FOR INFORMATION

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COUNTY COUNCIL

Cumbria Health & Wellbeing Scrutiny Committee

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March 2005
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Mrs Maggie Mooney (Acting Chief Executive)
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Dear Madam

Acute Health Services in the North Cumbria area

The Cumbria Health & Wellbeing Scrutiny Committee has completed its examination of the NHS consultation on the future of Acute Health Services in North Cumbria.

I attach for you information a copy of the report.

Yours sincerely

Doug Scott

Doug Scott
Health Scrutiny Manager

NHS Consultation on the Future of Acute Health Services in North Cumbria

Scrutiny Examination of the NHS Proposals

COUNTY COUNCIL

Cumbria Health and Well-being Scrutiny Committee

NHS Consultation on the Future of Acute Health Services in North Cumbria

Scrutiny Examination of the NHS Proposals

Members of the Committee:

Mrs A. Burns (Cumbria County Council)
Mrs A. Bradshaw (Copeland Borough Council) [from January 2005] *
Mrs S. Brown (Cumbria County Council)*
Mr J. P. Farmer (Cumbria County Council) (Chair) * °
Mr D. Fairbairn (Cumbria County Council) *
Mr J. Garnett (Barrow Borough Council)
Mr J. D. Jefferson (Cumbria County Council) *
Mrs J Jenkinson (South Lakeland District Council)
Mrs J Johnston (Copeland Borough Council) [to December 2004]
Mrs E Langan (Eden District Council) *
Mr S. A. J. Leyton (Cumbria County Council) * °
Mrs J. Prest (Carlisle City Council) (Deputy Chair) * °
Mr D. Southward (Cumbria County Council) *
Mr D. Wilson (Allerdale Borough Council) *

* Members of the Scrutiny Task Group on the Future of Acute Health Services in North Cumbria
° Lead Members for the Scrutiny

All members of the Committee are elected Councillors who are members of either Cumbria County Council or a District Council in Cumbria.

Officer Support:
Mr D. Scott, Health Scrutiny Manager

28 February 2005.

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Appendices

1. EXECUTIVE SUMMARY

1.1. This report concerns proposals by the North Cumbria Primary Care Trusts on the future of acute health services in North Cumbria. The Cumbria Health and Well-being Scrutiny Committee has carried out a scrutiny examination of the proposals as part of the statutory duty of the NHS to consult with local authority health scrutiny committees on plans to substantially develop or vary health services.

1.2. The key elements of the NHS package of strategic proposals, which would be implemented over a 3 to 5 year period are:

- Two acute hospitals in North Cumbria, both providing emergency services and each with an Intensive Therapy Unit.
- GP Treatment Centres adjacent to the two Accident and Emergency Units
- A new acute hospital for West Cumbria, replacing the existing West Cumberland Hospital
- A new Diagnostic and Treatment Centre for planned operations and investigations.
- Complex surgery to be based at the Cumberland Infirmary.
- Specialist rehabilitation to be more community-based
- Services for people with long term conditions to be more community-based

1.3. The Committee, through a range of initiatives, has briefed itself on the proposed changes and the need for them, considered the public response to them, and looked more closely at the specific concerns raised by sectors of the public. The Committee has also looked at the way the NHS has consulted with patients, the public, staff and other stakeholders.

1.4. The Committee has concluded that all the NHS proposals should be supported, provided the conditions and matters of clarification referred to in this report can be met. The full set of the Committee's conclusions, and its recommendations, are set out in Section 2 of this report.

1.5. The Committee has observed many positive features of the consultation process but also certain weaknesses. It reserves its overall view on the consultation process until it has received feedback on the NHS's decisions following the consultation.

1.6. Whilst understanding the concerns expressed by members of the public about separating out the consultation on acute and community services, the Committee particularly wishes to highlight:

- Its support for the NHS approach of consulting on service provision before planning the location and content of particular buildings;
- The widespread public perception that the resources are not available in North Cumbria to deliver the whole of the modernisation strategy, and that it would be the community services that would suffer if the commitment were given to proceed with the acute sector developments before the resources needed for the community services were adequately assessed and identified;
- The need, in the light of this risk, for both the public and the Committee to have the opportunity to assess the acute and community service plans side by

side before a final commitment is made to the business cases for the acute sector developments.

2. CONCLUSIONS AND RECOMMENDATIONS

2.1. In this section of the Report, the Committee's recommendations are highlighted in italics. The majority of the recommendations are addressed to the North Cumbria Primary Care Trusts, with some recommendations to the North Cumbria Acute Hospitals NHS Trust and the Cumbria and Lancashire Strategic Health Authority, as indicated. The detail explaining the conclusions and recommendations is contained in Sections 5 and 6 of this report.

The proposals for there to be two Acute Hospitals with 24-hour emergency access, each with an Intensive Treatment Unit

2.2. The Committee considers that the proposal to have two acute hospitals in North Cumbria, each with an ITU, should be supported.

The proposal for a new hospital in West Cumbria to replace the existing West Cumberland Hospital

2.3. The Committee supports that there should be either a new hospital in West Cumbria or a major refurbishment of the existing West Cumberland Hospital to the same specification as for a new hospital. The Committee also supports the approach being taken by the NHS to reach agreement on the services provided for the people of West Cumbria before looking at the detail of hospital design and location.

2.4 The Committee welcomes the statement from the NHS that reductions in bed numbers for older people are not envisaged, although there may be a shift in the use of beds between acute and community.

2.5. The North Cumbria Primary Care Trusts should make the following commitments regarding public consultation on the specific proposal for the new hospital:

1. *That a "refurbishment of the existing hospital" will be included as one of the options to be assessed and discussed in the consultation*
2. *That the development of a new hospital on or adjacent to the existing West Cumberland Hospital site will be included as one of the options to be assessed and covered in the consultation;*
3. *That clear information will be shared with the public about the costs and benefits of the options considered.*

The proposal for GP Treatment Centres to be located next to A&E Facilities

2.6. The Committee has concluded that the concept of GP Treatment Centres being located next to A&E facilities in the two acute hospitals should be supported.

2.7. The North Cumbria Primary Care Trusts should clarify that the two GP Treatment Centres referred to in the consultation will be planned as part of a wider network of GP Treatment Centres located to ensure rapid access to primary care emergency services across North Cumbria; and also that the communication links

with A&E and other emergency services will be available for all GP Treatment Centres, including any not on an acute hospital site.

The proposal to locate complex surgery at the Cumberland Infirmary

2.8. The Committee supports the principle that *minimal-volume* complex work should be concentrated in Carlisle on the grounds of the need for high clinical standards of care and patient safety and Carlisle's greater proximity to tertiary centres.

2.9. The North Cumbria Primary Care Trusts should confirm both to the Committee and to the general public the reasons underlying their policy to concentrate complex surgery in Carlisle, and also to confirm that the proposal refers to minimal volume procedures.

2.10. The North Cumbria Primary Care Trusts should confirm, for the sake of clarity, that if in the future it is intended to transfer services between the two hospitals other than for minimal-volume complex surgery, such proposals would be the subject of public consultation.

2.11. The Committee supports the NHS's intention to make design improvements at the Cumberland Infirmary.

The Proposal for a Diagnostic and Treatment Centre

2.12. The Committee considers that the concept of a Diagnostic and Treatment Centre for North Cumbria, as set out in the Department of Health Guide on Treatment Centres, should be supported provided the issues listed in the following paragraph are addressed.

2.13. The North Cumbria Primary Care Trusts should confirm that the public consultation on the Diagnostic and Treatment Centre will specifically:

- *Include quantified information about the merits of alternative locations;*
- *Include a "two-site option" as one of the options to be appraised and discussed in the consultation;*
- *Demonstrate that the proposal is not about a wholesale shift of day surgery from the existing hospitals;*
- *Cover implications for access to and from the Diagnostic and Treatment Centre, including arrangements for ambulance and other transport, and for nearby overnight stay facilities.*

The proposals to transfer more care for people with long term conditions and more rehabilitation into community settings

2.14. The Committee notes and welcomes the NHS commitment to consult on plans for community services.

2.15. The NHS commitment to consult on plans for community services is noted and welcomed. The Committee considers that the proposed shift into community settings of care for people with long term conditions and of rehabilitation services should be supported, provided the issues listed in the following paragraphs are addressed.

2.16 The North Cumbria Primary Care Trusts should consult with the public and the Committee on their costed Community Strategy and demonstrate its affordability to the public and the Committee before they finalise their Business Cases for the acute sector developments. This should be done in a way which will allow the Committee to assess the acute and community proposals side by side.

2.17 As part of the community strategy, the North Cumbria Primary Care Trusts should clearly and urgently address the scale and phasing of the changes from acute to community settings of care. They should also seek to achieve equity of access to services between areas with community hospitals and those without. This work should take into account consideration of the availability and charging arrangements of residential and nursing homes, community hospitals and other community facilities.

2.18. The North Cumbria Primary Care Trusts should confirm that acute specialist rehabilitation should remain acute hospital-based, and that they will consult the public on the specific proposals for a community-based specialist rehabilitation facility – either as part of the community strategy or as a separate consultation.

2.19. The North Cumbria Primary Care Trusts should include a workforce strategy which includes recruitment in their community strategy and demonstrate its robustness.

2.20. The North Cumbria Primary Care Trusts should confirm publicly that carers will be involved in developing the various stages of the Community Strategy, including the locality proposals.

2.21. The North Cumbria Primary Care Trusts should confirm that adequate levels of community service provision will be put in place across both health and social services, backed up by proper communication systems, before the existing hospital capacity is reduced.

The overall package of proposals

2.22 The Committee welcomes the approach being taken by the NHS to plan and consult on the proposals for services before proceeding to plan and consult on the specific location and content of building developments.

2.23. The Committee recognises the conclusions of the Westlakes Consultancy that the assessment of options for acute services had given a sufficiently clear indication of the preferred options. The Committee recognises that the overall package of acute health service developments is based on the preferred options.

2.24. On the *finance* of the overall package, the Committee recognises the measures being taken in the NHS to achieve financial recovery without jeopardising services but retains concerns over the risks that still exist in delivering the strategic changes in the current financial climate.

2.25. The Committee recognises the support being given by the Strategic Health Authority to the NHS in North Cumbria in achieving its financial recovery, and seeks assurances from the Strategic Health Authority that

- *Support will continue to be given to the NHS in North Cumbria with its financial recovery so that it is not prevented from making the necessary investment in new community services*
- *Support will be given through the Workforce Directorate to meet the special retraining needs in North Cumbria to implement the new acute heath services and the community strategy.*

2.26. The North Cumbria Primary Care Trusts should discuss their 3 year recovery strategy for the North Cumbria health economy with the Committee once it has been developed.

2.27. The North Cumbria Primary Care Trusts should incorporate a strategy covering professional and patient communications in their Community Strategy. This should include the communications required to make the assessment arrangements between the NHS (both acute and community) and Social Services, fully effective across the whole of North Cumbria, including its rural areas.

2.28. The North Cumbria Primary Care Trusts and the North Cumbria Acute Hospitals NHS Trust should engage with other partners in exploring the concept of a Health Park for West Cumbria, but be mindful that it should not jeopardise the plans, including timing and location, for developing the new hospital in West Cumbria.

2.29. On the absence of explicit community service proposals in the consultation, the Committee understands the concerns expressed by members of the public. If however the NHS accepts the Committee's recommendations on community services, it gives the NHS the opportunity during 2005 to provide the appropriate reassurances about the future capacity of community services.

2.30.The North Cumbria Primary Care Trusts should give a public commitment to making sufficient alternative provision available in the community before hospital capacity is reduced.

2.31. The North Cumbria Primary Care Trusts are invited to suggest a workable means of engaging with the Committee throughout the implementation period of the acute and community service changes, including the forthcoming public consultations on the community services and acute sector developments.

The NHS Consultation process

2.32. The Committee welcomes the widespread involvement of patients, staff and the public that took place prior to consultation and the wide range of measures being taken to publicise the consultation itself.

2.33. The Committee shares to some extent the concerns listed above about aspects of the consultation, which if avoided might have improved the consultation. It does however recognise that the current consultation marks a stage in the process of

planning for future services, and that the NHS is committed to consultation on the stages that will follow.

2.34. As the consultation process is not complete until the NHS responds to the issues raised, the Committee reserves its final conclusion on the consultation process until it receives feedback on the NHS's decisions on the consultation.

In Particular

2.34. Whilst understanding the concerns expressed by members of the public about separating out the consultation on acute and community services, the Committee particularly wishes to highlight:

- Its support for the NHS approach of consulting on service provision before planning the location and content of particular buildings;
- The widespread public perception that the resources are not available in North Cumbria to deliver the whole of the modernisation strategy, and that it would be the community services that would suffer if the commitment were given to proceed with the acute sector developments before the resources needed for the community services were adequately assessed and identified;
- The need, in the light of this risk, for both the public and the Committee to have the opportunity to assess the acute and community service plans side by side before a final commitment is made to the business cases for the acute sector developments.

3. BACKGROUND

3.1 This report concerns proposals by the North Cumbria Primary Care Trusts on the future of acute health services in North Cumbria. The area covered by the proposals comprises the Districts of Allerdale, Carlisle, Copeland and Eden. The Cumbria Health and Well-being Scrutiny Committee has carried out a scrutiny examination of the proposals as part of the statutory duty of the NHS to consult with local authority health scrutiny committees on plans to substantially develop of vary health services. The Committee, whilst being a Committee of Cumbria County Council, draws its membership from both County and District Councillors from across Cumbria. The Committee works closely with the Patient and Public Involvement Forums (PPIFs) in Cumbria, with PPIF members sitting with the Committee as advisers.

3.2 The formal consultation by the NHS on the proposals follows a period of some 9 months during which the NHS in North Cumbria have been developing proposals with the involvement of user representatives as well as staff interests. Details of the stages of involvement prior to the formal consultation are set out in the NHS Consultation Document (see references in Appendix 1).

3.3 The NHS consultation has been carried out by the three Primary Care Trusts (PCTs) in North Cumbria working together as the commissioners of the acute health services, namely Carlisle and District PCT, Eden Valley PCT and West Cumbria PCT. The consultation period ran from mid November 2004 to the end of February 2005.

3.4 A major part of the pre-consultation stage was an evaluation of four strategic options for change in terms of their impact on a set of standards which had been ranked in importance through a survey of the public, patients, carers, staff and partner organisations. They options were:

- One single acute hospital
- Two acute hospitals, both with Intensive Therapy Units (ITU)
- One acute hospital with an ITU, and one with some emergency services but no ITU
- One acute hospital with an ITU and one minor hospital with limited emergency services and no ITU.

3.5 Details about each option were developed by a set of four working groups. Two options scored favourably, and with very similar scores. These were a single acute hospital for North Cumbria and two acute hospitals, each with ITU.

3.6 The package of proposals on which the consultation has been taking place is a "hybrid" built from elements of both the favoured options. One particular element of the proposals, namely the provision of a Diagnostic and Treatment Centre, was introduced after the option appraisal had been completed.

3.7 The key elements of the NHS package of strategic proposals, which would be implemented over a 3 to 5 year period are:

- Two acute hospitals in North Cumbria, both providing emergency services and each with an ITU.

- GP Treatment Centres adjacent to the two Accident and Emergency Units
- A new acute hospital for West Cumbria, replacing the existing West Cumberland Hospital
- A new Diagnostic and Treatment Centre for planned operations and investigations.
- Complex surgery to be based at the Cumberland Infirmary.
- Specialist rehabilitation to be more community-based
- Services for people with long term conditions to be more community-based

3.8 Based on its discussions prior to the formal consultation, the Committee had expected the NHS consultation to include proposals for community health services. In the event, the consultation has only covered acute health services, with a statement of intention by the NHS to consult on plans for community health services during the summer or autumn of 2005.

3.9 The consultation document is a strategic document proposing a set of major changes to acute health services. Its stated aims are to deliver all the key national targets for 2008 as outlined in the NHS Implementation Plan, in particular a five percent reduction in emergency bed days and an average 9 week wait (18 week maximum) from referral to treatment. It is also aimed at providing sustainable acute healthcare that is affordable.

3.10 The NHS Consultation Document contains very little detailed information. It does however promise further public consultations on the design and location of a Diagnostic and Treatment Centre, on the new hospital for West Cumbria, and on any major changes in community health services.

4. The Committee's Approach to the Scrutiny

4.1 The Committee was informed early in 2004 of the intention of the NHS in North Cumbria to develop a new model of healthcare and to consult on it later in the year.

4.2 At its meeting on 2 March 2004, the Committee appointed Councillors Peter Farmer, Judy Prest and Simon Leyton, to act as its lead members for the anticipated scrutiny of the NHS proposals. These members met with NHS representatives on two occasions to discuss the emerging proposal and in particular the ways the NHS was engaging with patients and the public before and during the consultation. At its meeting on 28 July 2004, the Committee made several recommendations to the NHS about its consultation arrangements, which were accepted. Details are set out in Appendix 2.

4.3 On 10 November 2004, shortly before the consultation document was issued, NHS Directors met the Committee to discuss the consultation process and the expected proposals. The Committee appointed a Task Group comprising all the Committee's members from the area covered in the consultation, to carry out the detailed scrutiny. The Committee invited the Patient and Public Involvement Forums to appoint two of its members, one from the east and one from the west of the area, to sit with the Task Group as advisers. This role was filled by Mrs Meryl Parry and Mrs Anne Glazebrook.

4.4 The approach taken to the scrutiny is summarised below. A schedule of all relevant meetings involving the Committee and its members is in Appendix 3.

Briefing itself on the Proposals

4.5 The full Committee met Mr. Nigel Woodcock, Chief Executive of the North Cumbria Primary Care Trusts, and Ms. Marie Burnham, Chief Executive of the North Cumbria Acute Hospitals NHS Trust, on 7 December 2004, for a wide-ranging discussion on the proposals. Members of the Committee received and discussed the reports from the four working groups which examined the strategic options for change referred to in paragraph 3.4 above. The Committee put supplementary written questions to Mr. Woodcock, and these questions and the written response are attached as Appendix 4.

4.6 Members of the Task Group examined other key documents, including the Department of Health Document "Keeping the NHS Local – a New Direction of Travel" (which sets out current Government policy about acute health services), and Department of Health briefing documents about NHS Treatment Centres.

4.7 Members had planned to arrange one or more visits to "Good Practice" examples of facilities similar to those in the proposals – a Treatment Centre, a hospital similar to that proposed for West Cumbria, and a new-style community rehabilitation facility. Time constraints prevented this, but it is proposed to include visits as part of the Committee's role in association with the subsequent stages of consultation.

Sounding out the Views of Patients and Carers, Stakeholders, and the General Public.

4.8 The Committee made arrangements with the NHS at the start of the consultation to track the NHS consultation through attending public and other meetings, receiving notes of other meetings attended by the NHS, and receiving an analysis of the questionnaire replies returned to the NHS with comments on the proposals. Arrangements were also made within the County Council to receive notes of discussions on the NHS proposals at the Neighbourhood Forums. Details are given in Appendix 5.

4.9 The Committee also carried out its own consultation, through widely distributed leaflets and a web-based survey, asking the public about their awareness of the NHS proposals, any comments or concerns about the proposals, and any comments on the consultation. Over 100 leaflets and 20 letters were received in response. Details of the responses are given in Appendices 6 and 7. Members of the Committee have read all the comments received, and full details have been passed on to the NHS.

4.10 Additionally, the Task Group took soundings of GP views, particularly about what GPs saw as necessary for them to make the proposals work. Members met with a group of members of the Local Medical Committee on 1 February 2005

4.11 Finally, the Task Group made itself available on 16 February 2005 for interested parties to meet the Task Group directly, and on 16 February 2005, met Ms. Burnham and Mr. Woodcock to receive feedback on the NHS consultation and replies to further questions about the proposals. Details of the questions and responses at this and other meetings are given in Appendix 8.

Reaching Conclusions

4.12 In drawing together its conclusions about the proposals, the Committee took particular note of:

- The public support and concerns, taken from all the comments given directly to it in meetings, leaflets and letters and from the comments given to the NHS through public meetings, the NHS survey, and other means reported to the Committee from NHS Executives
- the need for the changes, as justified by the NHS
- the impact of the proposals on the "ten standards" that were ranked in a public survey carried out by the NHS prior to the consultation. The survey results showed fairly similar weightings to all these standards, with "Access and Responsiveness" and "Clinical effectiveness" scoring most highly.
- the robustness of the proposals
- their impact on other services and the wider community

4.13 The Task Group considered its conclusions at the end of its meeting on 16 February 2005. The full Committee met on 24 February 2005 and agreed this report, which has also been checked with the NHS for accuracy.

Thanks

4.14 The Committee wishes to thank all those who assisted with its scrutiny, either through arranging to meet the Committee or Task Group, or through the provision of information.

5. Findings – The NHS Proposals

The Committee's findings are set out below for each of the proposals in the NHS Consultation.

5.1 Two Acute Hospitals with 24-hour emergency access, including Intensive Therapy Units.

5.1.1 The reasons for the population of North Cumbria needing to have two acute hospitals with 24 hour emergency services including an Intensive Therapy Unit (ITU) were not directly spelt out in the Consultation Document. However in meetings with the Committee and in public meetings, Ms Burnham gave her assessment that, given the particular geography of North Cumbria, two acute hospitals were essential on grounds of safety. She commented that road traffic accident figures demonstrated this and confirmed that the consultant body was convinced of this. She explained that an Intensive Therapy Unit was an essential part of full emergency cover.

5.1.2 The replies to the NHS questionnaire and comments made to the Committee showed a very high degree of public support for having two acute hospitals with emergency facilities in North Cumbria.

5.1.3 The principal views against this proposal given to the Committee were based on the argument that a "single acute hospital" model for North Cumbria would be cheaper and allow more resources to be available for community services. This view was reflected in the views of some GPs and other professionals, and scored highly in the option appraisal. However, whilst the NHS Chief Executives accepted that there were additional costs, safety considerations were more important.

The Committee's conclusion

5.1.4 The Committee considers that the proposal to have two acute hospitals in North Cumbria, each with an ITU, should be supported.

5.2 A new Acute Hospital in West Cumbria to replace the existing West Cumberland Hospital.

5.2.1 The NHS Consultation Document justified this proposal on the grounds that a new hospital would be designed to support the proposed model of care. Economic arguments in favour of having a new hospital were also referred to by the NHS in public meetings, although it was accepted that figures had not yet been worked through.

5.2.2 Analysis of the NHS questionnaire results indicated that 67% of respondents were in favour of West Cumbria having a new hospital to replace the existing West Cumberland Hospital, but around 18% disagreed.

5.2.3 Amongst those unhappy with the proposals, a number of people commented that the existing West Cumberland Hospital was quite adequate, some noting that it is superior to the new Cumberland Infirmary in terms of space and ward size, and

therefore the hospital should be retained and refurbished. In response, NHS executives commented that

- The existing hospital was built in the 1960's, was not functionally suited to best modern practice, and was now far from being "future-proofed";
- Investment in the existing hospital's infrastructure had been very limited over the past 10 years, with the result that the refurbishment of the hospital would not be a cheap option;
- A new purpose built hospital would be an important factor in improving the recruitment of consultants and other professionals to work in West Cumbria;
- In designing a new hospital for West Cumbria, there would be proper involvement of the professionals delivering the service, which would avoid the design shortcomings of the Cumberland Infirmary.

5.2.4 The NHS Chief Executives also confirmed that the appraisal of options for the new hospital, which would itself be the subject of a further consultation, would include a refurbishment option. They also stated that a new hospital on the existing site would also be an option to look at.

5.2.5 Some members of the public expressed the view that it was unrealistic to be expected to comment on this proposal without knowing the location of the proposed new hospital. The NHS confirmed that, whilst a specific site had not yet been decided upon, it would be in West Cumbria and located where the main population is, because of the need for rapid access in an emergency. The comment was also made by leading clinicians that the first priority at this stage was to get agreement for the *service* to be provided in West Cumbria. A site could then be selected which best met the needs of the service.

5.2.6. Fears were also expressed about future reductions in bed numbers, particularly for older people, in the new hospital. Ms Burnham has confirmed that, although the NHS was making no commitments to maintaining bed numbers overall, she did not envisage any reduction in bed numbers for older people, given the population growth and the currently high level of bed occupancy. There could however be a shift in the use of beds between acute and community.

The Committee's Conclusion

5.2.7 The Committee supports that there should be either a new hospital in West Cumbria or a major refurbishment of the existing West Cumberland Hospital to the same specification as for a new hospital. The Committee also supports the approach being taken by the NHS to reach agreement on the services provided for the people of West Cumbria before looking at the detail of hospital design and location.

5.2.8. The Committee welcomes the statement from the NHS that reductions in bed numbers for older people are not envisaged, although there may be a shift in the use of beds between acute and community.

5.2.9 The Committee has also concluded that it expects the NHS to make or re-state in writing the following commitments regarding public consultation on the specific proposal for the new hospital:

1. That a "refurbishment of the existing hospital" is included as one of the options to be assessed and discussed in the consultation
2. That the development of a new hospital on or adjacent to the existing West Cumberland Hospital site is included as one of the options to be assessed and covered in the consultation;
3. That clear information is shared with the public about the costs and benefits of the options considered.

5.3 GP Treatment Centres to be located next to A&E in both Acute Hospitals

5.3.1 The argument given in the Consultation Document in favour of the proposal was to enable the hospital acute emergency services to concentrate on serious medical problems whilst the GP Treatment Centres could treat patients needing more minor medical care.

5.3.2 In terms of responses to the NHS questionnaire, 75% supported this proposal.

5.3.3. The principal concern expressed was to seek reassurances that this proposal did not mean that *all* out-of-hours treatment and minor injury treatment was to be centralised into the two acute hospitals. The NHS responded at public meetings that the important thing was to get joint working across primary and secondary care in each locality. It was recognised that something in addition to facilities in Carlisle and Whitehaven was needed to provide accessible out of hours emergency care.

The Committee's conclusion

5.3.4 The Committee has concluded that the concept of GP Treatment Centres being located next to A&E facilities in the two acute hospitals should be supported.

5.3.5 The Committee also considers that the NHS needs to clarify that these two GP Treatment Centres should be planned as part of a wider network of GP Treatment Centres located to ensure rapid access to primary care emergency services across North Cumbria; and also that the communication links with A&E and other emergency services should be available for all GP Treatment Centres, including any not on an acute hospital site.

5.4 Complex surgery to be located at the Cumberland Infirmary

5.4.1 The proposal to concentrate complex surgery at the Cumberland Infirmary was justified in the NHS Consultative Document by the need to have large specialist teams that could deliver better outcomes for patients. The Consultation Document also proposed redesign in the Cumberland Infirmary to make better use of space.

5.4.2 Information from the NHS questionnaire indicates that around 60% or respondents favoured the proposal but a significant minority disagreed.

5.4.3 Members of the Committee had difficulty in getting a clear understanding as to what "complex surgery" meant in this context. It was clear from replies to the Committee's leaflets and from questions at public meetings that these difficulties were

also widespread amongst members of the public. Related to this lack of understanding, there were real fears that the proposal could lead to a wholesale transfer of surgical work from West Cumbria into Carlisle.

5.4.4 In response to these fears, Ms Burnham explained to the Committee and also at public meetings that the term "complex surgery" referred to small volume procedures where there was a need to concentrate work on a single site in order to maintain the skills of consultants and the other professional staff. It was an issue of safety, and it was not safe for a consultant to carry out a procedure only 2 or 3 times per year. Carlisle was the preferred site for complex procedures because it was closer to specialist tertiary hospitals (e.g. in Newcastle) in case an emergency transfer of a patient was needed in a crisis.

5.4.5 Ms Burnham confirmed that the proposal for complex surgery reflected current practice, and that the increase in numbers of patients being treated in Carlisle instead of West Cumbria arising from this policy would be very small. She explained to the West Cumbria public meeting that decisions about the location of complex surgery procedures would be clinical, not managerial.

5.4.6 Ms Burnham further commented that the proposal did not mean that nothing complex would be carried out in Whitehaven. Apart from two regional specialties (radiotherapy and renal services) and complex surgery being located in Carlisle, there was little real difference between the proposed range of services of the two hospitals.

The Committee's conclusion

5.4.7 The Committee supports the principle that minimal-volume complex work should be concentrated in Carlisle on the grounds of the need for high clinical standards of care and patient safety, and Carlisle's greater proximity to tertiary centres.

5.4.8 The Committee considers that the NHS should confirm both to the Committee and to the general public the reason underlying its policy to concentrate complex surgery in Carlisle, and also to confirm that the proposal refers to minimal volume procedures.

5.4.9 The Committee also considers that the NHS should confirm, for the sake of clarity, that if it in the future it is intended to transfer services between the two hospitals other than for minimal volume complex surgery, such proposals would be the subject of public consultation.

5.4.10. The Committee supports the intention to make design improvements at the Cumberland Infirmary.

5.5 A new purpose built Diagnostic and Treatment Centre

5.5.1 The NHS Consultation Document justified this proposal on the grounds that dedicated space was needed for planned operations and investigations.

5.5.2 Information from the NHS questionnaire indicated that only half the respondents favoured this proposal and a significant minority disagreed with it.

5.5.3 The Committee studied the Department of Health Guidance on Treatment Centres which described the benefits of the "Treatment Centre" model and indicated many variations of the model across the U.K. It gave a general definition of treatment centres as "dedicated units that offer safe, fast, pre-booked day and short-stay surgery and diagnostic procedures in specialties such as ophthalmology, orthopaedics and a range of other conditions. These include hip and knee replacements, hernia repair and gallbladder and cataract removal, amongst others."

5.5.4 The Committee found considerable difficulty during the course of the consultation in obtaining specific information as to what this proposal meant for North Cumbria and which particular model was being considered. Similar difficulties in understanding this proposal were referred to in a number of the comments received by the Committee from members of the public.

5.5.5 In his written reply to the Committee's question on this, Mr. Woodcock stated that the key principle behind the Diagnostic and Treatment Centre (DTC) was to ensure rapid access to planned operations by separating emergency from elective work. The workload of the new DTC would need to be determined during the next stage of the process when its services and location(s) would be examined in full detail. As far as the Department of Health document on DTCs was concerned, the NHS in North Cumbria would learn from the experiences of the rest of the NHS but design a facility and service that was tailored to the requirements of North Cumbrians.

5.5.6 In the Carlisle public meeting, it was confirmed that the proposals was not about removing day surgery from existing hospitals in a wholesale way.

5.5.7 It was argued by the NHS Chief Executives that a Diagnostic and Treatment Centre development was needed to protect the availability of elective surgery in North Cumbria. Without it, there would be a threat from the development outside North Cumbria of cost effective and attractive Treatment Centre facilities which, under the NHS "Choice" agenda, would attract a proportion of patients from North Cumbria and make local facilities non-viable. The proposal would also help to meet new demand.

5.5.8 Discussion in public meetings and in comments given to the Committee also concerned the location of such a facility, which would be the subject of a further consultation. Mr. Woodcock informed the Committee that the DTC could be a single centre either in a new location or on one of the two main hospital sites. Alternatively another option to be examined as part of the option appraisal process for the DTC was whether it could be provided from 2 sites. It was also stated by the NHS at public meetings that the location would need to be where it was most cost effective.

The Committee's conclusion

5.5.9 The Committee considers that the concept of a Diagnostic and Treatment Centre for North Cumbria, as set out in the Department of Health Guide on Treatment Centres, should be supported provided the issues listed in the following paragraph are addressed.

5.5.10 The Committee is aware that a great deal still needs to be worked through and clarified about a specific proposal for North Cumbria, and considers that confirmation is needed from the NHS that the public consultation on the DTC will specifically:

- Include quantified information about the merits of alternative locations;
- Include a "two-site option" as one of the options to be appraised and discussed in the consultation;
- Demonstrate that the proposal is not about a wholesale shift of day surgery from the existing hospitals;
- Cover implications for access to and from the DTC, including arrangements for ambulance and other transport, and for nearby overnight stay facilities.

5.6 Care for more patients with long term conditions to be in the community; Care for more patients requiring rehabilitation to be in the community

5.6.1 The Consultation Document itself said little to justify the shift to more community based care for people with long term conditions and for rehabilitation. It did, through the use of a case study, give an example of how such a shift could improve both access and quality of care. In replies to questions from the Committee, the NHS representatives referred to the huge benefits to patients of being cared for nearer to their home, and to the fact that the proposals continue a programme of development that has been ongoing over a number of years.

5.6.2 Replies to the NHS questionnaire indicated substantial support for the proposals - 70% in favour of the proposal for people with long term conditions and 77% in favour of the proposal for rehabilitation.

5.6.3 It was made clear by the NHS in the consultation document and also at all the public meetings and in meetings with the Committee, that the proposals being consulted on did not include details about community services. Further consultation has been promised on future substantial changes to community services. Mr Woodcock confirmed to the Committee that the PCTs would be developing locality plans with local communities and consulting during 2005. Nevertheless, concerns about the implications of the proposals for community services featured strongly in responses received by the Committee and in virtually all the meetings involving members of the public that took place during the consultation.

5.6.4 Concerns brought to the Committee's attention fell into six categories.

1. Resources for community services

5.6.5 There was a widespread public perception that the resources would not be available in North Cumbria to deliver the whole of the modernisation strategy, and it would be the community services that would suffer - particularly once the commitment is given to progress with the acute sector developments. Several GP's also expressed apprehension about the lack of a community model in the proposals.

5.6.6 At the Penrith public meeting, NHS representatives stated that because each year North Cumbria was spending £19 million more than its allocation and services were only being kept going through loans, this had built up a cumulative deficit of around

£44m. Members were also told that the target cost reduction from the proposals being consulted on is £5 million. Even if that target were achieved, there remained an annual deficit of £14 million still to be found through other means. There were therefore serious concerns that the plans, including the community service plans, once developed, would not "stack up" financially.

5.6.7. Because of these funding considerations, people are concerned that acute hospital facilities will be reduced or closed before the community services are expanded sufficiently to meet both current and new demand. Members were made aware that community services need to function in a way which is both properly integrated and resourced, across both health and social care, and with good links to the acute hospitals service. This requirement applied to people in residential care as well as those at home.

5.6.8. In discussion with the Committee, the NHS representatives responded to these concerns by pointing out that

- The Acute Services would depend on improved community services for the strategy to work. Consultants could and would refuse to discharge patients into poor facilities. Therefore the steps necessary to ensure achieve the necessary capacity and effectiveness of the community services would have to be taken in good time.
- North Cumbria NHS had received a good financial settlement for the next 2 years.
- Both the Acute Trust and the PCTs were implementing a range of "good housekeeping" measures that were currently reducing costs substantially without affecting the level of services.
- Clinical staff were now working together much better than had been the case previously in North Cumbria and were beginning to make more effective use of the available resources.
- Partnership working with Social Services was also at a new level of co-operation, which would reduce duplication across health and social care
- The NHS in North Cumbria was working with the Strategic Health Authority to develop a three-year recovery plan focusing on those high cost areas of activity, based upon various benchmarking measures.

2. Workforce

5.6.9 Concerns about viability on grounds of available workforce were also raised. There were currently staffing shortages in some community services, including social care, and it did not follow that staff currently based in hospitals would want to transfer into the community even though re-training would be on offer. There was a perception amongst some staff that community based work is less attractive than a hospital based career.

5.6.10 The NHS responded that the proposals would increase the attractiveness of North Cumbria NHS to work in, and reference was made to the NHS engagement with educational bodies to develop a more local range of training opportunities for the workforce and to develop a medical school for Cumbria by 2007.

3. Existing Community Hospitals and Services

5.6.11 There were widespread concerns about the future of existing local community services, particularly community hospital services. These concerns have been generated to some extent by the circulation by the Primary Care Trusts to all their staff prior to the public consultation of a document setting out options for the future of all the community hospitals. These options were publicised in the local press in September 2004, but were not included in the public consultation when it was issued in November 2004. The NHS representatives commented that these discussions were on hold until after the consultation on the acute services.

5.6.12. The Committee was also given examples of how patients currently living in areas without community hospitals could be disadvantaged. A range of issues concerning the role of community hospitals, nursing homes and other community services, and their staffing arrangements, as well as the different funding and charging regimes, was brought to the Committee's attention, all of which are relevant to the forthcoming community services plans.

5.6.13. The Primary Care Trusts have undertaken to consult on any major changes to community health services, and have also indicated that they would be developing plans for community services during 2005. Mr Woodcock commented that they would be looking at all community services and drawing new and closer relationships between hospital and community services.

4. People with Long Term Conditions

5.6.14 Concerns were expressed that provision in the community for people with long term conditions was *currently* inadequate, even before the transfer of additional services out of the hospital setting. The NHS in its discussions with the Committee and in public meetings referred to measures already being taken to increase the capacity of community services.

5. Rehabilitation

5.6.15 There were comments that *acute* rehabilitation, such as for head injury services, should remain within the hospital service, and Ms Burnham at the Carlisle public meeting, gave assurances that it would. People were also concerned that the new facilities should be in place before people were moved out of hospital.

5.6.16 In discussion with the Committee, information was given by the NHS representatives about the significant numbers of people who were occupying acute hospital beds for very long periods, in a few cases for over 3 years. A specialist rehabilitation unit in a community setting, such as a community hospital, could provide a high quality service for some of the people who were currently in hospital beds for long periods or who currently had to use specialist facilities outside North Cumbria.

6. Carers.

5.6.17 Carers were concerned about the impact of a shift into the community of services currently provided in hospital.

5.6.18 Assurances were given by the NHS that carers will be involved in the planning of the new community services.

The Committee's conclusions about Community Services

5.6.19 The Committee considers that the proposed shift into community settings of care for people with long term conditions and of rehabilitation services should be supported, provided the issues listed in the following paragraph are addressed.

5.6.20 The NHS commitment to consult on plans for community services is noted and welcomed. On the specific concerns brought to its attention, the Committee has come to the following conclusions:

- Because of the public's need for reassurance that there will be sufficient resources for investment in community services, the NHS should consult with the public and the Committee on its *costed* Community Strategy *and* demonstrate its affordability to the public *before* it finalises its Business Cases for the acute sector developments. This should be done in a way which will allow the Committee to assess the acute and community proposals side by side.

- As part of the community strategy, there is a need to address the scale and phasing of the changes from acute to community settings of care.There should be an objective of achieving equity of access to services between areas with community hospitals and those without. This work should take into account consideration of the availability and charging arrangements of residential and nursing homes, community hospitals and other community facilities.

- Addressing this issue should do a lot to meet concerns of people with long term conditions and their carers

- On rehabilitation, the NHS should confirm that *acute* specialist rehabilitation should remain acute hospital-based, and that it will consult the public on the specific proposals for a community-based specialist rehabilitation facility – either as part of the community strategy or as a separate consultation.

- On the issues of workforce, the NHS should include a workforce strategy which includes recruitment in its community strategy and demonstrate its robustness.

- On carers, the NHS should confirm publicly that carers will be involved in developing the various stages of the Community Strategy, including the locality proposals.

- Adequate levels of community service provision need to be put in place across both health and social services, backed up by proper communication systems, before the existing hospital capacity is reduced.

5.7 The Overall Package of proposals

The Four Options

5.7.1 The Committee was informed that the NHS's overall package of proposals was based on a hybrid of the two most favoured options referred to in paragraph 3.4, which emerged from the appraisal of benefits as equal front-runners, namely two hospitals each with an ITU, and a single acute hospital.

5.7.2 The Committee examined the independent report prepared by Westlakes Scientific Consulting, which appraised the four options, using the public's scoring of the benefits criteria as part of that process. Members noted that the scoring of benefits both by the public and by health service staff had been taken into account. Members noted that, although the study had been broad brush, it gave a sufficiently clear indication of favourability towards the four options considered. It also noted that the high degree of engagement with professionals, carers and the public gave the process both depth and breadth. It did however warn that the study could not be used to compare the four options with the present service, as no baseline assessment had been made. It also warned against over-analysis of the data as the study was broad brush.

5.7.3 It was emphasised by the NHS that the options and proposals at this stage were about services, not about buildings, and that the intention was, following public consultation, to make a decision about future services before planning for the bricks and mortar.

Finance

5.7.4 Whilst recognising that the acute sector proposals are targeted to free up at least £5m in revenue, the widespread concerns over the availability of resources to invest in community services has been highlighted above in paragraph 5.6.6. The Committee was told that additional finance was also required to bridge the changes, including the training of the workforce for new responsibilities and the implications of job redesign throughout the period of change.

5.7.5 The NHS representatives discussed with the Committee the range of measures being taken to bring expenditure into line with resource allocations over a three year period (see paragraph 5.6.8). The NHS representatives also referred to discussions with the Workforce Directorate at the Strategic Health Authority over the need for funding for its retraining programme.

Communications

5.7.6 Members of the Committee discussed instances when patients had been disadvantaged by poor communications both between professionals, (including between hospital and community services), and with the patients.

Appendix 1

Principal Documents Considered by the Committee

National

"Keeping the NHS Local – A New Direction of Travel" – Government Policy Guidance on service expansion and redesign.
Published by the Department of Health, February 2003.

"General Information about Treatment Centres" – An Introduction to NHS Treatment Centres.
Published by the Departnment of Health, January 2005.

"Cutting Edge" – various news items on the Modernisation Agency Treatment Centre Programme.
NHS Modernisation Agency website, accessed January 2005.

Local

"Making Changes" – explanatory leaflet on the need for major changes in local health services, and questionnaire on the priorities of standards.
Published by Carlisle and District Primary Care Trust, Eden Valley Primary Care Trust, West Cumbria Primary Care Trust, North Cumbria Acute Hospitals NHS Trust, July 2004.

"The future of Acute Health Services in North Cumbria" – Public Consultation Document on Strategic Options for Change.
Published by Carlisle and District Primary Care Trust, Eden Valley Primary Care Trust, West Cumbria Primary Care Trust, North Cumbria Acute Hospitals NHS Trust, 10 November 2004.

Reports of the North Cumbria Working Groups on the four options for strategic change to acute Hospital Services
Unpublished working group reports, October 2004.

Appraisal of Four Options for the Future Provision of Acute Health Care Services in North Cumbria
Report by the Westlakes Scientific Consultants, January 2005.

In addition, Members of the Committee have read

- The comments from all the leaflets returned to the Committee
- All the leaflets sent to the Committee
- Notes of all the NHS public meetings

Copies of the above documents, or advice as to how to access them, can be obtained by contacting the Scrutiny Unit, Cumbria County Council, the Courts, Carlisle CA3 8NA.

Appendix 2

Recommendations of the Committee on the NHS Consultation, 28 July 2004 and the NHS Response.

The Committee's Recommendations to the North Cumbria Primary Care Trusts, 28 July 2004

1. The Trust and PCTs needs to cover the "No Change" option and explain very clearly why it is unsustainable
2. The Trust and PCTs should present the need for change as a "shared problem"
3. The Consultation should include all Councillors (both County and District); the Area Committees; the Local Strategic Partnerships; local community groups within Districts (e.g. Carlisle has a network of Residents Groups). Using the Area Support Managers as a contact was recommended;
4. Given that the focus of the strategy is on services and access rather than buildings/ institutions, the Trust and PCTs should make this distinction clear in their consultation.
5. In this context, The Committee accepts that no hard lines are being drawn at this stage on the location of facilities.
6. The consultation document should include the risk management criteria and the Trust and PCTs proposals to manage the major risks associated with the preferred option
7. The Trust and PCTs should seriously consider making their proposed pamphlet available to all households.
8. The Trust and PCTs should provide the Committee with full details of their user engagement.
9. Access needs to be given prominence as a key consideration.
10. The Trust and PCTs need to inform the Committee of what they are doing to ensure Consultants retain their generalist skills.
11. The Trust and PCTs need to ensure public ownership of the benefits criteria to be used in the decision making
12. The Trust and PCTs should be invited to meet the Cumbria Health and Well-being Scrutiny Committee at its meeting on 22 September to discuss the process and options with the full Committee. The Committee should also agree its own process for the scrutiny review at that meeting.

Response to the Committee's recommendations from the North Cumbria Primary care Trusts – 20 August 2004.

"Following the H & WB Scrutiny Committee's response to the North Cumbrian PCTs and Acute NHS Trust I am writing to confirm that your response has been put to the Options for Change Steering Group.

The steering group felt that the Committee's comments were useful and add value to our process prior to consulting the public. Furthermore, the comments were accepted in full with the following points noted.

In particular I have been asked to notify the committee of the following points that the Options for Change Steering Group felt should be fed back.

1) The PCT's have investigated the possibility of posting through each door in North Cumbria the pamphlet on why change is necessary and the opportunity to comment on the criteria used in forming our proposals. Due to the long lead in time for this, and the fact that some postcodes would not receive their copies until November, the Steering Group have decided a more rapid approach is required.

   There are 145,000 doors in North Cumbria who would have received the pamphlet. The sales of local newspapers are approximately 140,000 also, and often these are read by a number of people.

   Therefore, we have decided to place a whole page item in each local paper with the need for change outlined and a chance for readers to comment on the criteria, instead of a postal distribution of the same material.

2) Furthermore, the Steering Group felt that the Committee's comment on valuing access above other considerations was pre-empting the public's views on how criteria should be weighted. The Steering Group intend to take into account the public's view on all the criteria, not just access.

3) The Steering Group are looking at the nature of community services within the overall proposals and it is likely that specific proposals on community facilities will form part of the consultation, with the possibility of further consultation processes at a more focussed level thereafter.

I hope that you will be able to pass on the Steering Group's thanks to the Committee for their valuable contribution prior to a period of formal consultation and ensure that they receive our comments above at the earliest convenience."

Appendix 3

Schedule of meetings of the Task Group and the Committee

Nature of the Meeting	People who met the members	Purpose	Date
Lead Members	M. Smillie, PCT Director of Development and P. Mavin, Acute Trust Director of Planning	Initial briefing on the need for change and plans for public involvement process	7 May 2004
Lead Members	M. Smillie, and P. Mavin.	Further explanation of the options, and further dialogue of the public engagement process	24 June 2004
Full Committee	M. Smillie	Briefing for the full Committee. To agree the Committee's comments on the Consultation process.	28 July 2004
Full Committee	M. Smillie and P.Mavin	Discussion on the forthcoming consultation process, and the Committee's own process.	10 November 2004
Full Committee (Special meeting)	N Woodcock, PCT Chief Executive and M. Burnham, Acute Trust Chief Executive.	Discussion on the Consultative proposals	7 December 2004
Task Group	L Handley, Chair, Acute Patient & Public Involvement Forum.	Review of early evidence; agreement on supplementary questions and soundings to be taken.	10 January 2005
NHS Public meeting, Penrith		Individual Task Group Members attended to observe. (Mrs Langan attending)	26 January 2005
Task Group	Members of the Local Medical Committee: Drs D Lowe, I McGreavy, Chaudry, C Patterson, M Bewick, M Mort	Discussion on G.P. views about the proposals and how they could make them work in primary care.	1 February 2005
NHS Public meeting, Carlisle		Individual Task Group Members attended to observe. (Mr Farmer and Mrs Prest attending)	3 February 2005
NHS Public meeting, Whitehaven		Individual Task Group Members attended to observe. (Mrs Bradshaw, Mr Leyton and Mr Southward attending)	15 February 2005

Nature of the Meeting	People who met the members	Purpose	Date
Task Group	J Brown, Action for Health; N, Woodcock, M Burnham and M Smillie.	To take voluntary sector soundings on the proposals; to discuss feedback on the consultation with the NHS; to discuss conclusions and recommendations.	16 February 2005
Committee (Special meeting)		To agree the Committee's Scrutiny Report and Recommendations.	24 February 2005

Appendix 4

Written Reply to the Committee's Supplementary Questions to the North Cumbria Primary Care Trusts

The Committee's Supplementary Questions to the North Cumbria Primary Care Trusts (11 January 2005)

1. *Diagnostic and Treatment Centre*. The consultation document appears to be referring to the proposal being for a single Diagnostic and Treatment Centre for the whole of North Cumbria, although the verbal reply given on 7 December could be interpreted differently. Please could you confirm whether or not this is the case. If the proposal is indeed for a single centre, please could the Task Group have details as to whether an option of more than one centre was considered, and details of your option appraisal. Please could the Task Group also have an indication of the likely workload of the new centre, and how this compares with equivalent work levels at each of the existing hospitals. With regard to the attached general information about from the Department of Health, please could you indicate which aspects will be covered by your proposals and any points at which your proposals differ from its content.

2. *Emergency Services.* Please can you clarify whether there will be 24-hour surgical cover at both hospitals to support A&E.

3. *Surgery*. Please could you provide an indication of the amount of complex surgery to take place at Carlisle, and of this amount, how much would be transferred from West Cumbria. What will be the considerations in the decisions as to what is complex surgery to be done at Carlisle? How much elective surgery will be carried out in West Cumbria in the future (please can you give an indication of scale as compared with now)?

4. *Workforce*. The Task Group are concerned to understand what is the risk of failing to maintain a sufficient professional workforce to sustain the new service particularly in West Cumbria. Please can you provide your assessment on this matter and summarise what is being done to encourage and engage with the development of more locally based medical and other key professional education.

5. *Finance*. The Task Group needs to understand how the robustness of the proposals, including the implications for community services, is affected by the NHS financial position in North Cumbria. Please could you provide an outline of your financial strategy to achieve financial balance, how it related to the proposals and in particular its implications for investment in community services, both for health and for Social Services. Please would you also provide comparative information for each broad service area showing how

North Cumbria expenditure compares with the national picture and with similar health economies.

6. *Shift to Community settings for rehabilitation and long term conditions.* Please can you provide some more detail on the proposed shift to community settings, indicating its benefits, how it will work in practice, and implications for community services. From whom will the enhanced community services be commissioned? What implications, particularly financial, do the proposals have for Social Services?

7. *NHS transport.* Please can you give an indication of the implications for NHS transport, particularly ambulance, and how they are accommodated in your financial proposals.

8. *Communications.* Task Group members are aware of examples of communication breakdown between acute and community services, and between service providers and the patient in the current service. The strategic changes will make good communications even more important. What proposals are there to improve communications?

9. *Risk.* What is your assessment of the main risks in implementing the changes and your plans to manage the risk?

Reply from Mr N Woodcock, Chief Executive of the North Cumbria Primary Care Trusts (9 February 2005)

1. DTC

This could be a single centre either in a new location or on one of the two main hospital sites. Alternatively another option that we would need to examine as part of the option appraisal process for the DTC is whether it could be provided from 2 sites. The key principle behind the DTC is to ensure rapid access to planned operations by separating emergency from elective work. The workload of the new DTC will need to be determined during the next stage of the process when the services it delivers and the location(s) will be examined in full detail. As far as the DH document on DTCs is concerned we would want to ensure that in our proposals we learn from the experiences of the rest of the NHS but design a facility and service that is tailored to the requirements of North Cumbrians. I would like to propose that OSC members visit DTC(s) elsewhere during the next stage of the Strategic Options process.

2. Surgical Cover

There will be 24 hr access to surgical cover on both sites to support A&E.

3. Complex Surgery

There is no clear answer yet to the volumes of complex surgery that will be undertaken in Carlisle and this will need to be determined during the next stage of the process. The key determinant in what surgery will be done on which site will be

patient safety. Although we can't be definitive at this stage on volumes we can confirm that surgery will be undertaken in the new West Cumbria facility and that for the vast majority of patients surgery will continue to be provided locally.

4. Workforce

The key risk associated with workforce is that if we failed to address the issues that currently face us and which were described in the 'Making Changes' leaflet then some of our services could become vulnerable. Our proposals we feel tackle these issues and have a real potential to make North Cumbria an extermely attractive place for staff to come and work. As for longer term plans around engaging with education and training providers to help develop a more 'local ' workforce we are building on the existing links we have with the Medical School at the University of Newcastle and expanding the number of undergraduates taught in the Trust. We are also involved in the ongoing discussions with the Strategic Health Authority on the possible development of a new medical school for Cumbria in 2007.

5. Finance

The Acute proposals are not affected by the current financial position within North Cumbria because:

(i) the financial position was known at the time of the formulation of the proposals; and

(ii) the proposals will generate in excess of £5m on a recurring basis to assist in reducing the overall financial problem

The current strategy to achieve financial balance is being developed with the Strategic Health Authority. It will be a three-year recovery plan focussing on those high cost areas of activity, based upon various benchmarking exercises.

The PCTs are also reviewing other areas outwith the above including management costs to try to minimise the impact upon frontline services.

The PCTs and NHS Trusts have statutory duties to breakeven and it is important that the Scrutiny Committee recognise that future NHS proposals for consultation will reflect this reality.

6. Community Services

The proposed shift to community settings is a natural extension of the exisitng work underway in North Cumbria to reduce acute hospital lengths of stay. For example, the establishment of two stroke units in the two district general hospitals provides for more rapid recovery of acutely ill patients.

Improved discharge into community services (such as community hospitals, intermediate care and domiciliary care) is a longstanding programme of development over a number of years. This includes the introduction of new services such as heart failure & COPD specialist nursing, intermediate care based rehabilitation and evening nursing services. A number of our community hospital facilities have worked in conjunction with the acute service to develop pathways of care for Stroke and Hip Fractures, all of these measures have resulted in the vastly improved levels of delayed transfers of care in acute hospitals.

Our work with social services through our joint commissioning group is built upon four pillars of cooperation. These are agreed frameworks that provide us the joint ability to work together, as demonstrated by a number of pilot projects in North Cumbria where both community services resources and social services resources have been jointly managed. The Head of Adult Social Services has agreed that the joint commissioning group will continue to provide an effective forum for joint decision making as the options for change process continues and as proposals for community services are produced for consultation. It is intended that these proposals provide the impetus to increase the integration and joint working between health and social care.

The provision of specialised rehabilitation services for North Cumbria is provided by tertiary centres in addition to the two current acute units. These proposals include reviewing the nature of these services to build a service that has a stronger community skill base linked to the more specialised services that we provide locally and commission in the North East. This review will commence after the period of consultation has concluded this month.

The options for change proposals do not propose that acutely ill patients will transfer too early from acute facilities. The benefits for patients in being cared for closer to home are huge. Their rehabilitation into daily living and the proximity of familiar environments are just two factors that patients value. The proposals include our elderly care physicians working in a more coordinated and integrated way with our community services. This will provide for clearer medical supervision and accountability within community hospitals. It will provide for more continuous care for patients and improve communications flows alongside the patient journey.

7. Transport

The CAS have been involved throughout this process and have contributed to the development of the proposal. During the next stage of the process we will need to determine the exact impact on any service redesign on patient transport services. At this stage no changes to the costs associated with Ambulance Services have been built into the very broad financial assumptions we have discussed relating to these changes. In addition, we will liaise with relevant staff in Cumbria County Council to seek their advice.

8. Communications

The points are well made and we acknowledge that we will need to improve inter organisational and inter-professional communications and we are firmly committed to doing this and in ensuring communications issues do not become a barrier to delivering a better public service. At this stage there are no detailed proposals but there is a clear
public statement that we have to work more closely together.

9. The Henderson Unit

The Henderson Unit or the service it provides, that is the delivery of Day Case chemotherapy locally in West Cumbria will remain as a locally provided service.

Appendix 5

Analysis of the NHS Consultation

NHS CONSULTATION ON THE FUTURE OF ACUTE HEALTH SERVICES IN NORTH CUMBRIA
10 November 2004 – 28 February 2005

ANALYSIS OF THE CONSULTATION TO 4 FEBRAURY 2005 FOR THE COUNTY COUNCIL'S SCRUTINY COMMITTEE

A Report by:

Carlisle and District, Eden Valley and West Cumbria Primary Care Trust.

CONTENTS

3.2.5 Services especially complex surgery should be reorganised to improve care.

3.2.6 Planned surgery and investigations should be concentrated in a new Diagnostic and Treatment Centre.

3.2.7 A new acute hospital should be built in West Cumbria.

1.0 CONSULTATION DOCUMENTS

1.1 FULL CONSULTATION DOCUMENT

12, 000 full consultation documents have been printed by the Primary Care Trusts in North Cumbria. 9,564 documents have been issued to date.

The documents were widely circulated to:

- Cumberland Infirmary, Carlisle
- West Cumberland Hospital, Whitehaven
- GP surgeries
- Patient and Advice Liaison Services (PALS)
- Community hospitals
- NHS Staff
- Libraries
- Post offices
- Local media
- Councils
- MPs
- Neighbourhood Forums
- Patient and Public Involvement Forums
- Members of the public (including 1169 who requested a document via the FREEPHONE line)

1.2 SUMMARY CONSULTATION DOCUMENT

5000 summary consultation documents have been printed by the Primary Care Trusts in North Cumbria. 4,961 summary documents have been issued to date. These have been circulated to the groups outlined in section 1.1.

1.3 CONSULTATION POSTERS

1,000 consultation posters have been printed by the Primary Care Trusts in North Cumbria. 950 have been issued to date. These have been circulated to hospitals, GP surgeries, libraries and post offices.

2.0 MEETINGS ATTENDED AS PART OF THE CONSULTATION

A host of meetings were set up by the NHS for the consultation. The NHS has also attended many already established meetings; all are listed below. Approximately 600 people have attended consultation meetings to date.

2.1 NEIGHBOURHOOD FORUM MEETINGS:

Date	Area
17 November 2004	North West Copeland
23 November 2004	Aspatria
29 November 2004	Eden Fells
30 November 2004	Wigton
1 December 2004	Yewdale
13 December 2004	Maryport
13 December 2004	Longtown and Bewcastle
27 January 2004	Bootle and Seascale
27 January 2004	Workington
31 January 2004	Arcledon and Frizington

Still to be attended:

7 February 2005	Hillcrest and Hensingham
21 February 2005	Millom
22 February 2005	Keswick
22 February 2005	Alston/ East Fellside
24 February 2005	Upper Eden

2.2 NHS HOSTED PUBLIC MEETINGS:

Date	Area
27 January 2005	Eden Valley
3 February 2005	Carlisle and District

Still to be attended:

15 February 2005	West Cumbria

2.3 ROADSHOW EVENTS:

Date	Venue
19 January 2005	Carlisle Lanes
2 February 2005	Auction Mart, Penrith

Still to be attended:

16 February 2005	Carlisle Auction Mart

2.4 COUNCIL FOR VOLUNTARY SERVICES:

Date	Venue
2 November 2004	Maryport
24 November 2004	Carlisle
10 December 2004	Carlisle

2.5 STAFF BRIEFINGS:

Date	Area
15 November 2004	Carlisle
16 November 2004	Whitehaven
17 November 2004	Keswick
18 November 2004	Wigton
18 November 2004	Carlisle
19 November 2004	Maryport
22 November 2004	Alston

2.6 COUNCIL MEETINGS:

Date	Area
25 November 2004	Allerdale Local Committee
14 January 2005	Copleland Local Committee
19 January 2005	Eden Local Committee (cancelled)
21 January 2005	Copeland Labour Party
27 January 2005	Carlisle Local Committee
10 February 2005	Carlisle and District Scrutiny Committee

3.0 FEEDBACK

3.1 RESPONSES

The following responses have been received by the Primary Care Trusts in North Cumbria up to 4 February 2005:

- 506 questionnaire responses
- 298 responses with additional comments
- 70 emails
- 1,200 calls to the FREEPHONE Consultation line
- 25 letters detailing views on the consultation

Of the correspondence received, many were from members of the public. However, there was a substantial amount of correspondence from NHS staff, statutory organisations and voluntary groups. Statutory and voluntary organisations who have responded during the consultation include:

Statutory Organisations

- Cumbria County Council Health and Wellbeing Scrutiny Committee
- Cumbria County Council Audit Business Unit, Social Services
- Copeland Borough Council
- Cumbria County Council, Community, Economy and Environment, Neighbourhood Development – Copeland
- Allerdale Borough Council, Democratic Services
- Copeland Constituency Labour Party
- Patterdale Parish Council

Community/ Voluntary Groups

- The League of Friends of Brampton and District Cottage Hospital
- St Bees Guild
- Bridekirk Parish Council
- Keswick Senior Citizens Club
- West Cumbria University of the Third Age
- Lorton Parish Council
- St Bridget's Beckermet Parish Council

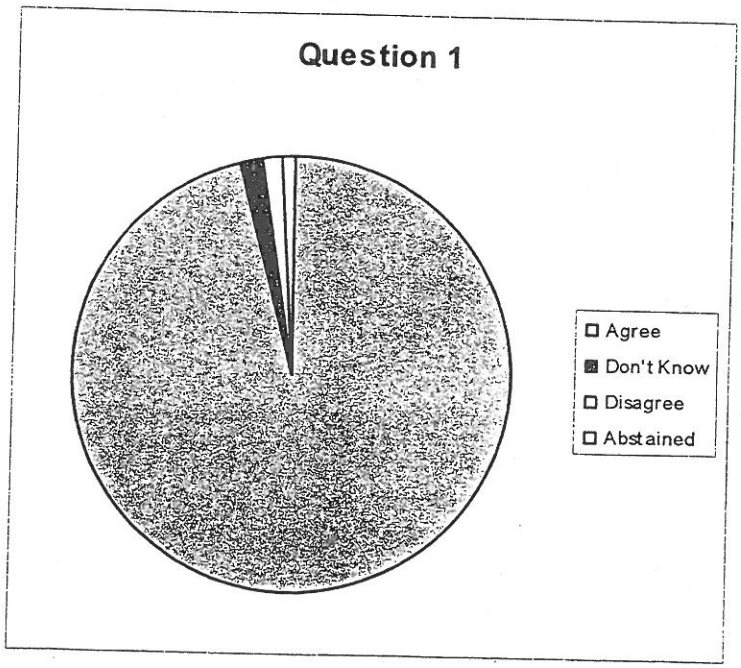
3.2 ANALSYSIS OF RESPONSES

Responses to the seven questions are outlined below. There is also a comments section for each question in which comments received relating to the specific questions are identified.

3.2.1: Question 1

Around the clock access to emergency care should be on both acute hospital sites. Agree? Disagree? Don't Know?

Agree:	483 responses	(96% of responses)
Disagree:	7 responses	(1% of responses)
Don't know:	9 responses	(2% of responses)
Abstained:	5 responses	(1% of responses)



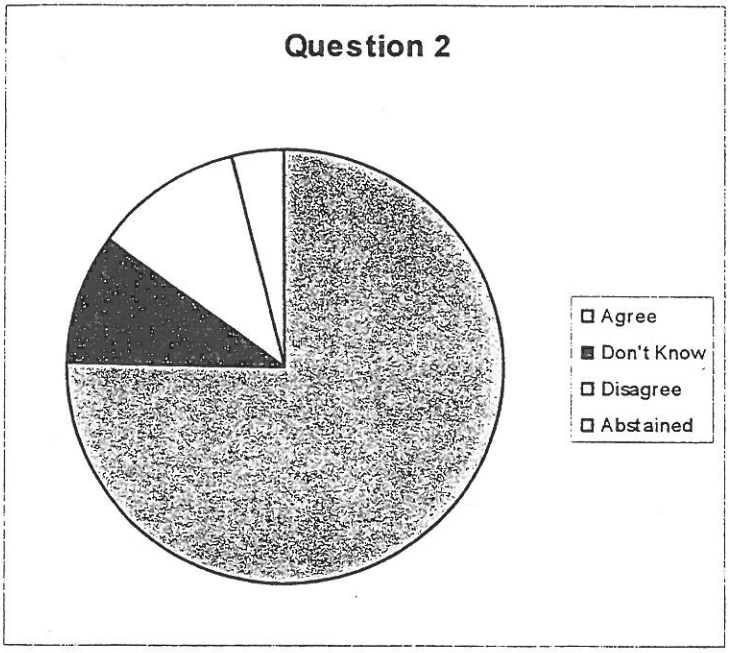
Comments:

- Overwhelming support for around the clock access to emergency care on both acute hospital sites.
- Recognition that emergency care is needed at both sites for safety of patients.

3.2.2: Question 2

The GP Treatment Centre and Minor Injuries Unit should be located near to the Accident and Emergency Unit at both acute hospitals. Agree? Disagree? Don't Know?

Agree:	381 responses	(75% of responses)
Disagree:	57 responses	(11% of responses)
Don't know:	49 responses	(10% of responses)
Abstained:	19 responses	(4% of responses)



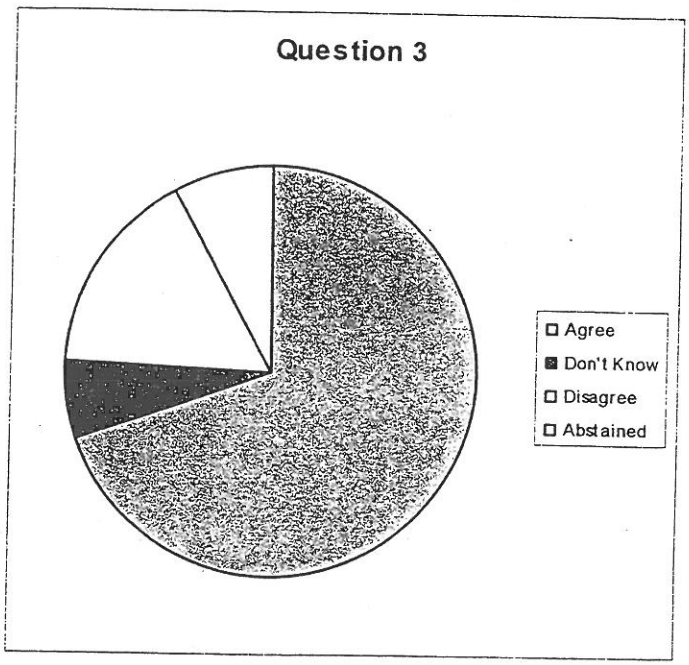
Comments:

- Three quarters of respondents support GP Treatment Centres and Minor Injuries Units near to Accident and Emergency Units at both acute hospitals.
- Some support for GP Treatment Centres to be provided in the community, particularly from those living in rural areas such as Eden Valley.

3.2.3: Question 3

Care for more patients with chronic or long-term illnesses or conditions should be provided in community-based settings rather than in the acute hospitals. Agree? Disagree? Don't Know?

Agree:	351 responses	(70% of responses)
Disagree:	83 responses	(2% of responses)
Don't know:	31 responses	(6% of responses)
Abstained:	40 responses	(8% of responses)



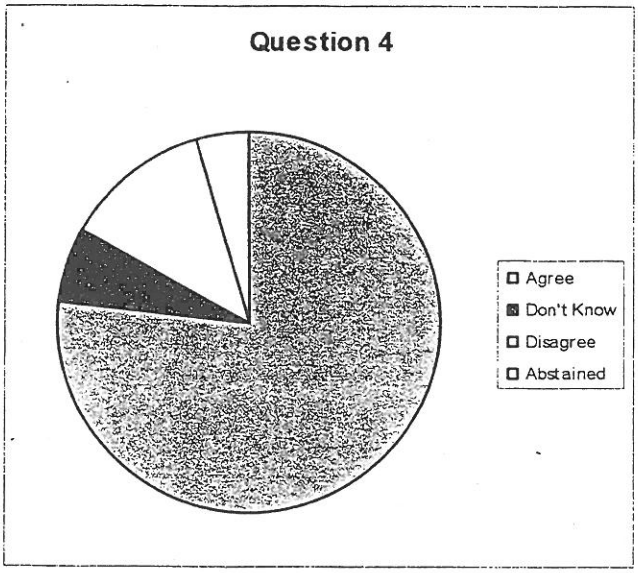
Comments:

- Majority support for more patients with chronic or long term illnesses or conditions to be supported in the community.
- Concern regarding adequate provision in community to care for people with chronic or long term illnesses.
- Wide-scale support for community hospitals to be utilised and even extended to provide services provided in acute hospitals from respondents living in areas with community hospitals (particularly Alston and Brampton residents).
- General agreement with the need to treat more people in their homes or in community settings.
- Concern from some carers on burden this may place upon carers.
- Some would have liked to have seen one proposal/ consultation on acute and community services.
- Concern about lack of community hospitals in Carlisle and North Copeland.

3.2.4: Question 4

Care for more patients requiring rehabilitation should be provided in community-based settings rather than in the acute hospitals. Agree? Disagree? Don't Know?

Agree:	387 responses	(77% of responses)
Disagree:	64 responses	(13% of responses)
Don't know:	32 responses	(6% of responses)
Abstained:	22 responses	(4% of responses)



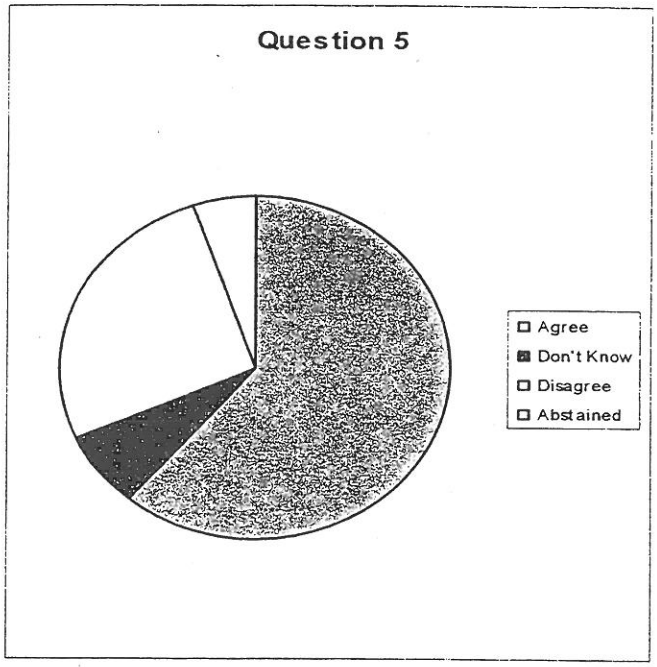
Comments:

- Over three quarters of respondents support the proposal of more care for people needing rehabilitation to be provided in the community.
- Support for enhanced rehabilitation services in the community.
- Support for people only being treated in the community when well enough to leave hospital.
- Concern from carers and carer organisations on 'burden' on families.
- Need to have facilities in place in the community before people are discharged from acute settings.
- Praise and support for specific rehabilitation groups such as Acquired Brain Injury Services and enthusiasm for extension of such services.
- Some concern about NHS staff moving from acute settings to the community.

3.2.5: Question 5

Services especially complex surgery should be reorganised to improve care. Agree? Disagree? Don't Know?

Agree:	308 responses	(61% of responses)
Disagree:	132 responses	(26% of responses)
Don't know:	37 responses	(8% of responses)
Abstained:	27 responses	(5% of responses)



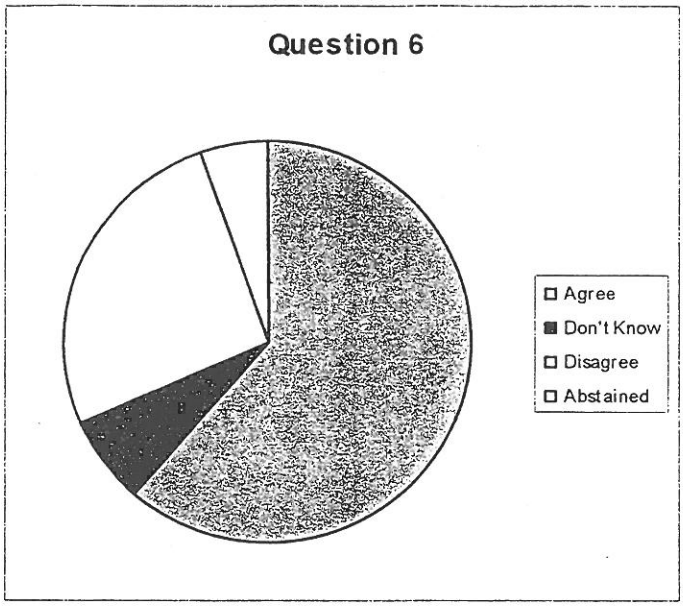
Comments:

- Majority support for complex surgery to be reorganised, with the public understanding that this may mean most complex surgery being performed at the Cumberland Infirmary.
- However, over quarter of respondents disagree with the proposal
- Support for only most serious of conditions to be treated at a distance.
- Many concerns about what is meant by complex surgery.
- Some support for complex surgery to be carried out at both acute hospitals, particularly from respondents living in West Cumbria.
- Concerns about issues of poor public transport and distances between east and west Cumbria for patients who may have to travel for complex surgery and their families.

3.2.6: Question 6

Planned surgery and investigations should be concentrated in a new Diagnostic and Treatment Centre. Agree? Disagree? Don't Know?

Agree:	249 responses	(50% of responses)
Disagree:	165 responses	(33% of responses)
Don't know:	58 responses	(12% of responses)
Abstained:	26 responses	(5% of responses)



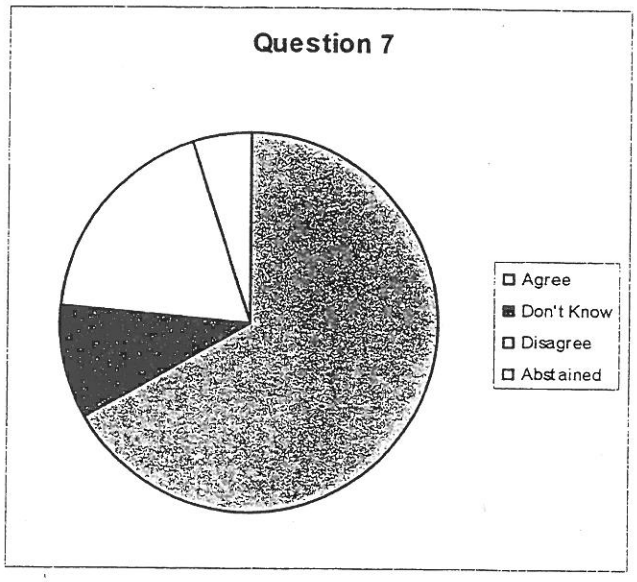
Comments:

- Half of respondents agree that planned surgery and investigations should be performed in a new Diagnostic and Treatment Centre.
- However a third of people of people disagree with the proposal.
- Support for planned operations not being cancelled due to emergency work taking priority.
- Interest in location of Diagnostic Treatment Centre – general feeling that it needs to be on one of the acute hospital sites.
- Some requests from Eden Valley residents to locate the Diagnostic and Treatment Centre in Penrith.
- Concerns about travelling for planned operations if the Diagnostic and Treatment Centre is at a distance to patients.
- Some suggestions for two Diagnostic and Treatment Centres – one at each acute hospital.
- Some concern that a Diagnostic and Treatment Centre will mean a duplication of costs, particularly in light of the North Cumbria NHS' financial situation.

3.2.7: Question 7

A new acute hospital should be built in West Cumbria. This will be different to the existing hospital as it will be designed to support the 'model of care' described in this document. Agree? Disagree? Don't Know?

Agree:	337 responses	(67% of responses)
Disagree:	93 responses	(18% of responses)
Don't know:	50 responses	(10% of responses)
Abstained:	26 responses	(5% of responses)



Comments:

- Majority support for a new acute hospitals being built in West Cumbria.
- Over a quarter of respondents either disagreed or didn't know how they felt about the proposal.
- More detail on hospital wanted.
- Issues about whether hospital should be in Copeland or Allerdale.
- Concern from some that hospital will not be on the existing site.
- Some believe it would be better to upgrade the existing West Cumberland Hospital; majority of these people from West Cumbria.
- Learn lessons from the design and build of the Cumberland Infirmary.
- General requests for confirmation on size of a new hospital and services to be provided.
- Some support for one acute hospital in North Cumbria due to population size, need to attract clinical staff and financial constraints. Some of this support came from clinicians working in the Acute Trust.
- Questions regarding how a new hospital in West Cumbria would help the Trust to appoint more specialist clinical staff.
- West Cumbria majority support for no down sizing or down grading of a hospital in West Cumbria; and that it should be the same in status as the Cumberland Infirmary.
- The planning of the new hospital should involve clinicians.
- Concerns about travelling times from Millom

Appendix 6

List of Letters Received by the Committee

Letter from:	Key Points
P. Ackred	Public not given enough background to make the judgements requested in the consultation.
Allerdale Borough Council	New hospital in West to have full diagnostic services and bed provision; retail cottage hospitals and minor injury facilities in Allerdale.
Alston Moor Parish Council	Process unsatisfactory: acute and local facilities are linked; consultation questions ambiguous; need to protect future of Alston Community Hospital.
S. C. Bannerjee	Need to look at community services together with acute; suggests use of Cumberland Infirmary Tower Block for DTC.
Bridekirk Parish Council	New hospital in West Cumbria should minimise travelling time and retain or improve beds and services as now.
Catholic Caring Services	I looking at acute services, don't ignore organisations that work to reduce sulial isolation.
Cockermouth Town Council	Supports 2 Acute Hospitals; Small hospitals like Cockermouth should retain ancillary services and minor injuries.
Copeland Borough Council Chief Executive	Council likely to support "Equality not Duplication" between the 3 hospitals, and new build hospital in West Cumbria to be based on Health Park
Eden Carers	Concern that the term "community based Care" is unclear - changes may put yet more stress on carers, already under stress.
Mrs S Glencross	Support for the Cumberland Infirmary, but need more car parking.
N Holmes	Improve bed base and ward space in Carlsile; don't duplicate many facilities in west Cumbria but instead make more use of cottage hospitals and an intermediate sized hospital in the west; strengthen links with Newcastle and merge the PCTs to save money/.
Holme Abbey Parish Council	Supports 2 Acute hospitals
L. Kirkbride	Need for hospital-based primary care mental health provision.
Mrs V Lowe	Need to tackle poor head injury rehabilitation services in North Cumbria and continue use of hospitals for this purpose.
Maryport town Council	Supports 2 Acute Hospitals with full emergency facilities.
Patterdale Parish Council	Insufficient detail in the consultation;
Patient and Public Involvement Forums - North Cumbria Joint Sub Committee :	Consultation Document confusing & repetitive; community services should have been included; concerns about the new hospital in West Cumbia –why not refurbish?; concerns about DTC – problems of transport; consultation document was not sufficiently widely distributed.

Silloth Town Council	Supports 2 acute hospitals
Stanwix Rural Parish Council	Supports 2 acute hospitals both with ITU
W Cumbria University of the 3rd Age	Location of DTC; proposals inadequately spelt out; need to take account of transport

ANALYSIS OF REPLIES TO THE HEALTH & WELLBEING SCRUTINY QUESTIONNAIRE

	Public	Patients	Carers	Councillo	NHS staff	Others/Not known	Total
Total Number of Replies Received	45	8	6	23	13	7	102
1. Were you aware of the proposed changes to the provision of acute health services before reading this leaflet?							
• Yes	38	7	4	20	12	2	83
• In part	3	0	0	1	0	0	4
• No	0	1	1	2	0	0	4
2. What are your comments or concerns about the NHS proposals?							
Those in general agreement	**2**	**1**	**0**	**2**	**4**	**0**	**9**
Those with comments or concerns	**43**	**7**	**3**	**21**	**9**	**3**	**86**
Concerns about Community services	10	3	0	7	2	1	23
Concerns remain about the acute hospital in West Cumbria	10	3	1	7	1	0	22
Consultation proposals are too vague/ unclear	3	0	0	3	0	1	7
Concerns/views about the Diagnostic & Treatment Centre	7	0	0	2	1	0	8
Need for more consultation	2	0	0	0	0	0	2
Complaints about the Cumberland Infirmary	4	0	0	3	0	0	7
Need for 2 acute hospitals	2	0	1	2	0	0	5
Preference for just one acute hospital	0	0	0	1	0	0	1
Support for shift to community settings	2	1	0	1	1	0	5
Concern over shift towards community settings	0	0	1	0	0	0	1
Concerns over bed numbers	1	1	0	0	0	0	2
Finances don't add up	2	0	0	0	3	0	5
Staffing Problems	0	0	0	0	2	0	2
Other	2	1	1	2	1	1	8
3.What are your comments or concerns on the way the NHS is undertaking its consultation?							
Those who are happy/ no concerns	**9**	**1**	**0**	**2**	**2**	**0**	**14**
Those with comments or concerns	**21**	**8**	**6**	**16**	**8**	**1**	**60**
Questions are "leading"/not objective	3	0	0	1	0	0	4
Document is unclear/insufficient coverage or detail	3	1	1	5	2	1	13
Not enough people/organisations have been invited to comment	3	2	2	0	0	0	7
Insufficient publicity	3	1	0	5	1	0	10
Not enough consultation early on	1	0	0	0	0	0	1
Management needs to listen to /respond to what's being said	4	3	2	3	2	0	14
Other	4	1	1	2	3	0	11

Appendix 8

The Committee's Questions and Replies at its meetings

1. Committee meeting with Nigel Woodcock, Chief Executive, North Cumbria PCTs (NW) and Marie Burnham, Chief Executive, North Cumbria Acute Hospitals Trust (MB), 7 December 2004

Questions/ concerns/ issues	response
THE OVERALL PROPOSAL	
1. How and to what extent do the proposals contribute to the NHS financial targets in North Cumbria?	NW – they will enable us to deliver acute services at less cost – objective £5m per annum
2. How serious are the financial problems in North Cumbria as compared with the rest of England?	NW – They are worse here than most other areas – we are in the top 10 or 12 most challenged health economies in the NHS – reasons include geography and morbidity
2a. Why do we just compare ourselves with the rest of England. What about Scotland?	MB –Dumfries for example have around £6m more than I have for same population. Also in Carlisle we have a new linear accelerator which is good for us, but people in, say, Gretna get referred to Edinburgh where there are waiting times, not to Carlisle. This is because of the way cancer services in Scotland are commissioned through their network. In Scotland commissioners are keen to keep Scottish people being treated in Scotland. GPs do prefer Carlisle so do make some referrals to Carlisle.
Did the Carlisle PFI contribute to our problems in West Cumbria?	MB - No. The main problem with Carlisle is the hospital is too small, plus because of the urgency to get it built, the departments, designed by staff, are nice, but the wards were all designed uniformly. Our proposal with the Cumberland Infirmary is to raise capital to make it physically bigger – not necessarily more beds - through decanting a ward and redesigning.
3. How do the proposals fit in with the Department of Health Guidance on "keeping the NHS local"?	NW – We seek to maintain as many services as possible locally
4. Have the proposals been "rural-proofed"?	NW They are not yet tested – a separate exercise will be done during the consultation – but it will be difficult without more specific details in our proposals. So it will be done again later with specific schemes which will be subject to further consultation.

Questions/ concerns/ issues	response
5. It would be helpful for the Committee to have a full list of the services which will be provided in each hospital and the Diagnostic and Treatment Centre under the proposal with an estimated number of patients in each category, and which services are 24 hours.	NW - At the moment these are strategic proposals to give a clear framework – specific details will come later. MB – The most important thing to understand is that if there is an ITU you need to have core services to support it. If we didn't have an ITU in W Cumbria we would have a further 3-5 losses of young people's lives per year. So we'll have 2 hospitals both with the range of core services. The differences between the hospitals will be in specialist services eg complex cancer surgery. In the past, when we discussed individual specialties with medical & nursing staff, they would fall out. So our clinical management structure is to provide clinical services for North Cumbria. Our proposal is not the most cost-effective but provides a future for hospital services in West Cumbria. And also it says to Carlisle people that it isn't safe to have just one ITU for North Cumbria. The document is based on the care stream approach, not individual specialties. The most important thing is patient safety – this proposal gives people access to emergency services on both sites for best safety. It is the best way to get people to work together across 2 very different cultures.
6. What provision will be made for private patients in the hospitals and the Diagnostic and treatment Centre?	MB - You only attract consultants if you have a private arm available to them. In the NW of England it's not a major part of healthcare provision. Consultants now have to do 11 NHS sessions before they can to private work. Our proposal will have a private element to it.
7. What is the overall timeframe for all the changes being implemented, including community?	MB - 3-5 years from end of March 05. This is about changing mind sets across professionals, eg on the provision of elderly services across hospital and community.
8. Will you be ensuring there will be no reduction to existing services until the new facilities (including required community facilities) are in place?	NW - At all times we will make changes in whole system way. Our commitment is to make sure patients will not be placed at risk through bad timing of changes. Changes will be delivered in a managed structured way with full clinical engagement. Fundamentally, our responsibility is not to place patients at risk. Patients will not be put at risk.
9. Who do you regard as being responsible for ensuring that the public and patient/ family transport implications of the proposals are planned for and put in place?	NW - PCTs will commission NHS transport. For public transport we'll work with relevant authorities to improve if needed.

Questions/ concerns/ issues	response
10. What is the expected impact on staff, including present staff, and long term employment prospects in the affected areas?	MB – I have told staff on both sites there will be no staff losses or redundancies. We have a major recruitment problem especially in West Cumbria , not helped by the BNFL issue. There isn't a hidden agenda. At the moment especially in nursing we have held people to account for certain professional standards, also other clinicians – not always a popular thing. There's a need for new staff and to improve our ability to attract: we have 45 nursing vacancies across the 2 hospitals. We are courting the educational teams to get more in. If we fill the vacancies we'll have enough staff. On the medical side, we have too many in some areas, not enough in others. We have never made North Cumbria Acute Hospitals attractive – it was zero star rated. We have had good clinical staff but badly managed. This proposal gives a role for each hospital. If we create the facilities for modern medicine, we will attract. One plus is we're in a nice part of the world. If we can solve the estate problem in West Cumbria, we'll attract. We have at present the highest consultant attraction rate in the country.
10b. – In various documents, people believe that 24/7 emergency care is not possible on 2 sites	MB - Some consultants in W Cumbria do not believe in a future for their hospital. But I can give assurance of 24/7 emergency care in both places.
10c. – This could boost the case for university status for Cumbria – can we use this to put pressure?	MB - Absolutely critical – even if not a new Cumbria University, we need local dedicated courses. There's nothing to stop North Cumbria Acute Trust declaring itself a university hospital if that helps.
10d. – it will help you and us if you clarify what you mean by your terms eg complex surgery. There is a lot of mistrust in the west. People don't believe you can weigh up what the future holds without details of costs and locations. Surely you can get more money from DTI because of the BNFL proximity?	NW - We are engaging with the LSP in West Cumbria to make sure this is joined up with other issues. We would like to use this as leverage to get other benefits or open doors in Whitehall. This has to be fit for purpose for the next 2 generations in West Cumbria. MB- I don't want one hospital to feel inferior to the other. I just want really good acute hospital services on both sites. I want this to be seen as correcting mistakes in Carlisle and also providing a new hospital in West Cumbria to provide good services. I want N Cumbria to be a rural exemplar.
10e. Penrith isn't mentioned - what is the plan for Penrith?	MB – Penrith is a good hospital, and might do more. Alongside this we'll draw up proposals for the community services to reflect the overall needs of the community. NW - During next year we'll be coming out with a consultation for community services including community hospitals.

Questions/ concerns/ issues	response
THE CONSULTATION PROCESS	
1. How robust is the exercise on prioritisation of benefits?	MB - We felt it was robust in informing the proposals; it allowed staff and public to be involved. It was validated and independently reviewed by W Lakes Research institute. It's not a statistically valid public vote, but was effective in informing the development of the proposals. MB – the hybrid model emerged from the public view – if we'd just listened to NHS staff, the proposals would have been different.
2. How do you intend to ensure you get a full and fair response from the consultation document?	MB - As well as the public meetings, we're taking part in at least 3 Neighbourhood Forums in each district, engaging the voluntary sector, local authority partners, the 4,500 people who took part in the health survey earlier this year, also targeting hard to reach communities. Also our website is running and well used and consultation document is easily accessible. Documents were tested by lay readers panel.
3. We have concerns that some of the questions in your consultation document can be regarded as leading questions. Can you confirm (for the record) that answers to these questions will be regarded as for guidance only, and not to pre-empt or discredit other responses received?	NW – The questions were road tested with a lay readers panel, but I recognise what you say – we will record all comments in an unbiased way – genuinely looking for all comments.
4. The committee is likely in its report on the consultation to ask to see a clear schedule and timescale for the following consultations and plans, and in particular to see in quantified terms how all the proposals fit together - including in particular how the community services will cope with the additional workload implied by the changes in the hospital services. Members would like to discuss with you how and when this can be achieved.	NW – On community services, we'll develop locality plans with local communities and consult next year. We see this as an ongoing dialogue with the scrutiny process. We're to be developing 3 year plans as in other parts of the country. In community services we want to develop links with Social Care.
4a. The chronic conditions group commented that we can't comment on proposals without knowing more about the community services.	MB- That's our professional staff talking – they don't know enough about the community services. That's why the next stage of planning for community services is important.

Questions/ concerns/ issues	response
4b. People see the community services as only getting the crumbs after the main acute issues are sorted	NW – We've not been very good in the past in making sure we run integrated services – we've worked in "silos". What we're trying to do is turn this on its head through looking at care streams. 70 percent of our resources are staff – we want to deliver more effective services through better use of staff and making the care less disjointed. Not rocket science, but it's our aim – and delivering the targets and providing safe services. None of this is sustainable unless it's done in a balanced approach. The issue is fundamental, about getting staff to think and work differently. We're getting some response from staff by involving them, rather than this being seen as top down. We could be on the verge in N Cumbria of a model of integrated working as an exemplar for rural economies.
4c. We still need to hear a public commitment in a credible form to give equal priority to community services.	
4d. It's about creating a seamless service – ITU needs core services, acute needs community services. Have we this assurance that the new hospital won't diminish community services in the west?	MB Yes. We need the community services, eg for older people, people with diabetes.
4d. You and we have to be more convincing about this – what's the catch?	MB There's been a history of suspicion, but it's all common sense.
EMERGENCY CARE SERVICES	
1. Can you confirm for the record that the 24-hour emergency cover will include surgery/ anaesthetics as well as medicine on both hospital sites?	MB - yes

Questions/ concerns/ issues	response
2. If so, how will this be provided in West Cumbria if there is no other surgery practiced in the hospital?	MB - There will be other surgery practiced. D&T centres only provide less than 24 hour care – day surgery. Hips, knees etc will be on both sites. Also general surgery. We need to be better at emergency surgery. eg for upper GI bleed, we need to be better at preparing and transfer. We need a D&T for, say, a cataract treatment centre for North Cumbria. I want to treat cold elective cases in North Cumbria. If we don't do this, they will have to go outside North Cumbria under the Government's Choice agenda. I want the NHS to provide elective surgery in North Cumbria – patients would not have to go to, say, Liverpool. We need to test the idea clinically over the next 12 months. We are creating NHS choice in North Cumbria.
2a. What's the financial implication of the choice agenda at present?	MB- At present the government injects sums of money outside the local commissioning system to implement choice, and it takes people out of the area for their treatment. We need to be both self-sufficient and cost effective in North Cumbria.
{Response to question 2 – continued]	MB - Complex surgery happens now at Carlisle – all we're doing is declaring that.
3. If not, what will be the implication in terms of additional numbers of emergency transfers from West Cumbria to Carlisle?	[Not relevant]
4. What emergency cover will there be for children on both sites?	MB - 24/7
5. Does the statement of proposals to have GP Treatment Centres and Minor Injury Units located near A&E apply to all treatment centres/ minor injury services, or just to some? Will the GP treatment centres be 24 hours?	NW - There will be minor injury units developed as part of community review
6. Please could you provide us with further information about what the ITU service provides, in particular what additional provision as compared with other categories of intensive care?	MB - Basically, it's for people who need ventilation.
SERVICES FOR PEOPLE NEEDING PLANNED OPERATIONS	
1. What is actually meant by a diagnostic and treatment centre?	MB – we need to hammer home an easier to understand definition

Questions/ concerns/ issues	response
2. What range of people and conditions would it provide for?	[not answered]
3. What proportion of all surgery will take place there?	MB – This is being tested.
4. Will it include overnight beds?	MB - no, but capability to transfer to a 24/7 site if needed
5. Will it have its own surgeons distinct from the two hospitals?	MB - there will be a rotation, say a week at each type of care
6. In terms of numbers, how many visits would be made (per year) to a single centre for diagnostic and treatment centre services and complex surgery for people in North Cumbria? How many of these people would travel further than now? (Some statistics would be appreciated)	MB - We're developing one stop shop model which will reduce travel
7. Why is the proposal for just one diagnostic and treatment centre? Were options of having more than one D&T centre examined?	MB – Our proposals are just saying this might happen.
8. Would the D&T Centre have to be on an acute hospital site?	MB - Not necessarily. It helps if there are complications.
9. Whilst you have stated that this consultation is not about the location of the D&T Centre please comment on the range of feasible options for such a centre. In particular, are there any options ruled out by other proposals in your consultation?	MB – We have deliberately avoided making a statement. Want it to be determined by patient flows. We need to determine patient flow rates, required some more thought.
10. Who will manage the D&T Centre? In particular, will it be NHS managed?	MB - I want it to be NHS managed
11. What is meant by "complex surgery" in terms of numbers and conditions?	MB - Procedure-based.
COMMUNITY SERVICES	
1. What does "maximising the use of the community health services" actually mean?	MB - People with non-acute care needs will be cared in non-acute settings. We have variable utilisation of our facilities including community hospitals, and want to get full occupancy and use them more consistently.

Questions/ concerns/ issues	response
2. Will there be any services moving OUT of the community under thee proposals?	MB – There is no current thinking around that - but integration with social care might result in some services being in different settings.
3. Do you intend to put forward any proposals for changes in community services at your Board meetings in March (following the consultation)? If so, how can the Committee comment on them?	NW – The proposals will give a setting for shaping services later – we will initiate some early work on community services early in the new year, involving PPIF people.
4. Will your community service proposals cover support for hospice/ terminal care provision and for elderly mentally ill people?	NW – Yes. There may be an opportunity to develop intermediate facilities between health and social services to fill gaps – the independent sector does not always fill these gaps.
4a. Have you discussed impact for social services	NW - We are discussing acute proposals with Social Services colleagues, as part of our generally improved working arrangements with Social Services.
4b. Concerns have been expressed that we're planning to move people out of hospital before we plan the community services.	NW - None of this is being done in isolation. We are doing things now. One practical example – out of hours 24 hour nursing would enable a significant number of patients to avoid admission to an acute hospital and earlier discharge. There are things we can do marginally which will make a significant difference. Changes will be undertaken in a managed way.
4c. What input to the consultation is there from carers associations? Their role is important.	NW – It's a bit early to give feedback, but we are working though the CVS's to seek views of carers. Also we are thinking about developing a role of generic care worker/ support worker. We are exploring this with Social Services colleagues. Models elsewhere show that this works. Our aim is to provide a menu of services to fit in with local needs.

2. Task Group Meeting with Mr L Handley, Chairman of the Acute Trust's Patient and Public Involvement Forum, 10 January 2005.

1 Mr Hanley summarised views so far from the Patient and Public Involvement Forum, whose membership is well balanced across east and west Cumbria.

- Concerns in the east are principally about community facilities
- Concerns in Carlisle are around possible dilution of the Carlisle service
- Concerns in the south (Millom) cover both community facilities and the new facility
- Concerns in the west are around the new facility
- There is a general concern about what happens next. We have been told there will be further consultations.

2 Mr Hanley referred to his views, which were being discussed with the PPIF, that the next consultation should include an option for a "Health Park" in West Cumbria, encompassing education, commercial and hospital developments. The new hospital should not be seen just as a replacement, but as a catalyst to improve employment and other infrastructure. It could bring together current plans, e.g. University of Central Lancashire were looking at developing a medically related campus using part of the West Lakes site. A similar concept in being developed in North Staffordshire, and there is American experience. The PPIF were preparing a bid to the Commission for Patient and Public Involvement in Health for a scoping study into the idea.

3. Meeting with Members of the North Cumbria Local Medical Committee (LMC) – 1 February 2005

Members of the LMC present: Dr D Lowe (Brampton); Dr I McGreavy (Workington); S Dr Chaudry (Maryport); Dr C Patterson (Carlisle); Dr M Bewick (Egremont); D Dr M Mort (Workington).

Points made by members of the LMC at the meeting:

- Early on in the planning process, the PCTs were asked to design a community model, but it was put to the end of the timescale. There are fears that the provision of the acute hospital proposals will be at the expense of the community hospitals.
- In some areas with no cottage hospitals at present, the service feels under strain.
- Community services should as far as possible be home-based. This is not cheaper than hospital services, but is better. At the moment, there is often no option but to admit people into hospital
- Views of the GPs present about the hospital model varied – some considering a single acute hospital is the answer, other that two hospitals are required. There was general concern of those present that the proposed model was not viable.
- The GP's present were concerned about the changes.

4. Meeting of the Task Group with Mr J. Brown, Chairman of the North Cumbria Action for Health

Note: The North Cumbria Action for Health is a representative body of voluntary sector organisations with an interest in health.

Points made by Mr Brown:

He thought the consultation had been well organised apart from the voluntary sector and others not being involved at the start of the process, and commented that the views of the North Cumbria Action for Health are as follows:

- There is a need to know where the Diagnostic & Treatment Centre will be situated

- Clarification is needed of the position of cottage hospitals
- The timescale of 3-5 years as mentioned by the NHS at the Public Meeting on the 15 February appeared optimistic.
- Clarification is needed of what funds are available for the proposals
- Further consideration should be given to the relationship between Community and Acute Services

5. Follow-up meeting of the Task Group with Mr Woodcock and Ms Burnham, 16 February 2005

Questions/ concerns/ issues	Response
1. Please can you give us your summary position on feedback on your consultation	NW: Overall, we are pleased with the consultation process – we issued 9000 copies of the consultative documents; there was good attendance at meetings; there have been meetings with staff and engagement with groups; there were around 1000 questionnaire responses received including on-line and a good cross-section. We are evaluating comments and working towards the joint PCT meeting on 18 March. We have key pieces of work to move on with, e.g. planning for a new hospital, D&T Centre, plus plans for community services. There have been concerns that the process will compromise community services. That's not a real risk, because we are thinking forward and engaging GPs etc. Also the degree of collaboration is strengthening, including amongst clinical staff. This is new in North Cumbria. The focus is on the needs of patients, whatever the locality. This is critical to underpinning the whole strategic process. The staff want to get on with this now – not just the clinical staff. There are big opportunities now for services for future generations. MB I agree – I have never seen staff so keen to make this step-change. If it doesn't go through, things will go sadly wrong. It's never been a better time.
2. At the Whitehaven meeting, there were concerns about the design of the proposals. People were anxious they couldn't respond to the consultation without knowing the location of the hospital in West Cumbria.	MB – The staff at the meeting said it was services rather than location which were the most important. The key thing is the feasibility of having a hospital in West Cumbria, and we need to recruit good quality staff. So the first thing is to set the marker for a hospital in West Cumbria. The next thing is location, and we don't want to make the same mistakes as Carlisle. The consultation talks about permission for a new hospital, not about having a new hospital – it's about services.

Questions/ concerns/ issues	Response
3. Above all, concerns have been expressed about the financial background to the whole situation in north Cumbria, and whether there will be a similar financial prospect for developing the community services as there is for the acute services. Mr Woodcock's reply letter referred to discussions with the Strategic Health Authority (SHA) – are you in effect saying that if we recognise these public concerns, should we send these concerns to the SHA as well as to you?	MB: On the financial point, where you work through health planning, you need enabling provisions to allow services to move forward. We need first and foremost to make sure the acute hospital (as the place of last resort) is safe. You have to plan acute services first, then community, then social. At present, my consultants have no confidence in the community services, e.g. geriatricians have been saying they have no confidence in the community hospitals, and so won't discharge into community hospital beds. We are working with them on the basis of the important thing being the patient care, and we are now getting a change in attitude. Also we have many patients who have been in an acute bed for many months – 12 people have been there over 3 years. We have to plan the acute service first and then disinvest to allow reinvestment into the community infrastructure. I have taken over £2m from the Acute Trust through competent housekeeping. Mr Woodcock will have to both invest in community services but de-invest in management overheads. Also in some areas I have too much resource, e.g. 8 ophthalmologists when I only need 6. By working together to tackle issues, the deficit in the health economy will be recovered. NW: It's also about working closer with Social Services – that's about getting a better focus on delivery – we have duplication between the PCT's and between health and social care. Also the PCT's have just had a good health settlement for the next 2 years which will help with our £19m recovery plan. We are no longer "paddling round the edges". I will be consulting next month on arrangements to reduce my management costs by £400k. We are doing things in the right order. If we can empower staff to work within a "virtual health services" we can achieve better value. The Green Paper on social care will open up more opportunities to work closer together. We are taking a hard nosed approach to getting better and more cost effective services. There is a joint commitment from our Boards as well as Chief Executives to do this. This strategy is the first key plank to taking this forward.

Questions/ concerns/ issues	Response
4. We need to speak with one voice and not lose our hospital in West Cumbria because we bicker over the site. We need a transparent, open and reasonably brief consultation paper on the new hospital. A timescale of 3 to 5 years sound optimistic. The important other thing is how we get the services into the community. Hospital doctors need a range of options to be able to discharge patients from hospital beds.	NW I welcome this comment. Scrutiny has a key role in working alongside us in taking the thinks forward. We want the right outcome and it's got to have public confidence. We want to talk to you about how we take things forward.
5. There is confusion about the definition of "complex". There is some "muddying", e.g. Ms Burnham is saying surgery will still mainly be in both the hospitals – this is different from what's in the consultation document.	MB It's difficult to articulate what you mean by complex surgery. It's procedurally based – there are several hundred procedures in each specialty. It is very much a clinical decision about the complexity of the procedure. It's not acceptable clinically for consultants just to do 2 or 3 cases of a procedure per year. It's about safety. So I don't want locums doing complex procedures in our hospitals, or any consultants doing procedures outside the national parameters. Certain complex procedures in surgery will take place at the Cumberland Infirmary – as now. For example, for GI bleed, we have to locate the complex procedures at Carlisle because if the patients "go off" they have to be transferred to Newcastle. And there are 2 sub-regional specialisms in Carlisle – renal services and radiotherapy. Otherwise there's no real difference between the hospitals. These arrangements happen now. The change in numbers is so small you probably wouldn't notice. This consultation is about being honest with the public about what takes place in the hospitals. Carlisle needs West Cumberland Hospital , for example the during the recent floods. I originally thought we needed just one hospital for North Cumbria, but over the past 18 months I've become convinced of the need for 2. We need to have 2-man consultant teams on both sites. There is a 2-way movement of patients now – some patients go to West Cumbria.

Questions/ concerns/ issues	Response
6. You need to say to the public that there is only a marginal difference between the hospitals – the 2 sub regional specialties and small-volume complex surgery.	MB: I agree, and also we need to stop West Cumbria GPs referring to Carlisle. Now they are not convinced about West Cumbria's hospital services, e.g. because of dependence on locums. NW: We've stopped clinicians arguing in public between the hospitals. We've now got increased collaboration – people working to a common end.
7 Community services are still a concern.	NW: We recognise we need different models for community services and are working with local communities.
8. The wheelchair service was just shifted to Carlisle and people only told later. When you plan community services (and community rehab) is there a possibility of services moving back to West?	MB: Specialist rehabilitation including the wheelchair service will include services for people who have been in hospital for years and shouldn't be. We could locate a specialist rehabilitation unit in one of our community hospitals – I personally feel it should be in the west. It could be a "Hunter's Moor" for North Cumbria. It should be a multi-professionally driven model.
9. That's great, but you need to tell the public. They are afraid and don't know and don't get definitive answers.	MB: If we'd started the consultation based on specialties, spelling out what would be where, we would get nowhere, because the staff would argue over location. Our approach is to take a care stream model – right across the hospital and the community – designed for what people really need across the whole of North Cumbria.
10. Are you confident you're getting a unified team?	MB: Yes – consultant teams are led by consultants on either side (east or west). There are still in-depth cultural issues not just in the hospitals, but the consultants are working together to deliver the service.
11. Do you "rural-proof"?	NW: There is not a formal requirement, but we are taking a basic common sense view because of the way we have to manage services across North Cumbria, to make sure any services generally reflect the needs of sparse rural communities. MB: If we hadn't "rural-proofed" we wouldn't have ended up with a proposal for two hospitals.
12. There is still some "NHS" bed-blocking. With rural-proofing you could move such people out into community hospitals. Why can't you move them out?	NW: We are trying to achieve this though improving the way the clinicians use the community hospitals. MB There is a problem that community hospitals are not located in all communities. We need to focus on community *provision.* NW And with different forms of out-of-hours community staff, we can discharge earlier. MS: Also we are building on joint work with Social Services. We have a joint commissioning group. We have to put the new arrangements in practice with our clinicians.
13. Are there health visitor vacancies?	MS: Not many. There are more in community nursing. We are also reviewing their work profile.

Questions/ concerns/ issues	Response
14. Communications across hospital/ community are poor. This is a concern.	
15. Do you have the funding to provide the capacity for retraining and new job specifications?	NW: We're working with the SHA to secure funding to achieve these changes. I'm confident we'll get support to achieve that. It will take 2 years or so to work through. I think we're a special case and have written to the SHA about it. Much training now is by E-learning which avoids staff having to travel away. MS: We're already taking measures to avoid admissions. We're not starting from scratch.
16. The PPIFs are trying to get funding for a researcher to pull together modernisation issues to do with rurality etc.	MS: We'll look at that with you.
17. At the meeting with GPs there was unanimity of concern amongst the GPs there about the relation between the acute and primary care proposals. Can you "take on" GPs in the same way as you took on the consultants so they can become leaders in taking forward tha changes? This seems urgent.	MB The GPs you met were from the Local Medical Committee (LMC). The LMC are like a trade union . One of the GPs whom you met led the single hospital option. He did some good work, but firmly believes that a single hospital is the way forward. The LMC have not engaged the PEC chairs. They don't represent the full view of GPs. NW: GPs depend on the local acute services, and are committed to work with us on taking forward the community services, e.g. on practice-based commissioning and also on the actual community services. I'd be concerned if this context isn't made clear to you. The "silent majority" of GP's welcome the approach we're taking. The proposals have been supported by the PCT Boards, which includes the PECs voice. This is important for you to know.
18. [One Councillor commented on the support for the plans from his GP practice]	NW: That's the general view.
19. Another underlying anxiety mentioned in the GP meeting was the doctor's role in 24 hour community cover. This needs answering in the next round of consultation.	MS: Yes – it's already being tackled. It's the PCT's responsibility now to provide 24 hour cover, not the individual GP.
20. It would be useful if details of the West Cumbria Hospital options are shared as openly as possible.	MB: Agreed.

Appendix 9.

Glossary of Abbreviations

A&E	Accident and Emergency
BNFL	British Nuclear Fuels Limited (Sellafield)
CAS	Cumbria Ambulance Service
CVS	Council for Voluntary Service
COPD	Chronic Obstructive Pulmonary Disease (chronic bronchitis)
DTI	Department of Trade and Industry
DTC	Diagnostic and Treatment Centre
GI bleed	Gastro-intestinal bleeding
GP	General Practitioner (Family Doctor)
ITU	Intensive Treatment Unit
LMC	Local Medical Committee (Local representative body of GP's)
LSP	Local Strategic Partnership
NHS	National Health Service
OSC	Overview and Scrutiny Committee (in this context, the Cumbria Health and Well-being Scrutiny Committee)
PEC	Professional Executive Committee (body responsible for the professional policies in a Primary Care Trust)
PCT	Primary Care Trust (Local NHS body responsible for managing primary care, commissioning hospital and other health services, and health improvement)
PPIF	Patient and Public Involvement Forum (local bodies to represent patient views to the NHS)
SHA	Strategic Health Authority