1. Executive Summary

1.1 Introduction to the executive summary

The NHS Cumbria Clinical Commissioning Group Governing Body meeting is an important step on the journey to deliver a high quality, sustainable and affordable health care system for West, North and East Cumbria.

Whilst the recommendations being put forward result from a long-standing development process undertaken through wide-ranging discussions with partner organisations, the decision-making responsibility falls solely with the NHS Cumbria Clinical Commissioning Group Governing Body.

As such, this document, whilst set in the context of the work of the Success Regime, is owned and authored by NHS Cumbria Clinical Commissioning Group. This report supports the Governing Body in making decisions in line with the NHS Cumbria Clinical Commissioning Group Constitution.

1.2 Background to the proposed options

The Success Regime is a national initiative led by NHS England and NHS Improvement in three of the most challenged health economies in England. In September 2015 the West, North and East Cumbria Success Regime was launched. It is comprised of local NHS partner organisations, including NHS Cumbria Clinical Commissioning Group, and is led by Sir Neil McKay as the Independent Chair.

One of the key aims of the Success Regime is to develop a sustainable clinical strategy. This recognised the significant challenges in relation to the sustainability of clinical services, financial sustainability, workforce recruitment and retention and indeed the immediate performance challenges in seeking to deliver the NHS Constitution Standards. This also recognised the requirement of the Care Quality Commission to produce a system wide Clinical Strategy which would enable transformational service improvement.

The first iteration of the Clinical Strategy was produced in March 2016 to meet the timescale required by the Care Quality Commission. The strategy then widened into the full range of proposals across the wider NHS as described in the Pre-Consultation Business Case in summer 2016. The local partner organisations always had a clear commitment to ensure an appropriate Public Consultation prior to deciding on any permanent major service change.
A two-stage process was used to identify, develop, appraise and prioritise the service model options put forward for Public Consultation that will address:

- the clinical sustainability issues as described in the Clinical Strategy, and
- the financial challenges facing the West, North and East Cumbria health economy as described in the wider Success Regime terms of reference.

### 1.3 Engagement and consultation

Public, patient, staff and stakeholder views have been a key feature of the Success Regime process, from engagement to inform the development of the long list of options and then through consultation on the short-listed options.

The programme undertook a significant amount of engagement work prior to consultation including stakeholder meetings, staff engagement meetings, use of an online staff survey and numerous location visits using the Healthwatch Cumbria Chatty Van.

The formal public consultation process ran from the 26th September 2016 to the 19th December 2016. The consultation activities included sixteen public meetings across West, North and East Cumbria, the establishment of a consultation website, a representative telephone survey undertaken which contacted over 1000 people and the distribution of 20,000 hard copies of consultation documents.

The full set of responses were independently analysed by The Campaign Company. The analysis shows that a large number of respondents did not indicate a preferred option from any of the consultation options, and in the comments explained that they did not support any of the options. However, where respondents did indicate a preferred option, there was support for the Consultation document preferred options for the following service areas:

- Children’s services
- Community Hospitals Inpatient beds
- Emergency and acute care

Respondents indicating a preferred option did not support the Consultation document preferred options for the following areas:

- Maternity services
- Hyper-acute stroke services
For emergency surgery and trauma and orthopaedic services, a proposal to substantiate service changes already in place on an interim basis was included in the Consultation document, rather than a series of options. In this instance the qualitative feedback heard through public consultation was used to test the proposal put forward before making a recommendation to the Governing Body.

1.4 The decision-making process

Following the completion of the public consultation, collectively all the partner organisations including NHS Cumbria Clinical Commissioning Group reviewed the responses.

Where new models were identified the model was evaluated using the same criteria as used in Stage 1 of pre-consultation process.

The Governing Body is not bound by the recommendations or conditions put forward in this report and can choose to support, reject or amend them as it sees fit.
1.5 The decision-making context

The vision as set out in the Pre-Consultation Business Case is to develop West, North and East Cumbria as:

“A centre of excellence for integrated health and social care provision in rural, remote and dispersed communities”

The choices made by the Governing Body will be a key part of delivering this vision by providing the foundations upon which to enable a step change in workforce recruitment and retention. Decision-making will do this by providing two clear messages:

1. Certainty on service development to convince people to come here, stay here and put down roots / by a house they need certainty around the model of care

2. The creation of an innovative model of care that creates a unique selling point over all other parts of the country where NHS organisations are also chasing the same workforce and that meets the employment expectations of the modern workforce

1.6 Summary of recommendations

The following section sets out the recommendations made to the Governing Body. The rationale for each recommendation is set out in later sections of the document.

Recommendation 1: The Governing Body is requested to confirm that NHS Cumbria Clinical Commissioning Group has met its statutory duties in ensuring that an effective and robust Public Consultation has been undertaken and will be used to inform the decisions made.

Recommendation 2: The Governing Body is requested to approve the following proposal (recommendations 2.1 – 2.4 inclusive) for implementation. All Options relate to those described in the Healthcare for the Future in West, North and East Cumbria Public Consultation Document, pages 20 – 23 inclusive:

Recommendation 2.1: To test the viability of Option 1 over a 12 month period

Recommendation 2.2: If Option 1 is not proven to be deliverable or sustainable then implement Option 2 at the end of the 12 month period

Recommendation 2.3: Whilst testing Option 1, to prepare for Option 2 by implementing a Midwifery Led Unit (MLU) in Whitehaven alongside the Consultant Led Unit, in order that the MLU can be audited as if it was freestanding
**Recommendation 2.4:** To implement Option 3 if Option 1 is not proven to be deliverable or sustainable and, following audit of the MLU, Option 2 is not deemed to be safe.

**Recommendation 3.1:** The Governing Body is requested to approve Option 1 for implementation.

This option involves the development of an inpatient paediatric unit serving West, North and East Cumbria based at Cumberland Infirmary Carlisle along with a Short Stay Paediatric Assessment Unit. At West Cumberland Hospital, Whitehaven, there would be a Short Stay Paediatric Assessment Unit for children requiring short term observation and treatment. There would be some overnight beds at Whitehaven for children with less acute, low risk illnesses but children who needed more acute inpatient admission would be transferred to Carlisle.

**Recommendation 3.2:** The Governing Body is requested to approve that should Option 1 ultimately prove to be unsustainable then Option 2 for Children’s Services may need to be implemented.

**Recommendation 4.1:** The Governing Body is requested to approve Option 1 for implementation.

This option includes the consolidation of inpatient Community Hospital beds into six sites. In total there would be 104 inpatient beds at Whitehaven (Copeland Unit), Cockermouth, Workington, Penrith, Brampton and Keswick.

**Recommendation 5.1:** The Governing Body is requested to approve Option 1 for implementation.

This involves a 24/7 A&E at Cumberland Infirmary Carlisle along with acute medical inpatient services, including for the most complex cases. There would be assessment and inpatient beds for the frail elderly, as well as specialist rehabilitation. The number of intensive care beds currently on site would increase slightly, as would the number of emergency assessment unit beds.

There would also be a 24/7 A&E at West Cumberland Hospital along with acute medical inpatient services and rehabilitation. There would also be a small intensive care unit but some of the most seriously ill patients would be transferred to Carlisle if it was felt they would benefit from the extra support available there.
**Note:** This will not change the bed base of the Intensive Care Unit at West Cumberland Hospital. This will also not change the previously implemented high risk pathways including those relating to cardiology and respiratory.

**Recommendation 6.1:** The Governing Body is requested to approve Option 2 for implementation.

This would see all acute stroke cases managed in a single hyper-acute stroke unit based at Cumberland Infirmary Carlisle. Ambulances would take possible stroke patients direct to Carlisle. Patients arriving at West Cumberland Hospital by other means would be transferred by ambulance to Carlisle. On leaving the hyper-acute stroke unit patients resident in West Cumbria would be transferred to acute stroke and rehabilitation facilities at West Cumberland Hospital if further hospital care was needed. This service would be complemented by ensuring improved, early supported discharge in both Carlisle and Whitehaven.

**Recommendation 7.1:** The Governing Body is requested to approve the proposal set out in the Public Consultation document for implementation.

**Recommendation 8.1:** The Governing Body is requested to approve the formation of an Implementation Reference Group to feedback on the implementation process. The membership of this group will be agreed in discussion with patient and the public representative groups, stakeholders and partners but would include representation from the Clinical Commissioning Group including the Lay Member Lead for Patient Engagement and the Medical Director.

This group may wish to use a sub-group structure around each of the main areas of change (i.e. maternity and paediatrics, acute and emergency care and community hospitals).

### 1.7 Implementation considerations

In early 2016 as part of the national process, the West, North and East Cumbria area was recognised as a Sustainability and Transformation Plan area. The Sustainability and Transformation Plan governance arrangements include a new System Leadership Board that will oversee the implementation of these decisions made by the NHS Cumbria Clinical Commissioning Group Governing Body.

As part of the implementation process, it is recommended that the Clinical Commissioning Group establish an independent Implementation Reference Group to feedback on the implementation process.
1.8 Next steps for the decision-making process

Following the Governing Body meeting, the Clinical Commissioning Group will formally write to Cumbria Health Scrutiny Committee to inform them of each decision made.

The Cumbria Health Scrutiny Committee will then review these decisions and choose whether or not to give feedback to the Governing Body on each decision.

Once the position of the Cumbria Health Scrutiny Committee is known and any feedback received, NHS Cumbria Clinical Commissioning Group will work through the Sustainability and Transformation Plan governance mechanism in partnership with other organisations to develop a full implementation and delivery plan to enact the decisions made.

NHS Cumbria Clinical Commissioning Group will also work with local partner organisations to ensure a full business case is provided to NHS England and/or NHS Improvement if required.
2. Introduction

The NHS Cumbria Clinical Commissioning Group Governing Body meeting is an important step on the journey to deliver a high quality, sustainable and affordable health care system for West, North and East Cumbria.

The Success Regime is a national initiative led by NHS England and NHS Improvement in three of the most challenged health economies in England. In September 2015 the West, North and East Cumbria Success Regime was launched. It is comprised of local NHS partner organisations, including NHS Cumbria Clinical Commissioning Group, and is led by Sir Neil McKay as the Independent Chair.

One of the key aims of the Success Regime is to develop a sustainable clinical strategy. This recognised the significant challenges in relation to the sustainability of clinical services, financial sustainability, workforce recruitment and retention and indeed the immediate performance challenges in seeking to deliver the NHS Constitution Standards. This also recognised the requirement of the Care Quality Commission to produce a system wide Clinical Strategy which would enable transformational service improvement.

The first iteration of the Clinical Strategy was produced in March 2016 to meet the timescale required by the Care Quality Commission. The strategy then widened into the full range of proposals across the wider NHS as described in the Pre-Consultation Business Case in summer 2016. The local partner organisations always had a clear commitment to ensure an appropriate Public Consultation prior to deciding on any permanent major service change.

The decisions that will be made are a sub-set of the full range of actions that West, North and East Cumbria need to take to ensure clinical and financial stability for the population, based on the better integration of care that will underpin the changes to the way services are provided in our hospitals.

Each decision will be made taking into account the impact they will have in terms of:

- the population’s health outcomes and health inequalities,
- impacts on quality (in terms of clinical standards, patient experience and safety) and ongoing clinical sustainability
- the deliverability of the proposed service model (both in its own right and in combination with the other decisions being made), and
- the financial consequence of implementing the change

Whilst the recommendations put forward result from a long-standing development process undertaken through wide-ranging discussions with partner organisations, the decision-
making responsibility falls solely with the NHS Cumbria Clinical Commissioning Group Governing Body.

As such, this document, whilst set in the context of the work of the Success Regime, is owned and authored by NHS Cumbria Clinical Commissioning Group. This document contains:

- an overview of the process taken to develop the options that went to public consultation
- an outline of the pre-consultation engagement and public consultation process and how they informed the development and appraisal of the options
- a description of the decision-making process
- an overview of the decision-making context based on the Clinical Strategy and the Pre-Consultation Business Case
- Recommendations for each service subject to decision-making
- Considerations for implementation of the final decisions, and an outline of the next steps following this meeting

3. Overview of the process to date

This report comes to the Clinical Commissioning Group Governing Body at the decision-making stage of the process following the conclusion of the earlier stages depicted in figure 1.

![Success regime programme stages](image)

Figure 1: Success regime programme stages

3.1 The Clinical Strategy for West, North and East Cumbria

The Clinical Strategy was developed as the local response to the significant challenges faced in the health economy. It was also developed in response to the Care Quality Commission’s requirement for both a sustainable clinical strategy for West, North and East Cumbria and...
assurance that the issues highlighted in relation to services provided by North Cumbria University Hospitals NHS Trust were being addressed.

The strategy confirmed the actions being taken to stabilise the most fragile acute hospital services as well as outlining how improved performance against key constitutional targets including Accident and Emergency performance and waiting times would be achieved.

The Care Quality Commission accepted the Clinical Strategy in March 2016 and the programme moved to the second stage of its work.

### 3.2 Pre-consultation stage

The pre-consultation stage was used to identify, develop and appraise the service model options that will address:

- the clinical sustainability issues as described in the Clinical Strategy, and
- the financial challenges facing the West, North and East Cumbria health economy as described in the wider Success Regime terms of reference.

As described in the Pre-Consultation Business Case (and shown in figure 2) a two-stage process was used to identify the options to be put forward for public consultation from the long lists of conceivable options.

![Figure 2: Long-list to preferred option process](image-url)
Stage 1: the application of a set of three ‘hurdle criteria’ against each option in the long list. These hurdle criteria were:

- **Hurdle 1:** compliance with essential national quality / safety standards within two years (Can the option meet a minimum level of safety and required quality standards?)
- **Hurdle 2:** operational deliverability within two years (Are the staffing assumptions for this option credible and training requirements feasible?)
- **Hurdle 3:** contribution to reducing financial deficit within five years (Can this option be delivered with the capital funding we can secure and make a net positive contribution to the 2020/21 forecast gap?)

Stage 2: appraisal of the short-listed options that passed stage 1 the following evaluation criteria:

- the impact they would have on the health and wellbeing of the population
- the impact they would have on the quality of care (including the sustainability of the current workforce, patient experience, safety and the achievement of clinical standards)
- the impact they would have on closing the funding and efficiency gap across West, North and East Cumbria
- how easy or hard it would be to deliver the option if agreed and the timeframe over which this would take

All the options passing Stage 1 went forward for public consultation. Stage 2 of the process identified the preferred option for each service area.

### 3.3 Independent expert advice and assurance

Throughout the pre-consultation stage, the programme sought external expertise and independent assurance to ensure that the development of the options put forward for consultation were as robust as possible.

This external advice and assurance included:

- **Clinical assurance**— to ensure that the best clinical opinion and advice was received in the development and assessment of the options for new service models.
  - Development support from the Northern England Clinical Senate.
  - Development support and review of evidence by the Northern England Clinical Networks
- A formal Clinical Assurance Review from Greater Manchester, Lancashire and South Cumbria Clinical Senate
• External clinical advice. Advice from national experts such as:
  - Dr Matthew Jolly - National Clinical Director: Maternity Review and Women’s Health for NHS England and Professor Jacqueline Dunkley-Bent - Head of Maternity, Children & Young People for NHS England in relation to the maternity services options
  - Dr Tony Falconer - former President Royal College of Obstetricians and Gynaecologists, lead author of the Royal College of Obstetricians and Gynaecologists Review 2014, who supported the maternity working group throughout the process
  - Dr David Shortland - Vice-president for the Royal College of Paediatrics and Child Health in regards to the children’s services options
  - Peter Colclough (expert on integrated care) which would inform the wider work on the Integrated Care Community concept
  - Dr Tony Rudd - National Clinical Director for Stroke for NHS England in regards to the hyper-acute stroke model

• Engagement and consultation assurance from the Consultation Institute – to ensure that engagement and consultation with the public was undertaken effectively and appropriately

• Programme assurance – to ensure that the programme was run effectively and robustly using a Gateway Review process

As well as engaging outside expertise and assurance, the programme has met with the requirements of the regulatory processes of national arms-length-bodies (NHS England and NHS Improvement). These processes ensure that national guidance and policy on the assurance of service change was followed by the programme.

3.4 Impact and risk assessment

To ensure the Clinical Commissioning Group comply with the requirements of the Equality Act 2010 (the Public Sector Equality Duty) the programme carried out an Equality Impact Assessment.

Equality Impact Assessment is a process designed to ensure that a policy, project or scheme does not discriminate against any disadvantaged or vulnerable people. The full methodology and findings of the Equality Impact Assessment can be found in appendix 1.

As well as the Equality Impact Assessment, a range of other impact assessments were carried out to support the development of the proposed options and to test the risks (and mitigations) that were identified during the public consultation. These were:
A Health Impact Assessment (HIA). This is developed using a combination of public health procedures, methods and tools and is the means by which a policy, programme or project may be judged as to its potential effects on the health and wellbeing or health inequalities of, and the distribution of those effects within, a population. The full Health Impact Assessment methodology and findings can be found in appendix 2.

Travel impact assessments for acute hospital services, community hospitals and the proposed Integrated Care Communities. Travel impact assessments are used to model the effect the proposed service changes may have across West, North and East Cumbria. The full travel impact assessment methodologies and findings can be found in appendix 3.

A Rural Proofing assessment. Rural Proofing is a process that enables organisations and departments to ‘screen’ their policies and programmes at the development stage in order to ascertain their potential impact upon rural communities. The full methodology and findings of the Rural Proofing process can be found in appendix 4.

Alongside the impact assessment process, a robust risk assessment process has been utilised to:

- assess potential risks through the model generation and options appraisal process. The long list of options was assessed against hurdle criteria and then a more detailed set of evaluation criteria to appraise short-listed options. The criteria included option compliance with essential national quality / safety standards and operational delivery risks.
- review risks raised by the public consultation and identify appropriate mitigations for them when making the recommendations to the Governing Body. This included drawing on outside independent expertise such as Royal Colleges, Clinical Networks and Clinical Senates as well as working with partners such as the North West Ambulance Service on risks associated with access, conveyance and transfers.

A description of the approach to the assessment of risk can be found in appendix 5.
4. Engagement and the consultation

Public, patient, staff and stakeholder views have been a key feature of the Success Regime process, from engagement to inform the development of the long list of options and then through consultation on the short-listed options.

4.1 Pre-consultation engagement

As outlined in the Pre-Consultation Business Case and the consultation document, the Success Regime undertook a significant amount of engagement work prior to consultation including:

- 142 public or private stakeholder meetings
- 31 staff engagement meetings
- 161 responses to an online staff survey
- 210 comment cards completed by staff
- 163 written responses (letters, emails, blogs, etc.)
- 229 online responses through the ‘Have Your Say’ form on the West, North and East Cumbria Success Regime website
- 86 location visits from a travelling ‘chatty van’ engagement vehicle, led by Healthwatch, which has travelled to communities across West, North and East Cumbria, covering more than 3,700 miles and capturing the views of more than 3,400 people

The key themes that can be drawn from this engagement work were as follows:

- Recruitment and retention. This included feedback that staff feel stretched with low morale and that more should be done to solve recruitment problems before any services are changed. Many assert that a clear vision with a bright future for services in Cumbria will help attract and retain staff and that this is not helped by uncertainty about services in West Cumbria.

- West Cumberland Hospital. There was little evidence of public support for any option that reduces the level of service in the West Cumberland Hospital (particularly accident and emergency and consultant-led maternity services)

- Community hospitals. While people understand the difficulties associated with recruiting, retaining and rostering staff in community hospitals, there was considerable opposition to the idea of removing inpatient beds from any community hospital site.
• Finances. There were some people who believe North Cumbria University Hospitals NHS Trust should bear the burden of any cost reductions because its deficit makes up a large proportion of the overall health system overspend.

• Integration. All respondents agreed that better integration of services – between adult and social, residential, community and acute care – is essential to improve healthcare in Cumbria. As such, there was a great deal of support for the idea of Integrated Care Communities.

• New services. There was widespread support for the increased use of telemedicine or anything that aids service delivery in remote areas in delivering efficient and effective patient care.

• Factors specific to West, North and East Cumbria. The rurality and geography of west, north and east Cumbria – and its poor transport links – was perhaps the single most common concern among all responses received. There were concerns about expectant mothers and acutely ill patients not receiving adequate care during the so-called ‘Golden Hour’. Furthermore, while many supported the idea of care closer to or in people’s home, several people highlighted issues in such as the time it would take for nurses and other social care staff to travel from patient home to patient home.

This feedback was used to update the oversight groups for the programme (the Programme Executive Group meetings and Programme Board meetings) and was given to the Senior Responsible Officers for each programme work-stream to inform their development of their long list of options and support the option appraisal process.

4.2 The public consultation process

The formal public consultation process ran from the 26th September 2016 to the 19th December 2016. The consultation activities included:

• sixteen public meetings across West, North and East Cumbria
• the establishment of a consultation website
• a representative telephone survey undertaken which contacted over 1000 people.
• the distribution of 20,000 hard copies of consultation documents
• coverage in the local and regional media, and
• use of the Healthwatch ‘Chatty Van’
Responses mainly came through the consultation questionnaire, but also:

- Letters, emails and long form submissions
- Social media
- Public, stakeholder and staff meetings
- Petitions

To ensure compliance with the statutory requirement for NHS bodies to consult a Local Authority on proposals under consideration for a substantial development of or variation in the provision of health services the programme and NHS Cumbria Clinical Commissioning Group have kept the Cumbria Health Scrutiny Committee informed throughout.

To give the NHS Clinical Commissioning Group Governing Body additional assurance that the engagement and consultation process has been carried out to the highest standard, the Success Regime requested an external assessment by the Consultation Institute.

The Consultation Institute provide a formal Quality Assurance service to ensure that public consultation is carried out to best practice standards. The process involves several checkpoints at which the Institute checks whether best practice is being observed. These checkpoints are:

1. Scoping - When the basics of the consultation are agreed
2. Project Plan - When consultation activities are set out and organised
3. Documentation - Ensuring that hard copy and electronic documents are fit for purpose and that questionnaires conform to best practice
4. Mid-Point Review - To assess whether all relevant views are being collected
5. Closing Date - To finalise plans for analysis, feedback and to influence the outcome
6. Final Report - To confirm the Institute’s endorsement of the consultation

To date the Healthcare for the Future consultation programme has been successfully signed off with respect to the first four of the checkpoints described above with the final assessment to come in the near future.

The results of the public consultation have been assessed and analysed independently by The Campaign Company. The Campaign Company provided the final consultation report on the 23rd February 2017. The report was published on the NHS Cumbria Clinical Commissioning Group website on 24th February. This publication date was chosen in order to meet the pre-election period guidance relating to the Copeland by-election on the 23rd February 2017.
The total number of responses by the way in which the response was made can be seen in figure 3.

Responses came for a broad spectrum of the population. The breakdown by age, gender and ethnicity can be seen in figure 4.

**Figure 3: Number of responses to the public consultation**

<table>
<thead>
<tr>
<th>Method</th>
<th>Total number of responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Online consultation questionnaire</td>
<td>2856</td>
</tr>
<tr>
<td>Paper consultation questionnaire</td>
<td>840</td>
</tr>
<tr>
<td>Paper consultation questionnaire – Easy Read</td>
<td>14</td>
</tr>
<tr>
<td>Telephone survey</td>
<td>1002</td>
</tr>
<tr>
<td>Letters and e-mails (from individuals)</td>
<td>220</td>
</tr>
<tr>
<td>Letters, e-mails and long-form submissions</td>
<td>115</td>
</tr>
<tr>
<td>(organisations and elected representatives)</td>
<td></td>
</tr>
<tr>
<td>Public meetings</td>
<td>17</td>
</tr>
<tr>
<td>Stakeholder meetings and deliberative events</td>
<td>26</td>
</tr>
<tr>
<td>NHS Staff meetings</td>
<td>20</td>
</tr>
<tr>
<td>Video submissions</td>
<td>3</td>
</tr>
<tr>
<td>Social media (Facebook – 85; 9 – Twitter; 1 – Youtube)</td>
<td>95</td>
</tr>
<tr>
<td>Petitions</td>
<td>6</td>
</tr>
</tbody>
</table>

**TOTAL NUMBER OF RESPONSES: 5214**

**Figure 4: Demography of those responding to the consultation**
Responses also came from all localities within West, North and East Cumbria. A breakdown of this can be seen in figure 5.

<table>
<thead>
<tr>
<th>Town Area</th>
<th>Postcode(s)</th>
<th>Count</th>
<th>Total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whitehaven</td>
<td>CA28</td>
<td>918</td>
<td>25%</td>
</tr>
<tr>
<td>Workington</td>
<td>CA14</td>
<td>417</td>
<td>11%</td>
</tr>
<tr>
<td>Carlisle</td>
<td>CA1, CA2, CA3, CA4, CA5, CA6</td>
<td>278</td>
<td>8%</td>
</tr>
<tr>
<td>Cockermouth</td>
<td>CA13</td>
<td>265</td>
<td>7%</td>
</tr>
<tr>
<td>Keswick</td>
<td>CA12</td>
<td>258</td>
<td>7%</td>
</tr>
<tr>
<td>Egremont</td>
<td>CA22</td>
<td>246</td>
<td>7%</td>
</tr>
<tr>
<td>Cleator Moor</td>
<td>CA25</td>
<td>178</td>
<td>5%</td>
</tr>
<tr>
<td>Seascale</td>
<td>CA20</td>
<td>144</td>
<td>4%</td>
</tr>
<tr>
<td>Maryport</td>
<td>CA15</td>
<td>114</td>
<td>3%</td>
</tr>
<tr>
<td>Alston</td>
<td>CA9</td>
<td>109</td>
<td>3%</td>
</tr>
<tr>
<td><strong>Total of top 10</strong></td>
<td><strong>2927 (of 3641)</strong></td>
<td></td>
<td><strong>80% of overall response</strong></td>
</tr>
</tbody>
</table>

Figure 5: Consultation questionnaire respondents by locality

Public consultations are not necessarily representative exercises. Against the census profile there are some examples of this:

- People aged under 25 and over 65 in the consultation response were under-represented compared to the population of West, North and East Cumbria
- Women were over-represented in the consultation response compared to the population of West, North and East Cumbria
- Residents from Copeland District were over-represented in the consultation response compared to the population of West, North and East Cumbria

The consultation analysis undertaken by The Campaign Company and outlined later in this report is representative of the response received during the consultation.
4.3 Findings from the public consultation

The independent analysis of the public consultation found that:

- For all services there were very significant numbers of responders who could not support any of the options put forward for public consultation
- There is mixed support for many of the proposals outlined (this is consistent across all the different consultation channels).
- Most vocal response has been where people see a ‘loss’ or changes to current service provision.
- Patient safety and risk to life, accessibility to quality care, viability of proposals and health and social impacts are the key themes across the response.

The analysis shows that a large number of respondents did not indicate a preferred option from any of the consultation options, and in the comments explained that they did not support any of the options. However, where respondents did indicate a preferred option, there was support for the Consultation document preferred options for the following service areas:

- Children’s services
- Community Hospitals Inpatient beds
- Emergency and acute care

Respondents indicating a preferred option did not support the Consultation document preferred options for the following areas:

- Maternity services
- Hyper-acute stroke services

For emergency surgery and trauma and orthopaedic services, a proposal to substantiate service changes already in place on an interim basis was included in the Consultation document, rather than a series of options. In this instance the qualitative feedback heard through public consultation was used to test the proposal put forward before making a recommendation to the Governing Body.

Consultation responses specific to each of the service areas are highlighted in the decision-section later in this report.

The full independent analysis of the public consultation by The Campaign Company can be found in appendix 6.
4.4 Recommendations

Recommendation 1:

The Governing Body is requested to confirm that NHS Cumbria Clinical Commissioning Group has met its statutory duties in ensuring that an effective and robust Public Consultation has been undertaken and will be used to inform the decisions made.

This recommendation is made on the basis that:

- the public consultation was ran to the twelve week requirement of the Cumbria Health Scrutiny Committee,
- used a wide ranging approach to consultation with an appropriate level of response from people in the areas most affected by the proposals,
- had independent process assurance from the Consultation Institute, and
- was independently analysed by The Campaign Company
5. Decision-making process

This report supports the Governing Body in making decisions in line with Cumbria Clinical Commissioning Group Constitution.

Following the completion of the public consultation, collectively all the partner organisations including the Clinical Commissioning Group reviewed all of the responses. Where suggestions were made as to where models could be strengthened or improved or where alternative models not put forward for consultation and that weren’t considered during the pre-consultation process. Where new models were identified the model was evaluated using the same criteria as used in Stage 1 of pre-consultation process. The detail of where alternative models were suggested can be found in the following sections for each service area.

To support the Governing Body in making these decisions each service section will include the following:

- How each preferred option has been considered against the feedback heard through the consultation process. This includes how interdependent services have been considered, what risks have been identified and how they have been tested against the impact assessments carried out by the programme.

- For each service included in the public consultation, a recommendation has been made to the Governing Body as to which option would appear to be the strongest. This includes considering the feedback from the consultation and from each of the relevant NHS Trust organisations in relation to the deliverability of each option.

- Alongside some of the recommendations for each area consulted on, additional considerations for implementations have been highlighted which the Governing Body may also wish to consider. These were developed in response to issues raised during the consultation process or from the discussions around deliverability during the option appraisal process. They are intended to help define the grounds on which it would become possible to implement the recommendation put forward or provide additional safeguards that need to be put in place during implementation.

- In some instances there is further work may that may need to be carried out prior to the option chosen “going live”. This work is not material to the decision on the options being made in principle but is included for completeness as it will impact on the implementation phase of the programme in terms of both work-plan and timeline.
6. Decision-making context

The recommendations outlined in the following sections support delivery of the West, North and East Cumbria Clinical Strategy and the wider system development described in the Pre-Consultation Business Case.

NHS Cumbria Clinical Commissioning Group is committed to working in partnership to deliver the transformation in care services that will achieve improved outcomes for our population:

- Ensuring that all who use our services are at the centre of everything we do.
- Becoming world leaders in how to run the most efficient, safe and effective hospital services in remote and rural settings.
- Cultivating first class responsive and accessible community services, tailored around the needs of their communities.
- Returning our health and social care system to financial balance.

The vision is to develop West, North and East Cumbria as:

“A centre of excellence for integrated health and social care provision in rural, remote and dispersed communities”

The choices made by the Governing Body will be a key part of delivering this vision by providing the foundations on which to enable a step change in workforce recruitment and retention. Decision-making will do this by providing two clear messages:

1. Certainty on service development to convince people in order to come here, stay here and put down roots / buy a house they need certainty around the model of care

2. The creation of an innovative model of care that creates a unique selling point over all other parts of the country where NHS organisations are also chasing the same workforce and that meets the employment expectations of the modern workforce
7. Maternity services

The options included in the public consultation are shown in figure 6:

<table>
<thead>
<tr>
<th></th>
<th>Option 1</th>
<th>Option 2</th>
<th>Option 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CIC</td>
<td>WCH</td>
<td>CIC</td>
</tr>
<tr>
<td>Consultant-led unit</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Alongside midwife-led unit</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Standalone midwife-led unit</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>Antenatal and postnatal care</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Special care baby unit</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
</tbody>
</table>

Figure 6: Maternity service options

The preferred option outlined in the public consultation document was Maternity Option 2.

7.1 Specific findings of the public consultation in relation to Maternity Services

The independent analysis of the public consultation found that only 57% of respondents to the questionnaire indicated a first preference against one of the consulted on options. A significant number of the remaining 43% of respondents did not support any of the options.

There was strong support for Option 1 over the other two options put forward amongst the 57% of respondents indicating a first preference as shown in (figure 7).

<table>
<thead>
<tr>
<th>Maternity services options</th>
<th>First preference</th>
<th>Second preference</th>
<th>Third preference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Option 1</td>
<td>85%</td>
<td>13%</td>
<td>5%</td>
</tr>
<tr>
<td>Option 2</td>
<td>11%</td>
<td>79%</td>
<td>7%</td>
</tr>
<tr>
<td>Option 3</td>
<td>4%</td>
<td>7%</td>
<td>88%</td>
</tr>
<tr>
<td>Total responses by preference</td>
<td>2097 (100%)</td>
<td>1479 (100%)</td>
<td>1463 (100%)</td>
</tr>
</tbody>
</table>

Figure 7: Preferences in the consultation response for the maternity service options
This view was consistent across all localities, age, gender, and whether respondents have young children, but the strongest support for Option 1 came from respondents in West Cumbria.

A very significant number of responses rejected all three options, and put forward the view that they would like to retain the current model at the West Cumberland Hospital.

In terms of the qualitative feedback received on this across the consultation response, it is clear that the main influence on the response to the maternity options is the relative safety that is offered to expectant mothers and babies by each of the options. Maternity Option 1 was perceived by many as the safest option.

There was strongly expressed opposition to all of the options, across all the consultation channels, with many making the case for retaining the current level of maternity service provision at West Cumberland Hospital.

Other specific feedback included:

- Maternity Services Liaison Committee - “Community does not feel an acceptable option has been presented and on that basis would say that there is a need to work together to produce [one]”
- West Cumberland Hospital Midwives - “If the Children’s preferred option 1 is to be made a success of by recruiting paediatricians, why maternity option 1 would not also be a sustainable and therefore the preferred option?”
- GPs in Allerdale & Copeland - “All the [maternity] proposals are unsafe...and take away choice”
- West Cumbrians’ Voice for Health Care - “Why not have a moratorium [allowing option zero to continue] and do more co-production and see if it is still not sustainable? Risks of staffing failures are less than the risks of any other options [especially 2&3]. No clear evidence that proposals will improve outcomes [as demanded by policy]”

Responses from other NHS organisations (North Cumbria University Hospitals NHS Trust, Newcastle Upon Tyne Hospitals NHS Foundation Trust and Northumbria Healthcare NHS Foundation Trust) included formal Trust support for Option 2.

North West Ambulance Service highlighted concern about transfers, impact on overall performance and need for clear protocols / mitigations during the consultation. North West Ambulance Service has subsequently confirmed in writing that the Trust supports Option 2, the preferred option, for maternity services, having received a further explanation of the proposed approach to managing inter-site transfers. North West Ambulance Service
confirmed in their letter dated 23 February 2017 that the Trust was satisfied that it would be able to deliver the ambulance elements of any preferred option for maternity services.

There was also significant support from local some local clinicians for Option 2 (the preferred option in the Consultation document), particularly from different groups of Hospital Consultants, while other groups of clinicians including a significant number of Midwives and General Practitioners in West Cumbria expressed strong opposition to Option 2.

In the detailed review of all of the consultation feedback specifically referring to Maternity Services by the programme, no new alternative models were identified that had not already been considered during the option appraisal process.

### 7.2 Overall consideration of the options

The availability of obstetricians (maternity doctors), midwives, anaesthetists, paediatricians (children’s doctors) and other specialists is making it increasingly difficult, across the country, to provide 24-hour consultant-led maternity care in small district general hospitals with low numbers of births. This means that it is becoming increasingly challenging to maintain the quality of maternity services as defined by a range of regulatory and oversight bodies.

The workforce position as applies to both Maternity and Children’s Services is summarised below:

<table>
<thead>
<tr>
<th>Clinical Role</th>
<th>Cumberland Infirmary Carlisle</th>
<th>West Cumberland Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant Obstetrician non-resident on-call</td>
<td>All post substantively filled (5.7)</td>
<td>All post substantively filled (5)</td>
</tr>
<tr>
<td>Middle Grade &amp; 1st tier (Obstetrics)</td>
<td>2.8 vacancies out of 16.10 substantive posts.</td>
<td>All post substantively filled (7).</td>
</tr>
<tr>
<td>Consultant Paediatrician</td>
<td>6.2 substantive positions, 6 in post plus a long term locum.</td>
<td>5.4 substantive positions; 1.3 filled substantively with locums for remaining 4.1 vacant posts. (As at 8th Feb they were two twelve month fixed term “appointed candidates in due diligence’. The prospective post-holders require supervision and further training before they can be</td>
</tr>
</tbody>
</table>
Nationally, there is a forecast to be an oversupply of Obstetricians and Gynaecologists over the next 11 or so years, despite high attrition rates and expectation of 7 day consultant delivered services. However there is a 40% vacancy rate nationally in doctors coming into training in this specialty leading to a recent proposal that the 7 units in the North East and Cumbria should reduce to 3 training sites for middle grade doctors. This may mean that it will be more difficult to sustain an Obstetric model reliant on middle grade Doctors in the future.

Nationally there is a significant projected shortfall of Consultant Paediatricians over the medium term.

Nationally there is a significant projected shortfall for Consultant Anaesthetists, in part due to the differentiation in clinical roles in anaesthetics.

Paediatric medical staffing was noted as an area of concern by the Care Quality Commission Inspection Team on both sites in 2016.

In combination these factors mean that it is not possible to retain the current service model.

While developing the options, and during the Public Consultation, experts advised that option 1 will be difficult to sustain in the long term and option 3 (although more straightforward) would mean there would be less choice for women in the West thus making maternity option 2 the preferred option. Due to the substantive vacancies, particularly Consultation Paediatricians, and the subsequent reliance on Locums, it is also noted that there are challenges in sustaining the current model even in the medium term.

The consultation document was clear about how difficult this decision would be and further work has been done following the analysis of the public consultation to test the options in light of the concerns and risks raised.
7.2.1 External clinical view

As part of the programmes assurance arrangements, the Greater Manchester, Lancashire & South Cumbria Clinical Senate provided an Independent Review of the Proposed Clinical Models for the North, West & East Cumbria Success Regime prior to public consultation.

The Greater Manchester, Lancashire & South Cumbria Clinical Senate have since provided a second report which outlines their assessment of the options that went to consultation. In this report, their expert clinical panel found that:

“The review panel agreed with the preferred option (Option 2) and considered it a transformational model that needs testing. This is assuming the risks are robustly identified and properly mitigated against”.

The full Greater Manchester, Lancashire & South Cumbria Clinical Senate Update Report can be found in Appendix 7.

7.2.2 Travel time risk and impact on patients and their families experience

One of the key issues identified during consultation was the concern around the risk associated with increased travel times for patients in the West should the Consultant-Led Unit not continue at West Cumberland Hospital.

The travel impact assessment found that over 600 women would need to travel for more than an additional 30 miles in the options where consultant-led maternity care would be centralised at Cumberland Infirmary Carlisle each year. There are currently nearly 1400 in-patient admissions at West Cumberland Hospital (higher than the number of births as not all in-patient admissions lead to a birth).

To establish an independent view of the risks associated with travel time, the programme asked the Northern England Clinical Network for Maternity Services to review the evidence between access and outcome for maternity cases.

The Northern England Clinical Network for Maternity Services summarised their view as follows:

- “Overall, we do not feel that there is sufficient evidence in the papers referenced to justify a conclusion that increased travel times to the nearest maternity unit (at less than 4 hours distance) are associated with an increased risk of either stillbirth and/or neonatal death”.

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• “There is evidence.....that longer travel times might be associated with an increased incidence of interventions such as inductions of labour and / or hospitalisation, as might be expected when clinicians and parents might be taking decisions with the intention of minimising potential problems caused by longer travel times”

• “The evidence that longer travel times might lead to an increase in the numbers of out-of-hospital births is consistent across several studies, and is plausible. It is, therefore, particularly reassuring that even if out-of-hospital births are more frequent, overall perinatal mortality rates in these studies – when controlled for confounding factors – aren’t significantly affected by longer travel times (at < 4 hours from the nearest unit)”.

• “Detailed consideration of infrastructure issues such as transfer arrangements and accommodation near Cumberland Infirmary, Carlisle would help mitigate any potential increased risks.”

The full detailed response from the Northern England Clinical Network for Maternity Services can be found in Appendix 8.

Whilst accepting the expert opinion from the Northern England Clinical Network for Maternity Services on the clinical evidence base, the programme does recognise the impact on patient’s experience of the perceived risks associated with increased travel time.

7.2.3 Risk associated with transfer between sites

A significant number of concerns were raised during consultation about the risk to mothers and babies who may transfer between West Cumberland Hospital and Cumberland Infirmary Carlisle following complications in or after labour (under Option 2).

To address these concerns the programme has developed an outline proposal for commissioning a dedicated ambulance vehicle that would be stationed at West Cumberland Hospital solely to convey these patients, and children who require transfer (dependent on which of the Children’s inpatient options are taken forward -see section 8) to Cumberland Infirmary Carlisle.

This dedicated ambulance vehicle will only be used for this purpose. It will not be used for transferring other patients. The vehicle will not be unique or specially adapted, and other ambulance vehicles could also additionally be used for undertaking the transfers in the event that more than one patient required transfer at the same time.

The programme has modelled circumstances where more than one transfer is required at any one time. In this circumstance other emergency vehicles would then be utilised.
If a decision is made to implement a model which included a dedicated ambulance vehicle, further work on the development of detailed standard operating procedures will be required before the new service goes live.

In all future options, women would have a personalised birth plan which will be underpinned by the continual assessment of risk to the mother and child. This would reduce the number of women at risk of transfer due to complications arising during labour.

7.2.4 Impact on choice

Members of the public, and patients, would consider there to be a reduction of choice (in terms of location and accessibility, rather than the service delivered) if a Consultant Led Unit is not maintained at West Cumberland Hospital. This also applies to higher risk pregnant women who will not be able to book their birth at West Cumberland Hospital.

Choice (in terms of the range of different services available, rather than their location) will be enhanced by the delivery of alongside Midwifery Led Units. Choice would also be enhanced (in terms of the range of different services available, rather than their location) if a stand-alone Midwifery Led Units was developed at West Cumberland Hospital as this choice is not available in the current service configuration. It is recognised that the number of women who would be able to make a choice to birth at a stand-alone Midwifery Led Unit is comparatively small.

7.3 Recommendations for Maternity Services

As part of the decision-making process, two Clinical Workshops have been held to facilitate a consensus clinical view of the maternity options in the light of consultation responses. The second of these workshops weighed up the considerable concerns raised during the consultation, and the lack of support from both the public and GPs for the preferred option (2) against the positive backing of professional bodies, NHS organisations and consultants locally and regionally in the key specialities.

There was confirmation at the Workshop that the ‘status quo’ is not a long-term option and (as described in the consultation) that a de-risked CLU (option 1) was unlikely to be deliverable in the medium to longer term because of issues with both paediatric and anaesthetic recruitment (now and into the future). But we acknowledge that there is a widely expressed public and GP view that the status quo or option 1 is strongly preferred.

The conclusion of the Clinical Workshop was to advise the system leadership group to test further opportunities for transformational change that could support Option 1 but be in a
position to implement option 2 or 3 should Option 1 fail and to proceed on the basis of a collaborative and ‘co-production’ model both to make and to judge progress.

System leaders have reflected on this advice and have arrived at a set of Recommendations for the Governing Body which are as follows:

Recommendation 2: Maternity Services

The Governing Body are requested to approve the following proposal (recommendations 2.1 – 2.4 inclusive) for implementation. All Options relate to those described in the Healthcare for the Future in West, North and East Cumbria Public Consultation Document, pages 20 – 23 inclusive:

Recommendation 2.1: To test the viability of Option 1 over a 12 month period

Recommendation 2.2: If Option 1 is not proven to be deliverable or sustainable then implement Option 2 at the end of the 12 month period

Recommendation 2.3: Whilst testing Option 1, to prepare for Option 2 by implementing a Midwifery Led Unit (MLU) in Whitehaven alongside the Consultant Led Unit, in order that the MLU can be audited as if it was freestanding

Recommendation 2.4: To implement Option 3 if Option 1 is not proven to be deliverable or sustainable and, following audit of the MLU, Option 2 is not deemed to be safe.

The Governing Body is requested to **endorse** the following actions to be undertaken in order to deliver recommendations 2.1 – 2.4:

- Strenuous efforts will be made with local communities, GPs, patients and staff led by an independently chaired ‘co-production’ steering group to test to the limit the deliverability and sustainability of Option 1

- The criteria for testing the viability of Option 1 will be jointly agreed by the independently chaired ‘co-production’ steering committee. The criteria are likely to include the following:
  - The staffing and number of filled posts at agreed progress points
  - Evidence of adequate future supply of staff to maintain improvement with recruitment and retention
  - Monitoring of serious incidents / near misses / clinical outcomes
  - Measures of staff and patient satisfaction
Demonstrable change in ways of working for quality improvement including:
- a hub and spoke approach with risk stratification and transfer of high risk care,
- development of Short Stay Paediatric Assessment Units (SSPAU),
- development of the midwifery agenda including the MLU model,
- restructuring of medical working practices, arrangements for emergency cover, skills maintenance and improved leadership

- The criteria will be reviewed by an Independent Review Panel, involving regulators and Royal College experts, for a ‘stop/proceed’ decision at each milestone.

- Co-production approaches will be used to develop other care model innovations including development of the MLU(s), and proposals to mitigate the challenges of providing care at distance.

- The audit of the Whitehaven MLU will be undertaken using pre-agreed criteria and the outcome of the audit will be received by the Independent Review Panel which will decide if a free-standing MLU in Whitehaven could be safely instated.

- The Co-production Steering Committee and Independent Review Panel will fit within an agreed governance structure with jointly agreed terms of reference.

- There is an acknowledgement that much work will be required to collaboratively plan for and deliver a successful ‘co-production’ and this will begin in earnest as soon as possible should the recommendations be approved.

### 7.4 Implementation considerations for Maternity Services

The following issues have been identified through the public consultation or ongoing discussion with staff and clinicians as part of the programme. These issues do not affect the ability of the Governing Body to make a decision but will require consideration during the implementation phase:

- Significant work needs to be undertaken to provide a clearer vision for maternity services across the entire pathway of care in line with “Better Births” which outlines the choices available at all stages and develops the concept of community hubs.

- The development of the detailed standard operating procedures for the dedicated ambulance vehicle will need to take place before the new service model starts.
• All the relevant implementation issues raised in the second Greater Manchester, Lancashire & South Cumbria Clinical Senate should be addressed as part of implementation planning

• An organisational development plan should be developed that addresses the cultural challenge within the service that will come with the implementation of the new service model

• A full training plan needs to be developed for staff to address the required skill changes

• Any outstanding recommendations from the Royal College of Obstetricians and Gynaecologists report are completed.
8. Children’s services

The options that were included in the public consultation are shown in figure 8:

<table>
<thead>
<tr>
<th>Children’s services options</th>
<th>First preference</th>
<th>Second preference</th>
<th>Third preference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Option 1</td>
<td>94%</td>
<td>5%</td>
<td>3%</td>
</tr>
<tr>
<td>Option 2</td>
<td>5%</td>
<td>91%</td>
<td>3%</td>
</tr>
<tr>
<td>Option 3</td>
<td>2%</td>
<td>4%</td>
<td>94%</td>
</tr>
<tr>
<td>Total responses by preference</td>
<td>1690 (100%)</td>
<td>1270 (100%)</td>
<td>1259 (100%)</td>
</tr>
</tbody>
</table>

Figure 9: Preferences in the consultation response for the Children’s Services options

The preferred option outlined in the public consultation document was Children’s Option 1.

8.1 Specific findings of the public consultation in relation to Children’s Services

The independent analysis of the public consultation found that only 46% of respondents to the questionnaire indicated a first preference against one of the consulted on options. A significant number of the remaining 54% of respondents did not support any of the options.

There was strong support for Option 1 over the other two options put forward (figure 9) amongst the 46% of respondents indicating a first preference.
This view was consistent across all localities, age, gender, and whether respondents have young children, but strongest support for Option 1 was from respondents in West Cumbria.

A significant number of respondents rejected all 3 options in favour of a ‘fully functioning paediatric service’

In terms of the qualitative feedback received across the consultation channels, much of the response to the children’s services options relate to safety for patients as well as the impact on the wellbeing of their parents, carers and families. As is familiar with other service areas, location and distance from services is a major factor affecting respondents’ feelings on the options.

The consultation also heard from the public that:

- there was recognition that uncertainty has undermined recruitment
- there were concerns around the potential deterioration of the child during the journey to Cumberland Infirmary Carlisle and the extreme difficulty for some parents/children to travel (and the impact this has on the on the family)
- strong public expectation that there must be a full risk analysis of the proposals

There were numerous responses from organisations, clinicians and professional bodies. The predominant themes were:

- A need for ongoing public and clinical engagement and to adhere to national policy/clinical guidelines
- Mixed response from professional bodies on sustainability
- Local clinicians had mixed views, including the view that alternative proposals for West Cumberland Hospital were not expressed

Responses from other NHS organisations (North Cumbria University Hospitals NHS Trust, Newcastle Upon Tyne Hospitals NHS Foundation Trust and Northumbria Healthcare NHS Foundation Trust) showed formal support Option 1.

North West Ambulance Service raised concern about transfers, impact on overall performance, and need for clear protocols / mitigations in their response. North West Ambulance Service has subsequently confirmed the deliverability of the options, but in the context of the additional capacity that will be required.

In the detailed review of all of the consultation feedback specifically referring to Children’s Services by the programme, no new alternative models were identified that had not already been considered during the option appraisal process.
8.2 Overall consideration of the options

As described in the public consultation document, the current service configuration for Children’s Services in West, North and East Cumbria does not present an attractive option to newly qualified paediatricians. This is because it is not possible to offer them either the opportunity to work in a large specialist unit or in a specific area of children’s medicine.

Difficulty in attracting newly qualified paediatricians in turn makes it harder to attract paediatric consultants into permanent employment. At West Cumberland Hospital just one in five of our consultant paediatrician posts is currently filled by a permanent member of staff.

A fuller explanation of the current Paediatric workforce is provided in section 7.2 above.

The consequence of this is that West, North and East Cumbria has a heavy reliance on locums which can interrupt continuity of care and means the children’s service at both Whitehaven and Carlisle which makes it more at risk of temporary closure or reduction in service due to lack of staff.

A fuller explanation of the current Paediatric workforce is provided in section 7.2 above.

As well as these workforce issues, the way in which childhood illness is treated has changed considerably in recent years. National evidence suggests that up to 97% of children who come to hospital as an emergency can be safely cared for in a short stay paediatric assessment unit without the need to be admitted as an inpatient. These factors mean that maintaining the status quo was not considered for public consultation.

The consultation document put forward the programme’s preferred option as being Option 1. The programme believed that this option was the strongest as it provided the best balance of offering sustainability in the medium term while keeping significant children’s services at both West Cumberland Hospital and Cumberland Infirmary Carlisle.

Option 1 would see the creation of some overnight beds at Whitehaven for children with less acute, low-risk illnesses and would review the use of beds regularly to assess how often they were used along with their impact and effectiveness. This option was dependent on the successful recruitment of doctors and the training and development of advanced paediatric nurse practitioners to comply with current standards.
8.2.1 Travel time and transfers

In the options where West Cumberland Hospital introduces the short stay paediatric assessment unit model with all inpatient paediatric beds moving to the Cumberland Infirmary Carlisle, very poorly children requiring an in-patient admission presenting at West Cumberland Hospital would be stabilised and transferred using a dedicated ambulance vehicle to the other site.

In Option 1, low acuity beds would remain at West Cumberland Hospital which would mean a paediatrician would be available on-call out-of-hours. Very poorly children needing inpatient admission presenting at West Cumberland Hospital would still be stabilised and transferred using a dedicated ambulance vehicle to the other site.

8.2.2 External clinical view

As mentioned in the section on maternity services the Greater Manchester, Lancashire & South Cumbria Clinical Senate have provided a second clinical review report which outlines their assessment of the children’s services options that went to consultation.

In this report, their expert clinical panel found that:

“The review panel felt the best option was Option 2 [Not the preferred option]: Full service at Carlisle and 1-hour Short Stay Paediatric Assessment Unit at West Cumberland Hospital plus Dedicated Ambulance Vehicle.”

The rationale for this view was given as follows:

- It is a transformational model that has a good clinical case. This is demonstrated through provision of Short Stay Paediatric Assessment Unit on both sites, having consultants working across both sites in a network model to provide resilience and maintenance of skills, as well as integration of community and secondary care.

- Option 2 offers higher deliverability and sustainability than the other options by being more attractive to prospective consultants (offering an improved on-call rota ratio) and by requiring fewer overall whole time equivalent consultants than in option 1 (the preferred option).
• Option 2 would mean additional transfers required between West Cumberland Hospital and Cumberland Infirmary Carlisle than option 1 (the preferred option) as there would be no overnight low acuity beds

The Greater Manchester, Lancashire & South Cumbria Clinical Senate felt that for Children’s Services the preferred option (Option 1) had some merits:

“Option 1 also includes overnight beds at WCH. This would support overnight deliveries in maternity and again it was noted that the outcome of the consultation was that the current service or the least possible service reconfiguration (Option 1) were the preferred choices.”

However the independent review panel considered there to be a range of issues that that gave uncertainty as to whether Option 1 is deliverable or sustainable. These included:

• The requirement for two rotas or a dual rota across Whitehaven and Carlisle.
• The number of consultants required to support these rotas and associated daytime work
• No indication that it is possible to recruit the number of substantive consultants required to cover these rotas thereby placing an undue reliance on locums (often long term).
• Any maternity option based upon this paediatric option would also be at risk if Option 1 becomes unsustainable

The full Greater Manchester, Lancashire & South Cumbria Clinical Senate report can be found in Appendix 6.

**8.3 Recommendations for Children’s Services**

Below is a summary consideration of the four assessment domains in relation to the recommended option:

• There will be no adverse impact on health outcomes at a population level
• There will be an overall improvement in clinical quality, workforce sustainability and the achievement of clinical standards. The key risks and mitigations have also been identified.
• The model is deliverable
• There is no negative financial impact

**Recommendation 3.1:** The Governing Body is requested to approve Option 1 for implementation.
This option involves the development of an inpatient paediatric unit serving West, North and East Cumbria based at Cumberland Infirmary Carlisle along with a Short Stay Paediatric Assessment Unit. At West Cumberland Hospital, Whitehaven, there would be a Short Stay Paediatric Assessment Unit for children requiring short term observation and treatment. There would be some overnight beds at Whitehaven for children with less acute, low risk illnesses but children who needed more acute inpatient admission would be transferred to Carlisle.

**Recommendation 3.2:** The Governing Body is requested to approve that should Option 1 ultimately prove to be unsustainable then Option 2 for Children’s Services may need to be implemented.

The Governing Body is requested to **endorse** the following actions to be undertaken in order to deliver this proposal:

- Significant efforts will need to continue to address the recruitment issues within paediatric services regardless of the decision made

**8.4 Implementation considerations for Children’s Services**

The following issues have been identified through the public consultation or ongoing discussion with staff and clinicians as part of the programme. These issues do not affect the ability of the Governing Body to make a decision but will require consideration during the implementation phase:

- Significant efforts need to continue to be made to address the recruitment issues within paediatric services regardless of the decision made

- Detailed scenario planning needs to take place to ensure standard operating procedures for the stabilisation and transfer of children out-of-hours takes place safely and effectively

- The development of the detailed standard operating procedures for the dedicated ambulance vehicle prior to the new service model beginning

- All the relevant implementation issues raised in the second Greater Manchester, Lancashire & South Cumbria Clinical Senate should be addressed as part of implementation planning
• An organisational development plan should be developed that addresses the cultural challenge associated with the implementation of the service model

• A full training plan needs to be developed for staff to address the required skill changes
9. Community hospital inpatient beds

The options that were included in the public consultation are shown in figure 10:

The independent analysis of the public consultation found that only 45% of respondents to the questionnaire indicated a first preference against one of the consulted on options. A significant number of the remaining 55% of respondents did not support any of the options.

9.1 Specific findings of the public consultation in relation to the community hospital proposals

The preferred option outlined in the public consultation document was Community Hospitals Option 1.
There was strong support for Option 1 over the other two options put forward (figure 11) amongst the 45% of respondents indicating a first preference.

<table>
<thead>
<tr>
<th>Community hospitals inpatient options</th>
<th>First preference</th>
<th>Second preference</th>
<th>Third preference</th>
<th>Fourth preference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Option 1</td>
<td>86%</td>
<td>8%</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Option 2</td>
<td>6%</td>
<td>69%</td>
<td>22%</td>
<td>2%</td>
</tr>
<tr>
<td>Option 3</td>
<td>4%</td>
<td>21%</td>
<td>70%</td>
<td>3%</td>
</tr>
<tr>
<td>Option 4</td>
<td>4%</td>
<td>2%</td>
<td>3%</td>
<td>90%</td>
</tr>
<tr>
<td>Total responses by preference</td>
<td>1659 (100%)</td>
<td>1201 (100%)</td>
<td>1177 (100%)</td>
<td>1149 (100%)</td>
</tr>
</tbody>
</table>

Figure 11: Preferences in the consultation response for the Community Hospital Inpatient Bed options

Several key themes were found by the independent analysis of the consultation. Firstly, there were concerns regarding accessibility and patient safety:

- Major impact on rural areas
- Inadequate transport infrastructure and problem roads
- Difficulty of visiting
- Not in line with ‘Closer to Home’ principles
- Lives at risk, and end-of-life care particularly impacted

Secondly, there were concerns around resourcing and quality of care:

- Limited support for consolidation to improve staffing levels and quality of care
- Staffing issue not a reason to penalise patients – better recruitment and rewards needed
- Reductions in beds now not sustainable long-term with aging population and increasing pressure on acute hospitals

Throughout the consultation feedback, a clear case for community hospitals was made:

- Importance of locally accessible care – community assets, relieve pressure on acute hospitals
- Particularly important for rehabilitation, palliative care, some urgent care
- Role to play in Integrated Care Communities
- Concern about future function of those liable to lose beds
- Millom Community Hospital cited as an example of small inpatient service alongside varied care close to home
- Maryport – some consolidation with nearby hospitals accepted by some, but not at Maryport’s expense (noting the high levels of deprivation)
• Alston – remoteness emphasises hospital’s importance, great difficulty in accessing other services
• Wigton – provides easiest access to care for residents across Solway

There were also concerns of a financial, economic and social nature:

• Concern about health and social care budgets covering implementation of options and the Integrated Care Community model
• Possible long-term cost due to increased care at home
• Small financial gain maybe not worth it
• Criticism of the impact of the Cumberland Infirmary Carlisle Private Finance Initiative (PFI) and reduced public spending
• Options impacting the most vulnerable areas and communities

In the review of all of the consultation feedback referring to Community hospital inpatient beds some proposals were put forward for Maryport, Wigton and Alston.

9.2 Overall consideration of the options

As described in the consultation document, patients should spend only the time that is absolutely necessary in a hospital bed with as much being done to support them in their own home as possible. The main reasons why we feel that change needs to happen to deliver this ambition was set out in the document’s case for change:

• There is a major challenge in recruiting and retaining the necessary staff to support inpatients in our community hospitals where West, North and East Cumbria has much higher vacancy rates for nurses and health care assistants across community hospital inpatient units
• The model of small, isolated units offer limited opportunities for training, limited exposure to clinical experience and lack support from colleagues within other professions
• Rostering staff to support a small number of inpatients in a large number of isolated units is a significant challenge and less resilient when there are instances of staff sickness
• The small inpatient units find it harder to meet clinical standards set down by the National Institute for Health and Care Excellence. These guidelines recommend one registered nurse for every eight inpatients and there are clear benefits in having a minimum of two nurses working together in any inpatient unit overnight
Considering the factors above the programme considers it important to have inpatient units with at least sixteen beds (or as close to sixteen as possible where there are considerable restraints in adapting the current estate) in size to improve staff resilience, pool clinical expertise, offer staff a greater opportunity to develop and maintain skills whilst offering patients a better service.

Through the consultation process we have had feedback on the proposed closure of community hospital inpatient beds, but far more significantly we have been presented with some innovative and wide-ranging proposals for the role community hospitals can play in a different service offer for their local populations.

In particular this has come from work co-produced by staff from Cumbria Partnership NHS Foundation Trust working with the public, stakeholder groups (such as the Hospital League of Friends) and other action groups and local GP practices.

The most developed proposals came from Maryport, Wigton and Alston. These are positive proposals for how community hospital care could be delivered as part of the vision for Integrated Care Communities, rather than simply bed base reductions.

9.2.1 The Maryport proposal

Maryport is one of the most deprived communities in Cumbria poor public transport links and low car ownership. Over 50% of the Maryport health budget leaves the town to pay for acute hospital care. In 2014/15 there were 29,572 journeys out of the town for care (22,208 Outpatient appointments, 3,496 Accident and Emergency attendances, 1,995 non-elective admissions and 1,873 elective admissions)

The service provision in Maryport currently consists of:

- The community hospital with 13 beds
- 200 residential and nursing home beds
- 79 extra care housing units
- Strong general practice

The Maryport Alliance put forward two proposals; both based on a wider place-based population health system. In both models, the Alliance propose to keep the current resource in Maryport, but re-focussed on admission avoidance with Maryport Hospital as the hub of an emerging population health system.
Maryport Alliance proposal 1:

- An eight bed hospital running 24 hours a day, seven days a week focussing on rehabilitation and reablement
- These beds would be "Step-up" beds in the main (i.e. not part of the wider ‘medical’ bed model)
- The activities would see the community hospital focus on becoming a ‘bed avoidance unit’ for other parts of the system (i.e. avoiding care home and acute hospital bed use).
- More short and overnight stays and the continuation of palliative care provision

Maryport Alliance proposal 2:

- Maryport Hospital running seven days a week but no overnight stay
- The Maryport Alliance feel this would save around £373,000 by not staffing evening and night shifts which they would advocate reinvesting in improved local services
- Merging the hospital and community teams and focussing on proactive and reactive admission avoidance
- Funding some public health initiatives e.g. with schools
- Funding a doctor and increase palliative care nurse skills for the community

Proposal 1 is the preferred alternative of the Maryport Alliance.

9.2.2 The Wigton (Solway) proposal

The Solway area covers 500 square miles and a population 34000 people over (a significant proportion of which are elderly). There are transport challenges in the area and there are difficulties in recruiting staff. It is hard to provide some care services in Solway whilst hospital and residential care facilities are often dated. The Wigton hospital and residential beds also provide support for the wider system (including people from Carlisle).

The service provision in the Solway currently consists of:

- Hospital with nineteen beds, currently fourteen open beds occupied by Solway and Carlisle residents
- Wigton Hospital is a hub for Allied Health Professionals and community services across Solway, with good relationships between teams and services
- Six GP practices
- Base for Out-of-Hours GP for Solway
- Solway Integrated Care Community includes Keswick where there are 12 beds
- Inglewood care home in Wigton with forty beds
- 110 care beds in total across Solway
- Extra Care housing in Wigton Fair View Court.
The proposal put forward by the Solway Community Care Alliance is to create an integrated hub for care across the Solway. This hub will aim to deliver holistic, sustainable care that supports patients in or near to their own communities and will create the platform for effective delivery in the context of the challenges faced in this rural area.

The proposal includes:

- The creation a single bed base in Wigton through the integration of residential and step up/step down short term beds
- Supporting the beds and community services with one team working to meet needs wherever they are, with a flexible staffing model
- Supporting the development of the Integrated Care Community in delivering care to patients locally and the wider system by offering care to patients who come from outside of the Integrated Care Community
- Providing a service that provides ambulatory care support, prevents deterioration and avoids crisis in patients

9.2.3 The Alston proposal

Alston has a small population of circa 2600 people and is situated in a very isolated and remote location. The service provision in Alston currently consists of:

- A community hospital with six beds
- A residential care home with thirteen beds
- A GP surgery
- Eden Housing units
- A community ambulance

The services there are hard to support from a distance yet currently successfully keep hospital admission rates to a very low level when compared with other parts of West, North and East Cumbria. More importantly the services there are highly interdependent on each other and changes to one part of the service can have unintended consequences in the other.

The proposal put forward by the Alston Moor Care Alliance is intended to ensure sustainable resilient services that meet the needs of Alston, recognises the interdependency of the current services (and the risk of losing any component) whilst continuing to offer accessible holistic care in the spirit of the Integrated Care Community concept.
The proposal includes:

- The creation of one bed base for long term and step up/step down care
- The formation of one team around the beds and the community service
- Exploring alternative staffing models to ensure sustainability
- The creation of a hub for telehealth and access to specialist care
- Bringing together social day care, ambulatory care and rehabilitation

9.2.4 Assessing the models identified through public consultation

These proposals were assessed using the same process and criteria as used in the option appraisal process to define the four options that were consulted on. In terms of maturity, the Maryport proposal was the most fully developed with Wigton and Alston a few weeks further behind.

The assessment of the Maryport proposals found that:

- Maryport has some of the widest health inequalities in Cumbria (and nationally)
- the conversation in Maryport has been reframed from the issue of bed numbers to population health
- Proposal 2 is strongly supported by nursing teams – there is real excitement around the potential to create an exemplar of place based admission avoidance and improved population health.
- Proposal 2 will require reinvestment. If that reinvestment cannot be delivered then there would be strong opposition to take funds out of Maryport.

The programme concluded that the Maryport Alliance proposal 2 was in fact very similar to the preferred option in the consultation document except that it reinvested all of the resource released back into Maryport.

The assessment of the Wigton / Solway proposals found that:

- there was a strong recognition of the positive and constructive engagement in producing this proposal by the GPs, League of Friends and local community in the Solway.
- both Wigton Hospital and the local care home in Wigton operate out of old buildings. The population is super-ageing.
- the geography is challenging with long travel times, which means that the costs of multiple daily home visits could exceed that of residential care, which needs to be given careful consideration.
An innovative integrated model, built on a residential home platform but with a small number of step-up / step-down beds supported by an enhanced community clinical team, is considered a strong option requiring further exploration.

The assessment of the Alston proposals found that:

- the engagement of the community and local practice in this work has been extremely positive and constructive
- the conversation has moved from community hospital beds in Alston to finding a sustainable, affordable health and care model for the most remote town in England
- the principle of a single bed base between health and social care with a single integrated team was strongly supported but it was recognised that further detailed discussion with Cumbria County Council would be needed if this idea was to be progressed.

The programme concluded that the current very small, isolated medical ward in Alston posed significant operational risks, especially around safe staffing levels and medical cover making it vulnerable to sudden staff sickness. This requires the implementation of a new model as quickly as possible.

### 9.3 Recommendation for the community hospital bed base

Below is a summary consideration of the four assessment domains in relation to the recommended option:

- there will be no adverse impact on health outcomes at a population level
- there will be an overall improvement in clinical quality, workforce sustainability and the achievement of clinical standards. The key risks and mitigations have also been identified.
- the option is deliverable, though there is more work required on each of the complementary proposals for each of Alston, Maryport and Wigton, including in relation to investment and joint working with other partner organisations
- there is a financial benefit in reducing the community hospital inpatient bed base and increased chance of delivery of the Integrated Care Community concept which is linked to the delivery of efficiencies in the Pre-Consultation Business Case

**Recommendation 4.1:** The Governing Body is requested to approve Option 1 for implementation.
This option includes the consolidation of inpatient Community Hospital beds into six sites. In total there would be 104 inpatient beds at Whitehaven (Copeland Unit), Cockermouth, Workington, Penrith, Brampton and Keswick.

The Governing Body is requested to **endorse** the following actions:

- A process of co-production with stakeholders in each of Maryport, Wigton and Alston should continue. It is anticipated that co-production will lead to further proposals within the next twelve months, as part of the plans to implement Integrated Care Communities. Any such proposal will require further consideration and approval by the NHS Cumbria Clinical Commissioning Group Governing Body and the broader West, North and East System Leadership Board prior to implementation.

### 10. Emergency and acute services

The options that were included in the public consultation are shown in figure 12:

<table>
<thead>
<tr>
<th></th>
<th>Option 1</th>
<th>Option 2</th>
<th>Option 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CIC</td>
<td>WCH</td>
<td>CIC</td>
</tr>
<tr>
<td>24/7 Accident and Emergency</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Daytime Only Accident and Emergency</td>
<td>✗</td>
<td>✗</td>
<td>✓</td>
</tr>
<tr>
<td>24/7 urgent care centre</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Very complex medical services</td>
<td>✓</td>
<td>✗</td>
<td>✓</td>
</tr>
<tr>
<td>Emergency care for less complex cases</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Assessment and rehabilitation for frail elderly</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Step-up beds for the frail elderly</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Outpatient care</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

Figure 12: Emergency and acute service options
10.1 Specific findings of the public consultation in relation to emergency and acute services

The independent analysis of the public consultation found that only 46% of respondents to the questionnaire indicated a first preference against one of the consulted on options. A significant number of the remaining 54% of respondents did not support any of the options. There was strong support for Option 1 over the other two options put forward (figure 13) amongst the 46% of respondents indicating a first preference.

![Figure 13: Preferences in the consultation response for the emergency and acute services](image)

<table>
<thead>
<tr>
<th>Emergency and acute options</th>
<th>First preference</th>
<th>Second preference</th>
<th>Third preference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Option 1</td>
<td>95%</td>
<td>3%</td>
<td>3%</td>
</tr>
<tr>
<td>Option 2</td>
<td>3%</td>
<td>93%</td>
<td>4%</td>
</tr>
<tr>
<td>Option 3</td>
<td>2%</td>
<td>4%</td>
<td>94%</td>
</tr>
<tr>
<td>Total responses by preference</td>
<td>1709 (100%)</td>
<td>1145 (100%)</td>
<td>1123 (100%)</td>
</tr>
</tbody>
</table>

This preference was consistent across age, gender and localities, but strongest support for Option 1 came from respondents in Copeland and Allerdale.

A large number of respondents reject all 3 options, based on keeping a full service at West Cumberland Hospital and patient safety concerns for intensive care transfers to Cumberland Infirmary Carlisle.

The consultation also heard from the public that:

- there was concern about access to ‘Golden Hour’ interventions
- there is recognition of staffing issues, but viewed as a symptom of uncertainty and low morale, not intractable structural challenges
- there is a strong public expectation that there must be a full risk analysis
- that a full Intensive Therapy Unit bed retained at West Cumberland Hospital

There were numerous responses from organisations, clinicians and professional bodies. The predominant themes were that:

- there is need for ongoing public and clinical engagement and for adherence to national policy/clinical guidelines
- there was a mixed response from professional bodies on sustainability
• “a composite workforce does not support effective medical staff training”
• local clinicians had mixed views, including view that alternative proposals for West Cumberland Hospital were not expressed

Responses from other NHS organisations (North Cumbria University Hospitals NHS Trust, Newcastle Upon Tyne Hospitals NHS Foundation Trust and Northumbria Healthcare NHS Foundation Trust) showed support for Option 1.

The North West Ambulance Service raised concern about transfers, impact on overall performance, and need for clear protocols / mitigations. North West Ambulance Service has subsequently confirmed the deliverability of the options, but in the context of the additional capacity that will be required.

In the review of all of the consultation feedback specifically referring to Acute and Emergency Services there was a suggestion that there should be greater efforts to recruit medical staff and retain all categories of patients at West Cumberland Hospital.
10.2 Overall consideration of the options

The consultation document outlined clearly why maintaining the status quo was not put forward as an option. These reasons were:

- Providing care across two sites stretches available staffing and is expensive, particularly because it requires more doctors to run two sets of emergency rotas.
- Small teams and low volumes of activity on each site make roles less attractive and skills difficult to maintain.
- There are also difficulties providing the right sort of supervision and training for junior staff. The challenges are made more difficult by the fact that health regulation, professional standards and the expectations of the Royal Colleges are becoming more exacting.
- There are workforce gaps on both sites in Accident and Emergency and emergency medicine (40% staff vacancies in total) but these are most severe at West Cumberland Hospital.
- Currently the middle tier of acute medicine doctors working overnight are all locums and just three of the 11 consultants posts are filled by permanent staff.
- The geographical location of West, North and East Cumbria is a challenge to recruitment and retention, as is professional isolation. Health Education North East forecasts that the current recruitment issues are likely to continue into the future.
- In 2015 the Care Quality Commission judged general medical services at West Cumberland Hospital to be inadequate. This was largely due to the workforce difficulties, and the lack of a plan to address the challenges.
- The hospitals in West, North and East Cumbria are facing rising levels of activity. Accident and Emergency attendances have risen almost 10% over the past four years and emergency admissions have risen by 20%. In 2014/15, the number of Accident and Emergency attendances resulting in admission was more than 43%; the national average is under 25%.

North Cumbria University Hospitals NHS Trust has made significant progress in improving emergency care both in Carlisle and in Whitehaven. The introduction of assessment by a senior clinician very early after admission and the recruitment of a group of nurse practitioners undertaking roles previously performed by junior doctors has helped, but further change is needed if safe services are to be maintained.

The programme had strong external support in the development of the options for emergency and acute care from the North of England Clinical Senate. In particular the model put forward in the preferred option provides a truly innovative workforce solution to the challenges facing this service.
The preferred model addresses many of the concerns raised during consultation about access, principally because the vast majority of care would continue to be delivered locally.

Concerns were raised that “a composite workforce does not support effective medical staff training”. This is considered to be a matter of clinical versus educational supervision where the competency of the supervisor is more important than their title.

In response to the alternative suggestion put forward during consultation the programme (“greater efforts to recruit medical staff and retain all categories of patients at West Cumberland Hospital”) the programme found that:

- In regards to greater efforts to recruit medical staff, focused efforts to recruit a conventional medical workforce have not met with success. Nationally 44% of acute physician posts remain vacant (Reference - RCP 15/16) and it is unlikely that this situation will improve.
- In regards to the retention of all categories of patient at West Cumberland Hospital (unselected take) - not all medical specialties retain a presence at West Cumberland Hospital.

As such there are significant inherent challenges in recruiting to the service model.

10.3 Recommendation for the emergency and acute services

Below is a summary consideration of the four assessment domains in relation to the recommended option:

- There will be no adverse impact on health outcomes at a population level
- There will be an overall improvement in clinical quality, workforce sustainability and the achievement of clinical standards. The key risks and mitigations have also been identified.
- The model is deliverable
- There is no negative financial impact

Recommendation 5.1: The Governing Body are requested to approve Option 1 for implementation.

This involves a 24/7 A&E at Cumberland Infirmary Carlisle along with acute medical inpatient services, including for the most complex cases. There would be assessment and inpatient beds for the frail elderly, as well as specialist rehabilitation. There would also be a 24/7 A&E at West Cumberland Hospital along with acute medical inpatient services and rehabilitation. There would also be a small intensive care unit but some of the most
seriously ill patients would be transferred to Carlisle if it was felt they would benefit from the extra support available there.

**Note:** This will not change the bed base of the Intensive Care Unit at West Cumberland Hospital. This will also not change the previously implemented high risk pathways including those relating to cardiology and respiratory.

The Governing Body is requested to **endorse** the following actions to be undertaken in order to deliver this proposal:

- Efforts to recruit should be strengthened regardless of the implementation of any new model

## 11 Hyper-acute stroke services

The options that were included in the public consultation were:

- **Option 1** would largely maintain services as they are now but the service would be enhanced by ensuring improved, early supported discharge in both Carlisle and Whitehaven.

- **Option 2** would see all acute stroke cases managed in a single hyper-acute stroke unit based at Cumberland Infirmary Carlisle. Ambulances would take possible stroke patients direct to Carlisle. Patients arriving at West Cumberland Hospital by other means would be transferred by ambulance to Carlisle. On leaving the hyper-acute stroke unit patients resident in West Cumbria would be transferred to acute stroke and rehabilitation facilities at West Cumberland Hospital if further hospital care was needed. As with option 1 this service would be complemented by ensuring improved, early supported discharge in both Carlisle and Whitehaven.

The preferred option outlined in the public consultation document was Hyper-Acute Stroke Option 2

### 11.1 Specific findings of the public consultation in relation to hyper-acute stroke service

The independent analysis of the public consultation found that only 44% of respondents to the questionnaire indicated a first preference against one of the consulted on options. A significant number of the remaining 56% of respondents did not support any of the options.
There was strong support for Option 1 over the other two options put forward (figure 14) amongst the 44% of respondents indicating a first preference.

<table>
<thead>
<tr>
<th>Hyper-acute stroke options</th>
<th>First preference</th>
<th>Second preference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Option 1</td>
<td>68%</td>
<td>38%</td>
</tr>
<tr>
<td>Option 2</td>
<td>32%</td>
<td>62%</td>
</tr>
<tr>
<td>Total responses by preference</td>
<td>1635 (100%)</td>
<td>1216 (100%)</td>
</tr>
</tbody>
</table>

Figure 14: Preferences in the consultation response for the hyper-acute stroke service

There was variation in preference by locality where the first preference was supported by 56% of Carlisle respondents but 42% Eden respondents:

Option 1 was more strongly supported by under 45s (75% as 1st preference) than over 45s (63%).

The responses from the public also included:

- Recognition of the potential benefits of a hyper acute stroke service and delivery of rehabilitation and ongoing care as close to home as possible
- Major concern on access, including significant reference to the ‘Golden Hour’ and loss of timely interventions from a West Cumberland Hospital stroke service
- Strong public meeting expectation that there must be a full risk analysis

There were numerous responses from organisations, clinicians and professional bodies. The predominant themes were that:

- Need for ongoing public and clinical engagement and to adhere to national policy/clinical guidelines
- There was a mixed response from professional bodies on sustainability
- Local clinicians had mixed views, including the view that alternative proposals for West Cumberland Hospital (not do nothing) were not expressed

Responses from other NHS organisations (North Cumbria University Hospitals NHS Trust, Newcastle Upon Tyne Hospitals NHS Foundation Trust and Northumbria Healthcare NHS Foundation Trust) showed formal support for Option 2, the preferred option.

Following the close of the Consultation North West Ambulance Service confirmed the deliverability of the options, but in the context of the additional capacity that will be required.
During the Public Consultation there was support from some stakeholders to maintain clinical capacity at West Cumberland Hospital to undertake initial diagnosis and treatment prior to rapid transfer to Cumberland Infirmary Carlisle. This is sometimes referred to as the ‘drip and ship’ model where the initial receiving hospital undertakes some initial diagnosis and treatment (for example thrombolysis) under specific clinical protocols.

11.2 Overall consideration of the options

Despite great strides in improving stroke services in West, North and East Cumbria in recent years, they are still not as good as they should be. The care of stroke inpatients in both Whitehaven and Carlisle is provided in clinical areas that are not dedicated to stroke, the service operates for just five days a week and it has proved very difficult to recruit more stroke specialists to extend the available service. Transient Ischaemic Attack (TIAs - sometimes known as mini-strokes and a good predictor of full strokes) services are also not available on a 7-day a week basis.

By 2020/21 the challenge will be even greater than it is now. It is estimated that the number of local stroke cases will have increased from an annual figure of approximately 600 admissions to more than 700.

Stroke services are measured against a set of national quality standards (using the SSNAP audit) which are not being currently met. Largely this is because the service cannot recruit enough stroke specialists and is not able to offer those who may be available the opportunity to work in a dedicated stroke facilities with full service seven days a week.

As a consequence of these factors, remaining with the status quo was discounted as an option during the option appraisal process.

As outlined in the public consultation document, a sustainable hyper-acute stroke service is far more likely to be achieved if we concentrate our resources for stroke assessment and treatment on one site rather than spreading them across two.

This view was supported by an independent clinical review led by Professor Tony Rudd, National Clinical Director for Stroke, and involving members of the Northern England Strategic Clinical Network.

Whilst the analysis of the consultation process showed that there was support for the concept of the single hyper-acute site there were concerns about the risk surrounding access for patients living further away from the Cumberland Infirmary Carlisle site.
Also during the consultation, questions were raised about why the “Drip and Ship” model was not put forward as an option during the consultation. The programme has assessed the “Drip and Ship” model and found the following:

- Very few examples of this model being used successfully in other parts of the country
- The model would see low numbers of patients treated and therefore clinicians will not be able to maintain their clinical competency
- External clinical advice recommended that introducing mixed models for stroke should be avoided and focus be placed on the evidence based Hyper-acute Stroke Unit model. The Northern England Clinical Senate gave the clear view that “The worst possible pathway would be admission to one hospital Accident and Emergency followed by transfer to a second hospital Accident and Emergency”
- There is a greater clinical gain from immediate transfer to a Hyper-acute Stroke Unit therefore any intermediate intervention slows this down
- The ‘Drip and Ship’ model does not contribute to the wider clinical sustainability of West, North and East Cumbria.

The evidence suggests that creation of a single hyper-acute stroke unit would benefit all patients who were admitted to it (including those travelling the longer distances).

One of the key themes received during the public consultation was concerns around the introduction of Option 2 and the impact this would have on access (particularly the “Golden Hour”).

The key measure in terms of access for stroke is not the “Golden Hour”. For high quality stroke care, thrombolysis for those patients who require it should be within 3 – 4 hours. This standard would be deliverable in terms of travel time for all parts of West, North and East Cumbria (assuming a travel time from Seascale to Cumberland Infirmary Carlisle max of 1 hour and 40 mins).

11.3 Recommendation for the hyper-acute stroke services

Below is a summary consideration of the four assessment domains in relation to the recommended option:

- There will be no adverse impact on health outcomes at a population level
• There will be an overall improvement in clinical quality, workforce sustainability and the achievement of clinical standards. The key risks and mitigations have also been identified.
• The model is deliverable
• There is no negative financial impact

Recommendation 6.1: The Governing Body are requested to approve Option 2 for implementation.

This would see all acute stroke cases managed in a single hyper-acute stroke unit based at Cumberland Infirmary Carlisle. Ambulances would take possible stroke patients direct to Carlisle. Patients arriving at West Cumberland Hospital by other means would be transferred by ambulance to Carlisle. On leaving the hyper-acute stroke unit patients resident in West Cumbria would be transferred to acute stroke and rehabilitation facilities at West Cumberland Hospital if further hospital care was needed. This service would be complemented by ensuring improved, early supported discharge in both Carlisle and Whitehaven.

The Governing Body is requested to endorse the following actions to be undertaken in order to deliver this proposal:

• That the development of a 7-day Transient Ischaemic Attack service be considered part of the development of the hyper-acute stroke unit
• That the focus on the recruitment of stroke physicians continues regardless of the decision made

11.4 Implementation considerations

The following issues have been identified through the public consultation or ongoing discussion with staff and clinicians as part of the programme. These issues do not affect the ability of the Governing Body to make a decision but will require consideration during the implementation phase:

• Co-production was a significant part of the development of the Hyper-Acute Stroke Unit model. The Stroke Association were represented on the Hyper-Acute Stroke Unit planning group and there was involvement of previous service users / carers / advocacy groups. It is recommended that this approach continues into the implementation phase.
• That a second Computerised Tomography (CT) scanner be purchased and potentially sited to allow for direct access onto the hyper-acute stroke unit

• That the ongoing development of the Centre of Excellence for Rural Health concept at the West Cumberland Hospital includes scenario planning for future service delivery opportunities once the hyper-acute stroke service model is fully established
12. Emergency surgery, trauma and orthopaedic services

The proposal consulted upon was that the arrangements previously made for general surgery and trauma and orthopaedics on safety grounds last year are now made permanent but with some further changes which allow additional emergency surgery and trauma care to take place at West Cumberland Hospital.

Specifically the proposals are:

- Additional minor trauma surgery will take place on some days each week at West Cumberland Hospital with any displaced planned surgery being managed in an additional weekly list at West Cumberland Hospital

- Some non-complex day case general surgery is returned to West Cumberland Hospital including key-hole gall bladder operations, surgical treatment of abscesses, and investigation of abdominal pain (with keyhole procedure if necessary)

- Single ‘Professional Point of Access’ communication arrangements are used to allow the referrer (often the patient’s GP) to discuss directly with the hospital based surgeon the best place to see and assess individual patients

- Additional outpatient fracture clinics at West Cumberland Hospital.

12.1 Specific findings of the public consultation in relation to emergency surgery, trauma and orthopaedics

This service was described in terms of a proposal (rather than a series of options) in the consultation document. The main feedback in relation to these services was:

- Concerns about patient safety from transfers to Cumberland Infirmary Carlisle
- Strong support for retention of services at West Cumberland Hospital, and returning interventions temporarily delivered at Cumberland Infirmary Carlisle
- Repeated reference to the new estate at West Cumberland Hospital meaning more surgery should take place there
- Some support for the proposal in terms of staffing issues, and a small (Carlisle centric) support for more centralisation of surgery at Cumberland Infirmary Carlisle

In the detailed review of all of the consultation feedback specifically referring to emergency surgery, trauma and orthopaedic services by the programme team, an alternative model was put forward that differed from the proposal in the public consultation document. This
was for 24 hour emergency care (for everything but major trauma) with Consultant-led care 8am – 8pm every day for medicine, surgery, trauma and orthopaedics and Gynaecology provision at West Cumberland Hospital. Consideration of this model is outlined alongside the models put forward for consultation in the following section.

12.2 Overall consideration of the options

We do not believe that reverting to the model of emergency surgery and trauma at West Cumberland Hospital in place prior to any of the changes made is a viable option. The former model is unsustainable in terms of staffing, and the care it would be able to deliver would not be of the standard acceptable to regulators and clinicians in terms of safety and quality.

Whilst there is a clear clinical consensus that the substantiation of the interim changes is the best approach, the public consultation did receive strong support for retention of services at West Cumberland Hospital and returning the interventions temporarily delivered at Cumberland Infirmary Carlisle.

During consultation a suggestion was made for an option that was not put forward for consultation. This was for 24 hour emergency care (for everything but major trauma) with Consultant-led care 8am – 8pm every day for medicine, surgery, trauma and orthopaedics and Gynaecology provision at West Cumberland Hospital.

On review of the model put forward, the key issues would be the:

- ability to recruit and retain two skilled surgical teams on two sites
- volumes of clinical activity to retain skill base
- viability and sustainability of running full spectrum surgical services on two sites
- lower levels of clinical quality and outcomes

Evaluation of the alternative model proposed found the following:

- Previously West Cumberland Hospital trauma and orthopaedics service never achieved best practice tariff (a marker of high quality care) for any patients with fracture neck of femur, had a 30 day mortality rate of 9%, and ulcer rates of 3 to 6%
- Performance data since transfer (data until Dec 2016) show a sustained improvement in outcome. Best practice tariff is achieved in 60% cases (see figure 16 below), 30 day mortality 6.2% (national 6.2%), ulcer rates 2% (national 2.7%), and time to surgery 32 hours (national 32 hours)
• Years of trying to reinvigorate the local service running up to 2013 failed to achieve this quality of service

As the majority of the proposals have already been working in practice on an interim basis, we have some data by which to evaluate their impact.

The current model has been reviewed and shows that:

• Evidence shows that high risk patient pathway transfers (West Cumberland Hospital to Cumberland Infirmary Carlisle) have saved lives and improved outcomes in patients suffering orthopaedic trauma, emergency surgery, heart disease and intestinal bleeds.

• Fractured hip surgery - Based on a transfer of all cases to Cumberland Infirmary Carlisle from 2013/14, the standard of care achieved now matches the rest of England.

• Orthopaedic trauma - Deaths have reduced from 33 in 2013 to 21 in 2016 for residents of West Cumbria post codes, though there has been a rise since 2014 (figure 15 below)

• Emergency Surgery - Deaths for patients with West Cumbria post codes have reduced from 42 in 2012 to 28 in 2016, again with a slight increase from 2014 (figure 17)

• Emergency General Surgery Admission Deaths – for patients with a West Cumbria post codes since have reduced from 99 in 2012 to 71 in 2016 (figure 18).

Figure 15: Orthopaedic trauma deaths by West Cumbria postcode

Source: DWM – Admissions & Discharges
Figure 16: Best Practice Tariff Achieved In Broken Hip Surgery
As outlined in the public consultation document some patients will continue to have to go directly to Cumberland Infirmary Carlisle or be transferred there from West Cumberland Hospital. There were concerns raised during the public consultation about patient safety from transfers to Cumberland Infirmary Carlisle.
We have reviewed the patient transfers from West Cumberland Hospital to Cumberland Infirmary Carlisle and found that the increase in patient transfers (West Cumberland Hospital to Cumberland Infirmary Carlisle) actually began in 2012/13 (figure 19).

The proposal would save the NHS nearly £500,000 a year through savings on temporary staff. This would be offset by a small cost of about £65,000 per year relating to the additional surgical list each week.
12.3 Recommendation for emergency surgery and trauma and orthopaedics

Below is a summary consideration of the four assessment domains in relation to the recommended option:

- There will be no adverse impact on health outcomes at a population level
- There will be an overall improvement in clinical quality, workforce sustainability and the achievement of clinical standards. The key risks and mitigations have also been identified.
- The model is deliverable
- There is a small financial saving

Recommendation 7.1: The Governing Body are requested to approve the proposal set out in the Public Consultation document for implementation.
### 13. Final decision-making considerations

The table below shows a summary of the options recommended in this paper:

<table>
<thead>
<tr>
<th>Sector</th>
<th>Service</th>
<th>Recommended option</th>
<th>Site impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Hospital</td>
<td>Maternity Services</td>
<td>Option 1 implemented to test deliverability / sustainability</td>
<td>No change, unless Option 1 is not sustainable.</td>
</tr>
<tr>
<td></td>
<td>Children’s Services</td>
<td>Option 1</td>
<td>Higher number of admissions for higher acuity children at Cumberland Infirmary Carlisle</td>
</tr>
<tr>
<td></td>
<td>Acute and Emergency</td>
<td>Option 1</td>
<td>No change on sites, but new workforce model</td>
</tr>
<tr>
<td></td>
<td>Hyper-acute Stroke</td>
<td>Option 2</td>
<td>Creation of Hyper-acute Stroke Unit in Cumberland Infirmary Carlisle</td>
</tr>
<tr>
<td></td>
<td>Emergency Surgery, trauma and orthopaedic services</td>
<td>Support proposal</td>
<td>More specialist procedures carried out in Cumberland Infirmary Carlisle and minor trauma returning to West Cumberland Hospital</td>
</tr>
<tr>
<td>Community Hospital</td>
<td>Community inpatient beds</td>
<td>Option 1 (but with co-production on site-by-site basis)</td>
<td>Reduced bed base but better service model offer</td>
</tr>
</tbody>
</table>
As each decision is taken in isolation for each service, an assessment needs to be made by the Governing Body as to the ability to deliver and implement the recommendations as a group. This assessment will need to be based on the following:

- The consideration of interdependencies between the services that will be changed by the decisions made to see if they are mutually supportive
- The combined impact of the decisions on the ability to deliver the vision and meet the main challenges facing West, North and East as described in the Clinical Strategy and Pre-Consultation Business Case.

As outlined in the public consultation document, the main service areas subject to decision-making which are clinically dependent on each other are maternity services and children’s services.

The matrix below (figure 20) shows which of the maternity and children’s in-patient options are mutually supportive.

![Maternity services options matrix](image)

Figure 20: Cross-check of maternity and paediatric options

Following decision making by the Governing Body, the following pieces of work need to be completed prior to implementation:

- The completion of the assessment of the physical capacity and estate implications for the service configuration that reflects the final decisions made
• The completion of the assessment of the impact on activity flows across West, North and East Cumbria that would be the result of the final decisions made
• The completion of the assessment of the combined impact of the decisions on the impact on capacity and performance of the North West Ambulance Service that would be the result of the implementation of the final decisions made
• The completion of the transport plan that takes into account the findings of the travel impact assessments for acute hospitals, community hospitals and Integrated Care Communities and Equality Impact Assessment (especially in relation to areas with low car ownership) that reflects the final decisions made

Ensuring compliance of the “Four Tests” for service change

Throughout the service reconfiguration process, clinical commissioning groups are required to mind the “Four Tests” for service change set out by (then) Secretary of State for Health Andrew Lansley. The Four Tests are:

• a robust clinical case,
• strong patient and public engagement,
• consistency with choice and competition, and
• GP commissioner support

The table below outlines to the Governing Body how the Success Regime and clinical commissioning group have ensured that the Four Tests for service change have been met throughout this process.

<table>
<thead>
<tr>
<th>Test</th>
<th>Evidence of consideration of Test pre-consultation</th>
<th>Evidence of consideration of Test post-consultation / decision-making</th>
</tr>
</thead>
</table>
| 1. Robust clinical case                   | • West, North and East Cumbria Clinical Strategy developed and published in March 2016  
• Pre-consultation Business Case clearly outlines the case for clinical change  
• Use of external clinical experts through the process to give both independent advice and formal clinical assurance | • Clinical Strategy (CQC report)  
• PCBC (Section 2 Why we need to change)  
• Further independent expert opinion from professional bodies and NHS Organisations |
<table>
<thead>
<tr>
<th>Test</th>
<th>Evidence of consideration of Test pre-consultation</th>
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</tr>
</thead>
</table>
| 2. Strong patient and public engagement | • Long standing engagement activities (pre-Success Regime) on issues included in the Pre-Consultation Business Case for example, the maternity review extensive engagement process  
• Wide-ranging programme of engagement across West, North and East Cumbria involving HealthWatch as outlined in the Pre-Consultation Business Case that informed option development and assessment | • Full Public Consultation exercise carried out  
• Independent consultation process assurance provided by the Consultation Institute  
• Independent analysis of the findings of the public consultation by The Campaign Company  
• Incorporation of analysis by the Campaign Company into the recommendation to support decision-making  
• Commitment to ‘co-production’ for significant elements of the service changes recommended |
| 3. Consistency with choice and competition | • Legal advice has been sought from the outset on choice and competition. Due to the unique geography, Cumbria already has a large monopoly acute provider (as well as a large monopoly provider for community and mental health)  
• Some options for maternity services increase the choice of type of maternity care available (within the same provider)  
• The wider Integrated Care Community strategy in the Pre-Consultation Business Case will widen choice for out-of-hospital service options (within the same provider)  
• Patient choice will be maintained as patients will still be able to exercise their right to access services outside of the area. | • As at Pre-Consultation Business Case Stage |
| 4. GP commissioner support | • Engagement meetings and ongoing dialogue with GP commissioner has taken place throughout the pre-consultation process.  
• The clinical commissioning group governing body approved the Pre-Consultation Business Case and the Public Consultation strategy and documentation | • Local GPs have a number of concerns that have taken into consideration when preparing the Decision making report  
• It is recognised that there is some opposition to the proposals put forward for consultation. The Recommendations before the Governing Body have taken those concerns fully into account particularly in the areas of paediatrics and maternity. The |
<table>
<thead>
<tr>
<th>Test</th>
<th>Evidence of consideration of Test pre-consultation</th>
<th>Evidence of consideration of Test post-consultation / decision-making</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Governing Body will make the decision based on the service change options in line with the NHS Cumbria Clinical Commissioning Group Constitution</td>
</tr>
</tbody>
</table>
14. Implementation considerations

In early 2016 as part of the NHS England national planning process, the West, North and East Cumbria area was recognised as a Sustainability and Transformation Plan area in its own right.

The role of Sustainability and Transformation Plan areas is to co-ordinate the transformation of health services to address the three gaps (health and wellbeing, care and quality and finance and efficiency) identified in the NHS England Five Year Forward View. In October 2016 the transitional governance arrangements for the Sustainability and Transformation Plan became the mechanism for overseeing the development of the Success Regime programme proposals.

The System Leadership Board for West, North and East Cumbria (representing all of the NHS bodies, the County Council and Healthwatch Cumbria) is chaired by the Success Regime Independent Chair and co-chaired by the STP Chief Officer. The board makes recommendations to statutory organisations represented on the Board, each of which will then take the decision formally.

Figure 21 depicts the new governance arrangements following the introduction of the Sustainability and Transformation Plan area under a new System Leadership Board that will oversee the implementation of the decisions made by the Clinical Commissioning Group Governing Body.

![Figure 21: Sustainability and Transformation Plan Governance arrangements](image)
The implementation programme will be clinically-led and will involve clinical professions from all backgrounds and organisations. The programme will be built on a principle of co-production. Patients, carers and members of the public will be invited to participate in the transition and implementation planning and will be included as key members of the Implementation Reference Group (outlined below), which will include an independent Chair.

The “Our Infrastructure” group includes sub-groups responsible for the detailed planning on transport and estates and facilities work as mentioned in section 13.

A System Dashboard will be maintained throughout the implementation phase of the programme, reporting key success measures to the System Leadership Board on a monthly basis. Programme risk and issue management will continue to be in place to ensure risks to delivery are managed and escalated appropriately within the agreed governance framework.

As part of the implementation process, it is recommended that the clinical commissioning group establish an independent Implementation Reference Group to feedback on the implementation process.

A key part of the implementation process will be to continuously review and update the equality impact assessments, and to seek to reduce inequalities. We will develop an action plan to take this forward.

**Recommendations for Implementation**

A range of recommendations and issues to consider regarding implementation have been set out in each of the preceding chapters. Additionally, the following recommendation is made.

**Recommendation 8.1:** The Governing Body is requested to approve the formation of an Implementation Reference Group to feedback on the implementation process. The membership of this group will be agreed in discussion with patient and the public representative groups, stakeholders and partners but would include representation from the clinical commissioning group including the Lay Member Lead for Patient Engagement and the Medical Director.

This group may wish to use a sub-group structure around each of the main areas of change (i.e. maternity and paediatrics, acute and emergency care and community hospitals).
15. Next steps for the decision-making process

Following the Governing Body meeting, NHS Cumbria Clinical Commissioning Group will formally write to the Cumbria Health Scrutiny Committee to inform them of each decision made.

The Cumbria Health Scrutiny Committee will then review these decisions and choose whether or not to give feedback to the Governing Body on them.

Once the position of the Cumbria Health Scrutiny Committee is known and any feedback received, NHS Cumbria Clinical Commissioning Group will work through the Sustainability and Transformation Plan governance mechanism to prepare any required full business case(s) to be considered by NHS England and/or NHS Improvement.

Working in partnership through the Sustainability and Transformation Plan governance mechanisms NHS Cumbria Clinical Commissioning Group will also develop a full implementation and delivery plan to enact the decisions made, including practicable mitigations to any reasonable risks identified during the Public Consultation and from the impact assessments set out in the Appendices.
16. List of appendices

- Appendix 1 – Equality Impact Assessment
- Appendix 2 – Health impact assessment
- Appendix 3a – Travel impact assessment – Acute Hospitals
- Appendix 3b – Travel impact assessment – Community Hospitals
- Appendix 3c - Travel impact assessment – Integrated Care Committees
- Appendix 4 – Rural proofing
- Appendix 5 – Approach to risk assessment
- Appendix 6 – The Campaign Company Independent Consultation Response Analysis
- Appendix 7 - Greater Manchester, Lancashire and South Cumbria Clinical Senate Update Report
- Appendix 8 - Letter from Northern England Maternity Clinical Network
- Appendix 9 – Deliverability statements from each NHS Provider Trust