adoption will worsen workforce sustainability in some surgical specialities and limit the expansion of surgical services available in West Cumbria.

Maternity Service

Of all the areas considered in the public consultation, proposals for the future provision of maternity services are recognised as the most complex, emotive and contentious. The Trust has made strenuous efforts to understand public opinion, assess the comparative merits of the clinical service options proposed, absorb the clinical advice provided by a variety of external professional and expert sources, and take into account the relative risks associated with the options proposed.

After much deliberation, the Trust continues to support Option 2; the development of a Maternity Service configured with a single Consultant Led Unit (CLU) and an alongside MLU at CIC and an MLU at WCH, including retention of the midwife led Birthing Unit at Penrith Hospital.

*Maternity Option 1 – CLU & MLU at both sites:* This option is assessed as highly unlikely to be deliverable. Workforce sustainability concerns over Obstetrics middle grade recruitment, Consultant Paediatricians (new born resuscitation) and Senior Anaesthetists (emergency interventions, separate from intensive care and other duties) mean that this option is considered extremely challenging. There are no operational management issues, although some concerns have been expressed over effective clinical leadership of the current service, as a single team, across two sites. The estate at WCH & CIC will support this option.

*Maternity Option 2 – MLU only at WCH:* This option is assessed as deliverable. There are no definitive workforce concerns, although potential reluctance of WCH Midwives to relocate to CIC may be problematic in the short term. There are no operational management or clinical leadership concerns with this model and the estate at WCH & CIC will support this option. The relocation of births equates to the transfer of apx 15 beds from WCH to CIC – this will be offset by the planned transfer of emergency & more complex surgery and T&O activity from CIC to WCH.
Maternity Option 3 – Consolidation of births at CIC: This option is assessed as deliverable. There are no definitive workforce concerns, although potential reluctance of WCH Midwives to relocate to CIC may be problematic in the short term. There are no operational management or clinical leadership concerns with this model and the estate at WCH & CIC will support this option. The relocation of births equates to the transfer of appx 17 beds from WCH to CIC – this will be offset by the planned transfer of emergency & more complex surgery and T&O activity from CIC to WCH.

Children’s Services

The short stay assessment model is well recognised as best practice in paediatric care. Continuing difficulty recruiting and retaining senior Paediatric clinicians, as well as the inefficiencies of operating a twin site service for a comparative small population, are important considerations. The Trust Board therefore supports Option one; the provision of an Inpatient & SSPAU at CIC and the development of a SSPAU with associated low acuity overnight beds at WCH.

Children’s Services Option 1 - SSPAU on both sites, only low acuity overnight care at WCH: This option is assessed as deliverable. Reduction of overnight care at WCH to low acuity significantly improves workforce sustainability across the Paediatric team. This sustainability gain is not achieved if this option is combined with maternity option one –as this option requires Paediatrician availability within 30 mins 24/7 at WCH. Recruitment & training of APNPs to staff the low acuity beds at WCH might also prove challenging in the short term. There are no operational or clinical leadership concerns with this model. Increased admissions to CIC will be accommodated by converting day-beds to acute overnight beds plus an addition four beds. The existing service footprint will accept these changes so there are no estate / infrastructure concerns.

Children’s Services Option 2 - SSPAU only at WCH: This option is assessed as deliverable. Cessation of overnight care at WCH significantly improves workforce sustainability across the Paediatric team to a greater extent than option 1. There are no operational or clinical leadership concerns with this model. Increased admissions to CIC will be accommodated by converting day-beds to acute overnight beds plus an additional 7 beds. The existing service footprint will accept these changes so there are no estate / infrastructure concerns. Modest capital spend will be required to extend clinical areas into space currently used for administration.

Children’s Services Option 3 - Consolidation of paediatric inpatient care at CIC: This option is assessed as deliverable. Consolidation of day assessment and inpatient paediatrics at WCH radically improves workforce sustainability. There are no operational or clinical leadership concerns with this model. Increased admissions to CIC will be accommodated by converting day-beds to acute overnight beds plus an additional 10 beds. The existing service footprint will accept these changes so there are no estate / infrastructure concerns. Modest capital spend will be required to extend clinical areas into space currently used for administration.
NCUHT Estate – ‘Will it Fit?’

The chief consideration in reviewing the Public Consultation options has been that several propose the consolidation of clinical services at CIC. Clearly there are estate limitations upon the viability of adopting all those consolidation options concurrently.

The most significant consolidation options concern the partial and complete consolidation of A&E, emergency & acute medicine at CIC. These have both been assessed as not deliverable due to the number of additional acute beds required at CIC. It should be noted that partial consolidation of A&E, emergency & acute medicine at CIC (option 2) might become viable if ICCs deliver intended care closer to home / acute activity reduction effects.

The full consolidation of all maternity services at CIC (option 3) is another significant proposal with impacts on the CIC estate. It is assessed that maternity consolidation at CIC can be achieved, independently of any benefits derived from the SR strategy of ICCs delivering care closer to home / acute activity reduction, if the transfer of emergency & more complex surgery and Trauma & Orthopaedics to WCH takes place as proposed.

Lastly, Children’s Services – Full consolidation of paediatric inpatient care at CIC (option 3): This option is assessed as deliverable from an estates perspective (as is option 2). Increased admissions to CIC will be accommodated by converting existing day-beds to acute overnight beds, and adding an additional 10 beds. The existing service footprint will accept these changes so there are no estate / infrastructure concerns. Modest capital spend will be required to extend clinical areas into adjacent space currently used for administration.

I hope this letter provides a clear picture of our views concerning the deliverability of WNE Cumbria Public Consultation options.

Yours sincerely

Stephen Eames
CHIEF EXECUTIVE & STP LEAD FOR WEST, NORTH & EAST CUMBRIA

cc Trust Board Members
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23 February 2017

By email only
Peter Rooney
Chief Operating Officer
NHS Cumbria CCG

Dear Peter

THE FUTURE OF HEALTHCARE PUBLIC CONSULTATION IN WEST, EAST AND NORTH CUMBRIA

Thank you for your letter dated 17 February seeking the North West Ambulance Service NHS Trust’s (NWAS) position with regard to deliverability of the consultation options. With regard to the criteria to be considered by the CCG Governing Body, in making its decision, I can confirm that North West Ambulance Service NHS Trust (NWAS) are in a position to deliver the required service delivery changes to enable the implementation for each of the 6 areas for consideration in partnership with the other health providers involved.

The differing options from previous modelling completed by Deloitte require additional resource implementation varying from one to eight plus the potential for a dedicated vehicle for maternity and paediatrics. To enable this NWAS in the immediate and short term will utilise private providers with suitable governance structures in place as the interim measure to provide early support to change programmes following the decision making process.

This period of private provider provision will allow NWAS to utilise its current recruitment model including attracting suitably qualified international paramedics to provide the establishment uplift required for these models. Our recent track record of being able to improve our paramedic establishment from circa 30 paramedic vacancies in North Cumbria to just a few vacancies, and with a projection to 100% overall establishment, should give a high degree of confidence that NWAS will meet the workforce requirements and sustain this position into the future. In addition we have now put in place local level education for NWAS staff to progress to paramedic level qualifications through the University of Cumbria, providing a sound base to enable the required increase in establishment over a period of time.

The foundation for the future of NWAS rests in the clinical leadership model we have embarked upon which is applauded and supported by the Care Quality Commission. NWAS provides dedicated clinical leadership for staff through an academic based senior and consultant led paramedic model. Any increase in our establishment will be supported with the required increase in clinical leadership using our existing model to ensure small teams of circa 12 paramedics are supported by a dedicated clinical lead. NWAS is confident during implementation this increased level of support can be provided through our normal recruitment processes.
NWAS is currently undergoing a full estates review. This includes us looking at alternative sites and options. Once again we have a good track record of working with partners at both NHS levels and other emergency service providers to ensure a fit for purpose estate infrastructure. We do not see any reason for this to not continue should any increase in resources require estates support and would initially look towards NHS partners to assist in the provision of this infrastructure.

Changes to Community Hospital provision may change flow for both Paramedic Emergency Services (PES) and for Patient Transport Services (PTS). Flows would need to be monitored with regard to the level of change and any required change to PES or PTS contract and service provision outside of that in the original modelling. Overall any changes can be built into PTS contracts. The impact on PES is considered to be negligible and as such NWAS believe that by following the Deloitte recommendation for vehicle numbers and reviews, gives a high degree of confidence to deliver on this work stream.

In respect of the maternity service review, NWAS is assured by the work to date which essentially provides a midwife escort for maternity patient transfers between the two sites as appropriate. For maternity transfers where the clinical need is beyond the scope of the midwife and paramedic, and also for paediatric transfers, escort arrangements will be put in place which is commensurate with the patient’s clinical condition. The sharing of any residual risks will be jointly shared between organisations, working together in close partnership. As such NWAS is satisfied we will be able to deliver the ambulance service elements of any preferred option for maternity services.

I trust that this provides you with assurance that NWAS both supports and is in a position to provide the capacity to deliver service changes to enable the options being discussed. Senior members of the NWAS Executive and Management Teams will be on hand to assist with any detailed questions at the forthcoming Governing Body Development Day.

Yours sincerely

DEREK CARTWRIGHT QAM
Chief Executive

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