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Cumbria County Council

14 July 2017

To: The Chair and Members of the Cumbria Health Scrutiny Committee

Agenda

CUMBRIA HEALTH SCRUTINY COMMITTEE

A meeting of the Cumbria Health Scrutiny Committee will be held as follows:

Date: **Monday 24 July 2017**
Time: **10.30 am**
Place: **Council Chamber - County Offices, Kendal, LA9 4RQ**

Dawn Roberts
Corporate Director – Resources and Transformation

NB A PRE-MEETING WILL BE HELD AT 9.30 AM IN THE COUNCIL CHAMBER AND ALL MEMBERS ARE ENCOURAGED TO ATTEND

Enquiries and requests for supporting papers to: Lynn Harker
Direct Line: 01228 226364 / 07825340229
Email: lynn.harker@cumbria.gov.uk

This agenda is available on request in alternative formats

MEMBERSHIP

Conservative Members (3)

Mr P Dew
Mr CJ Whiteside
Mr S Wielkopolski

Labour Members (2)

Ms C Driver (Chair)
Mr M Hawkins

Liberal Democrat Members (2)

Mrs RC Hanson
Mr N Hughes

District Council Representatives (6)

Mrs J Riddle	-	Carlisle City Council
Ms C McCarron-Holmes	-	Allerdale Borough Council
Mr R Gill	-	Copeland Borough Council
Mrs V Rees	-	South Lakeland District Council
Ms V Taylor	-	Eden District Council
Mr M Cassells	-	Barrow Borough Council

ACCESS TO INFORMATION

Agenda and Reports

Copies of the agenda and Part I reports are available for members of the public to inspect prior to the meeting. Copies will also be available at the meeting.

The agenda and Part I reports are also available on the County Council's website – www.cumbria.gov.uk

Background Papers

Requests for the background papers to the Part I reports, excluding those papers that contain exempt information, can be made to Legal and Democratic Services at the address overleaf between the hours of 9.00 am and 4.30 pm, Monday to Friday.

A G E N D A

PART 1: ITEMS LIKELY TO BE CONSIDERED IN THE PRESENCE OF THE PRESS AND PUBLIC

1 ELECTION OF VICE-CHAIR

In accordance with the Committee's Terms of Reference to appoint a Vice-Chair who shall be a District Councillor representative for the ensuing year. The Vice-Chair shall be appointed by the District Council representatives serving on the Committee.

2 APOLOGIES FOR ABSENCE

To receive any apologies for absence.

3 MEMBERSHIP OF THE COMMITTEE

To note the membership and Terms of Reference of the Committee.

4 DISCLOSURES OF INTEREST

Members are invited to disclose any disclosable pecuniary interest they have in any item on the agenda which comprises

1. Details of any employment, office, trade, profession or vocation carried on for profit or gain.

2. Details of any payment or provision of any other financial benefit (other than from the authority) made or provided within the relevant period in respect of any expenses incurred by you in carrying out duties as a member, or towards your election expenses. (This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992.

3. Details of any contract which is made between you (or a body in which you have a beneficial interest) and the authority.

    (a) Under which goods or services are to be provided or works are to be executed; and

    (b) Which has not been fully discharged.

4. Details of any beneficial interest in land which is within the area of the authority.

5. Details of any licence (alone or jointly with others) to occupy land in the area of the authority for a month or longer.

6. Details of any tenancy where (to your knowledge).

   (a) The landlord is the authority; and

   (b) The tenant is a body in which you have a beneficial interest.

7. Details of any beneficial interest in securities of a body where

   (a) That body (to your knowledge) has a place of business or land in the area of the authority; and

   (b) Either –

      (i) The total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body; or

      (ii) If that share capital of that body is of more than one class, the total nominal value of the shares of any one class in which the relevant person has a beneficial interest exceeds one hundredth of the total issued share capital of that class.

Note

A "disclosable pecuniary interest" is an interest of a councillor or their partner (which means spouse or civil partner, a person with whom they are living as husband or wife, or a person with whom they are living as if they are civil partners).

5 EXCLUSION OF PRESS AND PUBLIC

To consider whether the press and public should be excluded from the meeting during consideration of any item on the agenda.

6 MINUTES

To confirm the minutes of the meetings held on 28 February and the Special meeting held on 22 March 2017 (copies enclosed).
(Pages 7 - 42)

7 CUMBRIA HEALTH SCRUTINY VARIATION SUB-COMMITTEE

To agree the new membership of the Sub-Committee in accordance with its Terms of Reference (copy enclosed).
(Pages 43 - 52)

8 LOOKING FORWARD - THE HEALTH AND CARE SYSTEM IN CUMBRIA

To receive a joint presentation by the Corporate Director – Health, Care and Community Services, Chief Operating Officer, North Cumbria NHS Clinical Commissioning Group and Chief Operating Officer, Morecambe Bay NHS Clinical Commissioning Group on the Vision and Priorities for Health and Care in Cumbria.

9 COMMITTEE BRIEFING REPORT

To consider a report by the Strategic Policy and Scrutiny Adviser (copy enclosed).
(Pages 53 - 56)

10 DATE OF FUTURE MEETING

To note that the next meeting of the Committee will be held on Monday 9 October 2017 at 10.30 am at Cumbria House, Botchergate, Carlisle, CA1 1RD.

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CUMBRIA HEALTH SCRUTINY COMMITTEE

Minutes of a Meeting of the Cumbria Health Scrutiny Committee held on Tuesday, 28 February 2017 at 10.30 am at Council Chamber - County Offices, Kendal, LA9 4RQ

PRESENT:

Mr N Hughes (Chair)

Mr J Bland	Ms V Taylor
Mr R Gill (Vice-Chair)	Mrs GR Troughton
Mr J Lister	Ms C Wharrier
Mrs V Rees	Mr M Wilson

Also in Attendance:-

Mr A Bennett	-	Senior Responsible Officer, Better Care Together, Chief Officer, Lancashire North CCG
Mr B Clark	-	NHS England
Ms J Clayton	-	Head of Communications and Engagement, NHS Cumbria Clinical Commissioning Group
Ms Y Fairburn	-	Associate Chief Operating Officer
Mr N Greaves		
Mrs L Harker	-	Senior Democratic Services Officer
Mr R Heaton	-	Chief Matron
Mr D Houston	-	Senior Manager - Health and Care Integration
Mr M Huddart	-	North West Ambulance Service
Dr G Ozuzu	-	Consultant Ophthalmologist & Lead Clinician, Ophthalmology at the University of Hospitals of Morecambe Bay NHS Foundation Trust
Mr G Raphael		
Mr T Rideout	-	NHS England
Mr P Rooney	-	Chief Operating Officer, NHS Cumbria CCG
Mr R Shaw	-	North West Ambulance Service
Mr D Stephens	-	Policy & Scrutiny Project Officer
Ms S Stevenson	-	Chief Operating Officer, Healthwatch Cumbria
Mr D Walker	-	Medical Director, University Hospitals of Morecambe Bay NHS Foundation Trust

PART 1 – ITEMS CONSIDERED IN THE PRESENCE OF THE PUBLIC AND PRESS

48 APOLOGIES FOR ABSENCE

Apologies for absence were received from Ms C McCarron-Holmes, Mr M Cassells, Mr A Toole and Ms J Williams.

49 MEMBERSHIP OF THE COMMITTEE

There were no changes in the membership of the Committee on this occasion.

50 DISCLOSURES OF INTEREST

Mr R Gill advised that his wife was an employee at the West Cumberland Hospital.

51 EXCLUSION OF PRESS AND PUBLIC

RESOLVED, that the press and public be not excluded from the meeting for any items of business.

52 MINUTES

RESOLVED, that the minutes of the meeting held on 13 December 2016 be agreed as a correct record and signed by the Chair.

53 BETTER CARE TOGETHER UPDATE

The Committee received a report which updated the Committee on the delivery of the Better Care Together Programme.

Members were informed that the Better Care Together had been awarded £4.73m of further Vanguard funding for the 2017-18 financial year which took the total amount received to almost £13m over a three year period. It was explained that progress was quicker than originally envisaged, bringing together health and care services and moving care closer to people's homes. The Committee noted that plans for 2017-18 were still being finalised but would continue the theme of developing care closer to people, bringing the organisations providing health and care closer together to prevent duplication and ensure seamless care, and continued to modernise services to ensure they were provided with the public at the centre.

The Committee discussed the workstreams, recent events and successes and STP alignment.

A discussion took place regarding the Integrated Care Community Development and members asked if collaborative working was progressing well. It was explained that integrated care was the future of health care and that individual organisations should not be working in isolation, highlighting many examples of joined up working.

Members were informed that the 2017/18 work plans were due to be finalised at the end of March 2017 with no major service reconfigurations expected.

The Committee noted that the DToC programme of work was launched in April 2016 which brought together partners from across the Morecambe Health community to take a co-ordinated look at how they might work together to reduce the rising number of patients who were "trapped" in an acute hospital bed.

Members discussed readmission figures following discharge. It was explained that there was evidence to show that patients were safer out of hospital in their own environment, emphasising that this was only carried out following assessment. The Committee emphasised the need for care in the community to be available to provide support following discharge and requested further data regarding this service be made available at a future meeting.

It was explained that readmissions were monitored and members requested further information regarding a detailed breakdown of DToC and readmission figures be made available at a future meeting of the Committee.

The Committee emphasised the importance of engagement with the community and it was agreed that Bay Health Care Partners through their engagement ambassadors and other mechanisms such as Healthwatch would draw up specific plans to engage effectively with rural areas.

During the course of discussion members were informed that ICCS in South Cumbria was variable at this stage as funding had only been available in the last 18 months. A discussion took place regarding the availability of ophthalmology services within ICCS. Members were informed there was the facility for patients to have an initial consultation in the community but highlighted the significant capacity shortfall. Discussions were, therefore, taking place with local optometrists to empower them with the necessary skills to carry out the service in the community. It was agreed that a further update would be made available to members in the future.

A further request was also made for a map of facilities in South Cumbria and the services offered from those sites to be circulated to all members of the Committee.

RESOLVED, that

(1) the report be noted;

(2) an update from ICC Clinical Leads be made available to the Committee within the next 12 months.

54 SUSTAINABILITY AND TRANSFORMATION PLAN FOR SOUTH CUMBRIA AND LANCASHIRE

The Committee received an update on progress to date on the production of the Sustainability and Transformation Plan (STP) for South Cumbria and Lancashire.

Members were informed that in December 2015, the NHS published guidance on the publication of Sustainability and Transformation Plans (STPs) which asked every health and care system to come together, to create its own ambitious local blueprint for accelerating its implementation of the Forward View.

The Committee noted that in the guidance, authored by the six national NHS bodies, a clear list of national priorities was set out for 2016/17 and longer-term challenges for local systems, together with financial assumptions and business rules. This reflected the settlement reached with the Government through its new Mandate to NHS England which was not solely for the commissioning system, but set objectives for the NHS as a whole.

The guidance also stated that as a truly place-based plan, the STPs must cover all areas of CCG and NHS England commissioned activity which, for Cumbria, meant:-

- the West, North and East (WNE) Cumbria – it would, however, be expected to have alignment with the STP covering the North East of England;

- the whole of Lancashire and South Cumbria - this would include sub plans for the more localised health economies including Morecambe Bay.

The Committee considered the eight transformational workstreams:-

- Prevention
- Primary Care Transformation
- Regulated Care Sector
- Urgent and Emergency Care
- Acute and Specialised
- Children and Young People Mental Health
- Learning Disabilities
- Mental Health Transformation

and it was highlighted they were all becoming important.

Members discussed the potential issues which could arise due to Cumbria being a two tier Authority and it was confirmed that agreement would be sought on which partner would take the lead with additional support being provided thereafter.

The Committee discussed the importance of collaborative working and raised their concerns regarding the lack of integration from all partners. It was noted that everyone was mindful of this and acknowledged that safe and appropriate decision-making together was essential rather than a fragmented approach.

A discussion took place regarding the reference to 'Three major gaps'

- Health and Wellbeing
- Care and Quality
- Finance and Efficiency

Members were informed there was a great deal of misunderstanding and highlighted that the main focus was to be as effective as possible within the resources available emphasising that the STP were working with all partners.

The Committee discussed the development of the Accountable Care Systems across the five areas and it was noted that Morecambe Bay were most advanced but all other areas were making progress with regards to working together. It was acknowledged that there were challenges ahead but there was a central resource to ensure the STP did progress.

Members felt that the clinicians provided a good service but concerns were raised regarding administration. The Committee were informed that there was a lack of resources at present but acknowledged that support to the clinical team was crucial.

Members felt that liaison should take place with other Health Scrutiny Committees, potentially to establish joint arrangements for scrutinising the STP as a whole.

The Committee discussed the development of draft communication materials on the STP and it was agreed this would be made available to members of the Committee prior to publication in mid March.

The Chair welcomed the update and emphasised the necessity for public engagement.

RESOLVED, that

(1) the report be noted;

(2) the draft communication materials on the STP be made available to members of the Committee prior to publication in mid March.

55 NWAS - CARE QUALITY COMMISSION REPORT

Members received a report which gave an update from the Care Quality Commission (CQC) on their inspection of the North West Ambulance Service (NWAS). It also contained the response from NWAS and an update on the performance of the Trust.

The Committee were informed that the CQC had carried out their announced focused inspection of NWAS, as part of their comprehensive inspection programme, between 23 and 26 May 2016, with an unannounced inspection taking place on 6 June 2016.

Members noted that three core services had been inspected - Emergency Operations Centres, Urgent and Emergency Care, Patient Transport Services, together with the inspection of the NHS 111 service provision.

The Committee were informed that overall, the CQC rated NWAS as 'Requires Improvement' and had identified specific areas for improvement. It was noted that concerns included a high level of vacancies among front-line paramedics, the Trust's Complaints Policy and mental capacity assessments.

A discussion took place regarding reviewing the process for pre-alerting hospital accident and emergency departments to ensure that communication was sufficient for the receiving department to be made fully aware of the patient's condition. The Committee were informed that improvements had been made which, it was anticipated, would reduce waiting times and members requested further information regarding the length of time ambulances were detained.

The Committee were informed that turnaround times for NWAS had increased, highlighting that North Cumbria had bucked the trend and improved by two minutes overall, noting that overall cycle time had increased. Members noted that work had been undertaken with the acute hospitals which had shown improvement and were informed that a dedicated team worked with individual acute sites to investigate the processes undertaken.

Members discussed why NWAS had recently retracted its formal response to the Success Regime consultation and asked what change in circumstances was the retraction based. The Committee were informed that if option 2 came to fruition there were concerns regarding transferring patients between sites. It was noted that maternity services was a key area of concern and detailed discussions had been undertaken with the Cumbria Clinical Commissioning Group and the acute hospitals where assurances had been made that clinicians would be provided for transfers.

The Committee noted that within the risk registers, some risk descriptions did not clearly describe the risk; some of the information recorded under controls and assurance were not actually controls or sources of assurance; there was no target rating for risks on the risk register, meaning it was unclear what level of risk the Trust was aiming for, and there were a number of risks without actions identified to mitigate the identified risk. Members were concerned at the lack of communication with staff and were informed that all staff had been informed of changes through staff forums in community/acute hospitals, media briefs etc.

Members discussed the possibility of pre-alerting patient transfers between Carlisle and West Cumbria hospitals. It was felt that this was important but did not take place at present but discussions were in place.

The Committee drew attention to the Trust reviewing the staff training requirements for the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) guidelines. Members were informed that staff had to undertake mandatory training on the Mental Capacity Act highlighting that this was also available as an e-learning course.

A member drew attention to the difficulties which arose regarding training for first responders and representatives from NWAS agreed to investigate this matter further and respond direct. During the course of discussion a concern was raised regarding safeguarding for first responders and it was confirmed that they all received level 2 safeguarding training highlighting this was considerably better than at the time of inspection.

A discussion took place on how NWAS measured its performance and members asked that further detailed information be made available in future.

RESOLVED, that

(1) the report be noted;

(2) a further progress report be made available at a future meeting of the Committee.

56 NHS ENGLAND - STATUS OF FORMAL DIRECTIONS TO THE CUMBRIA CLINICAL COMMISSIONING GROUP

Members received an update from NHS England on the status of formal directions to the Cumbria Clinical Commissioning Group.

The Committee were informed that on 8 July NHS England wrote to NHS Cumbria CCG to confirm the outcome of the 2015/16 financial year assurance process. It was noted that NHS England had placed formal directions (effectively regulatory requirements) on all CCGs assessed as Inadequate overall for 2015/16. On 24 August NHS England wrote to NHS Cumbria CCG to confirm that NHS England was placing formal directions on the CCG.

It was explained to members that on 15 September a fuller explanation of all of the formal directions requirements was provided by NHS England to NHS Cumbria CCG. This provided further clarity on the specific requirements of the formal directions, and included a key requirement to submit a further iteration of the Improvement Plan and the Financial Recovery Plan.

The Committee were informed that NHS England had commissioned PricewaterhouseCoopers (PwC) to review the CCG Improvement Plan during December 2016. The CCG was to provide documentary evidence to PwC to demonstrate progress on the Improvement Plan on 9 December 2016 and NHS England held its quarterly assurance meeting with NHS Cumbria CCG in January 2017.

Members noted that the areas of concern included leadership and financial management, therefore, the CCG were also requested to develop an in-year financial recovery plan.

The Committee were informed that further assessments had been undertaken with the CCG together with PwC which highlighted that good progress had been undertaken and most of the recommendations had been implemented.

The Committee noted that with regards to the Financial Recovery Plan NHS England were satisfied that a credible plan had been developed. Members were also informed that there had been significant improvements in leadership with robust management in place.

A discussion took place regarding the future boundary changes of the CCG and questions were raised regarding an equitable split. Whilst acknowledging there would be challenges members were assured processes were in place to ensure there were sufficient resources to ensure the needs of the population were met.

The Committee discussed the resource allocation, highlighting the ageing population in the county, and it was agreed that the details of the Advisory Committee on Resource Allocation and the evidence and recommendations submitted to the Secretary of State would be circulated to all members of the Committee.

RESOLVED, that

(1) the report be noted;

(2) a further update be made at a future meeting of the Committee.

57 HELME CHASE MIDWIFE-LED MATERNITY UNIT

The Committee received a report which outlined the outcome of the consultation on the proposed variation to Helme Chase Midwife-Led Maternity Unit.

Members were informed that the consultation resulted in coverage on local radio, regional television and local newspapers, including attendance by a television crew at the MSLC event. It was noted there was no media campaigning during that period and coverage overall was balanced.

The Committee noted that concerns had been expressed regarding the future viability of the Unit, women arriving at the Unit before the midwife and about services being watered down. It was explained that constructive in-depth discussions had taken place with a small number of service users who attended the MSLC event and midwives from the Unit were able to offer reassurances about the services available to women. Members requested further information on the number of occasions expectant mothers in the early stages of giving birth had to wait at the Unit for the midwife and the length of delays involved.

Members raised their concerns about further planned changes for the Unit, including possible closure. It was confirmed by the CCG that neither themselves or the University Hospitals of Morecambe Bay NHS Foundation Trust were intending to close the Unit.

Members were made aware that an independent research, which involved more than 90 mothers and future mothers, showed that just over half of the women interviewed supported the changes being made permanent. It was explained that positive feedback had also been received from midwives.

It was noted that a number of themes emerged during the consultation, the most prominent was concerns about the future viability of the Unit which was underlying in many of the comments received. A further concern was regarding the loss of inpatient postnatal care which had been very much valued in the past. It was explained that this change was in line with a national shift towards women returning home as soon as they were clinically well enough, with post natal care being provided in their own homes and in the community.

Further concerns were also raised regarding increased pressures on the consultant-led services at Furness General Hospital and Royal Lancaster Infirmary, difficulties contacting the on-call midwife, arriving at the Unit before the midwife, the impact on midwives and the need for better communication about the services available at Helme Chase.

The Committee were informed that as a result of the feedback received the Trust had already begun exploring the possibility of introducing a centralised telephone line for women to contact maternity services. It was also improving its verbal and written communication with women about how the service worked. In addition, it had stepped up public information about the range of services available at Helme Chase, including open days to enable women and families to see the range of services available.

A discussion took place regarding the timing of the interim changes noting that the University Hospitals of Morecambe Bay NHS Foundation Trust were under great pressure. Members were informed that the Care Quality Commission had carried out two inspections since the interim change and were rated as ‘good’ on both occasions and were confident that women would not disadvantaged.

RESOLVED, that

(1) the proposal would be in the interests of the health service in its area;

(2) the Committee receive a further report from the CCG after 12 months on the performance of the Unit and an assessment on how the new model is operating.

58 CANCER SERVICES

The Committee received two separate reports from the Cumbria Clinical Commissioning Group considering the progress made in delivery cancer service standards in Cumbria, and a report from Healthwatch on people's experience of cancer services to help the Committee consider how this supported or challenged those findings.

(1) CCG on the Clinical Outcomes

Members received a report detailing the progress which had been made in delivering cancer service standards in Cumbria, and in particular considered the improvements seen at North Cumbria University Hospitals NHS Trust during 2016, following a period when national performance standards were not achieved. It also reflected the better performance at the University Hospitals Morecambe Bay Trust (UHMBT).

The Committee raised their concerns regarding the lack of radiology support for additional breast clinics which hampered the ability to manage capacity in a flexible manner to meet demand in the UHMBT area, and asked how the proposed changes in the CCG would affect the service. It was explained that the UHMBT area would be part of the Sustainability and Transformation Plan for South Cumbria where a cancer network alliance worked across the whole area providing more resilience and clinical capacity.

Members discussed the services of North Cumbria University Hospitals Trust. Concerns were raised regarding the complex cancers which were more likely to legitimately extend beyond the treatment of 104 days emphasising the need to resolve issues with diagnostics. It was explained this was a minimal number of cases which was usually due to complex or rare cases which required specific diagnostic.

The Committee discussed the current performance which had resulted in improvements for Cumbrian cancer patients, however, it was noted there was still further scope for improvements.

Members raised their concerns at the capacity issues which meant that the services remained vulnerable to staff turnover, sickness and fluctuations in demand.

A concern was raised regarding the lack of radiotherapy equipment at the Cumberland Infirmary and it was agreed that a letter would be sent to NHS England, the specialised commissioning services, to seek confirmation that it was their intention to replace the LINAC radiotherapy machine and ascertain timescales and number of machines.

A discussion took place regarding the location of Lead Cancer GPs and it was explained that the service was in the process of management of change regarding future roles and an outcome was awaited.

(2) **Healthwatch on Patient Experience and View of Services in Cumbria**

The Committee received an update on Cumbria Cancer Services from Healthwatch Cumbria which provided an update on the experience of people of the Service.

The report highlighted that in most cases services provided by acute trusts was felt to be good, however, there were certain aspects of care that were a concern. It was noted there was evidence that patient experience was inconsistent across pathways.

Members noted that Healthwatch Cumbria was continuing to keep service provision and improvement under review, particularly in the south of the county where they were working with and monitoring effectiveness. It was explained that repeated issues of concern were investigated in detail and, in some cases, would be taken forward to the Healthwatch Board who would look at the issues as part of a project.

The Committee welcomed the information and asked for any further information at a future meeting.

RESOLVED, that

(1) the report be noted;

(2) a letter be sent to NHS England to seek confirmation it was their intention to replace the LINAC radiotherapy equipment at the Cumberland Infirmary, ascertaining timescales and number of machines.

59 NEVER EVENT AND SALINE INCIDENT EXCEPTION REPORT

The Committee received a report from North Cumbria University Hospitals NHS Trust which provided an update on how Never Events were being managed across the Trust.

Members received details of Never Events declared since April 2016 as well as progress made on previous Events. The Committee also received an update on the saline incident which had occurred at the Cumberland Infirmary on 4 January 2017.

It was noted that NHS England defined Never Events as serious incidents that were wholly preventable as guidance or safety recommendations that provided strong systemic protective barriers which were available at a national level and should have been implemented by all healthcare providers.

Members questioned whether the circumstances which led to the Never Events in 2012 and 2015, covered in the January 2017 Coroner report, had been addressed. It was confirmed that immediate remedial action, specific training and measures had been put in place.

The Committee highlighted the sharp rise in complaints received by NCUHT recently. It was explained that concerns were welcomed highlighting that the majority of complaints were in connection with operational pressures. It was noted that complaints around care were minimal since the introduction of matrons walking their area.

RESOLVED, that the report be noted.

60 COMMITTEE BRIEFING REPORT

Members received a report which gave an update on developments in health scrutiny, the Committee's Work Programme and monitoring of actions not covered elsewhere on the Committee's agenda.

RESOLVED, that

(1) the report be noted;

(2) an update on NWAS CQC Improvement Plan be considered by the Committee in 6 months time (earlier depending on the outcome of the Healthcare for the future of WNE Cumbria);

(3) an update on the Sustainability and Transformation Plan be considered by the Committee in six months time.

61 DATE OF FUTURE MEETING

It was noted that there would be a Special meeting of the Committee to be held on Wednesday 22 March 2017 at 10.30 am in Cumbria House, Botchergate, Carlisle.

The meeting ended at 3.55 pm

CUMBRIA HEALTH SCRUTINY COMMITTEE

Minutes of a Meeting of the Cumbria Health Scrutiny Committee held on Wednesday, 22 March 2017 at Cumbria House, Botchergate, Carlisle at 10.30 am

PRESENT:

Mr N Hughes (Chair)

Mr J Bland	Ms V Taylor
Mr R Gill (Vice-Chair)	Mr A Toole
Mr J Lister	Mrs GR Troughton
Ms C McCarron-Holmes	Ms C Wharrier
Ms J Riddle	Mr M Wilson

Also in Attendance:-

Mr D Blacklock	-	Chief Executive - Healthwatch
Mr G Blezard	-	Director of Operations North West Ambulance Service
Ms J Clayton	-	Cumbria Clinical Commissioning Group
Mrs J Currie	-	Senior Democratic Services Officer
Mr S Childs	-	Chief Executive – Cumbria Clinical Commissioning Group
Mr S Eames	-	Chief Executive – North Cumbria University Hospitals Trust
Dr D Freake	-	Director of Strategy – North Cumbria University Hospital Trust
Dr R Harpin	-	Medical Director – North Cumbria University Hospital Trust
Ms H Horne	-	Chair – Healthwatch
Dr J Howarth	-	Director of Service Improvement – North Cumbria University Hospital Trust
Ms E Hodgson	-	Director of Children and Families, Cumbria Clinical Commissioning Group
Mr D Houston	-	Senior Manager – Health and Care Integration
Ms C Molloy	-	Chief Executive - Cumbria Partnership Foundation Trust
Dr D Rogers	-	Medical Director – Cumbria Clinical Commissioning Group
Mr P Rooney	-	Chief Operating Officer, Cumbria Clinical Commissioning Group
Mr D Stephens	-	Policy & Scrutiny Project Officer
Ms G Tiller	-	Chair – North Cumbria University Hospital Trust
Sir N McKay	-	Programme Chair of the Success Regime

PART 1 – ITEMS CONSIDERED IN THE PRESENCE OF THE PUBLIC AND PRESS

The Chair welcomed everyone to the meeting and outlined the procedure to be followed for the day, which included:-

The Committee would consider 8 decisions of the 8 March CCG Governing Body in turn and for each would decide whether or not to refer each decision to the Secretary of State, and would follow the process set out below during the meeting.

For each decision:

1. The Chair would invite the relevant officer from the CCG to present information about the decision to the Committee.
2. The Committee would have an opportunity to ask questions of the CCG Officer. Owing to the amount of business to cover, and to allow as many members as possible to ask questions, members would be limited to two questions per member per decision - with time limited to 1min for each question with the opportunity for a single 1 minute supplementary.
3. At the end of questions, the Chair would ask if any member wished to move that the matter be referred to the Secretary of State.
4. If no member does wish to propose that the matter be referred to the Secretary of State, the Chair would move to the next decision to be considered.
5. If a member moved to refer the matter to the Secretary of State the Chair would adjourn the meeting (for about 10 minutes) for officers and the member to work together on the member's proposal and reasons.
6. When the meeting reconvened the Chair would ask for a member to second the proposal and if any member wished to speak further on the matter.
7. The Chair would open the matter up for debate and would remind members that they were considering whether or not the proposal was in the interests of the health service in the area. Members would only be allowed to speak once (except for the mover of the recommendation who would be given the right to sum up) and be limited to 5 minutes.
8. Once members had finished debating, they would vote on the proposal.

Reasons for Referral

The member should ensure that the recommendation covered the requirements set out in paragraph 3.11 in the covering report.

For example, by making reference the "Four Tests" for service change set out on pages 72 to 74 of the CCG Decision Making Report by (then) Secretary of State for Health:

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

Or by reference to the four domains used by the CQC – Safety, Quality, Patient Experience and Finance

Decision Making

When reaching a decision on whether or not to make a referral Members should treat the decisions as they would any other decision of the Council. As a result Members should apply the referral criteria when weighting up the evidence and considering the arguments and be prepared to give reasons for the decision.

Resolution Procedure

The variation protocol sets out the requirement for a resolution procedure if the committee decided to refer a decision to the Secretary of State. With the agreement of the CCG, if necessary the resolution procedure would be undertaken within an adjournment once all the decisions have been considered.

The Lead Health Scrutiny Members and the Clinical Commissioning Group would meet separately to discuss the disagreement in further detail. The Committee would then reconvene immediately after this on the 22nd to consider the outcome of the resolution process and then make a further decision about whether to refer the decision to the Secretary of State.

Members noted the process.

64 APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor M Cassells, Councillor V Rees and Councillor J Williams.

The Chair explained that the members travelling to the meeting from south of the county would be late due to the adverse weather conditions.

65 MEMBERSHIP OF THE COMMITTEE

It was noted that Ms J Riddle attended in place of Ms J Williams for this meeting only.

66 DISCLOSURES OF INTEREST

Mrs G Troughton declared an interest under the Members Code of Conduct in relation to Agenda Item No 5 – Healthcare for the Future, as she worked as a volunteer with St John's Ambulance Service.

Mr R Gill declared an interest In Agenda Items 5 – Healthcare for the Future, as his wife works at West Cumberland Hospital.

67 EXCLUSION OF PRESS AND PUBLIC

RESOLVED, that the press and public be not excluded from the meeting for any items of business.

68 HEALTHCARE FOR THE FUTURE - WNE CUMBRIA

Members considered a report from the Corporate Director – Resources and Transformation which outlined, for consideration by the Committee, the decisions made by NHS Cumbria Clinical Commissioning Group (NHS CCCG) Governing Body on 'The Future of Health Care in West, North & East Cumbria' proposals and as part of Stage 3 of the Committee's Variation Protocol.

At its meeting of 24 February 2016 the Committee were advised that both the Success Regime and the NHS CCCG considered the expected proposals (referred to at the time as the Clinical Strategy) to be a substantial variation. Having consulted the chair of the variation sub-committee, the Committee agreed that they would be a substantial variation and agree to move to stage two of the protocol. At that stage the detail of the proposals had not been announced.

The Cumbria Variation Protocol stated that where the parties agreed that a proposed variation was substantial the Committee would provide comments/recommendations to the NHS Organisation which would then consider the comments and go out to consultation formally with the relevant stakeholders in accordance with the relevant legislation.

The Committee received an update from the Success Regime/NHS CCCG on the development of the draft clinical Strategy at its 13 April 2016 meeting and again at its meeting of the 16 May 2016. At these meetings the Committee had opportunity to make comments and recommendations about the proposals for public consultation, and consultation process itself.

The Committee requested:

- additional public meetings, double the number of meetings originally proposed, including public meetings in all eight of the community hospital localities.
- monthly briefing meetings for stakeholders to update them on consultation progress.
- briefings for the County Council's four local committees on consultation progress.

These were all accepted by the NHS CCCG and incorporated into the consultation plan

At the 16 May meeting the Committee agreed that:

- the proposed extent of consultation activity is appropriate (incorporating the requests of the Committee);
- no specific additional consultation activity should be considered;
- That its comments and recommendations had been accepted by the NHS CCCG and that stage 2 of the variation protocol, with respect to consultation, had been discharged.

Stage 3 of the Variation Protocol stated that once the consultation had been completed the NHS Organisation would report the results of the consultation back to the Committee with its response and proposed next steps. If at this stage the Committee felt that the proposal would not be in the interests of the health service in its area, the Committee would then make a decision on whether or not to refer the matter to the Secretary of State.

The Senior Manager – Health and Care Integration explained to members that the circumstances for referral of a proposed substantial development or variation were laid out in legislation. That is, where a health scrutiny body had been consulted by a

relevant NHS body or health service provider on a proposed substantial development or variation, it may report to the Secretary of State in writing if:

- It is not satisfied with the adequacy of content of the consultation with the committee.
- It is not satisfied that sufficient time has been allowed for consultation with the committee.
- It considers that the proposal would not be in the interests of the health service in its area.
- It has not been consulted, and it is not satisfied that the reasons given for not carrying out consultation are adequate.

He also explained that as set out there were four grounds for referring a proposed substantial variation to the Secretary of State. Three of these grounds (grounds 1, 2 and 4) related to consultation between the CCG and the Committee which were addressed at the Committee meetings on 13 April 2016, 16 May 2016 & 13 October 2016.

As a consequence when considering whether or not to refer the substantial variation to the Secretary of State, the consideration for Members at this meeting was whether the proposal would not be in the interests of the health service in Cumbria.

The Chair explained that the Health Scrutiny Committee would be considering the CCG decision on paediatrics before the decision on maternity services due to the interdependencies between the two.

The Committee then considered each substantial variation in detail.

(A) Consultation Process

The Senior Manager – Health and Care Integration confirmed to members that this decision did not qualify as ground for referring to the Secretary of State for Health, on the basis that this had already been addressed at meetings of the Health Scrutiny Committee held on 13 April 2016, 16 May 2016 and 13 October 2016..

Representatives from the CCG outlined to members the significant, extensive public, patient and partner engagement work that had been undertaken prior to the Success Regime. He advised that the Success Regime had continued this work by holding over 170 public, private stakeholder and staff meetings, making 86 location visits and capturing the views of more than 3,400 people throughout the engagement process.

Members were also reminded that in order to ensure compliance with its statutory requirements, the CCG had kept the Cumbria Health Scrutiny Committee informed throughout the process.

The results of the public consultation were independently analysed by The Campaign Company and a final consultation report was received on 27 February 2017. This report could be viewed on the CCG website, if required.

Members confirmed that they felt the CCG had met its statutory duties in ensuring that a robust public consultation had been undertaken.

RESOLVED, that members agree that this decision did not qualify as ground for referring to the Secretary of State for Health, on the basis that this had already been addressed at meetings of the Health Scrutiny Committee held on 13 April 2016, 16 May 2016 and 13 October 2016.

(B) Children's Services/Paediatrics

The Chief Executive of the Cumbria Clinical Commissioning Group advised that the options for Maternity and Children's services were inter-related. He confirmed that the preferred option for Children's Services in the Consultation Document was Option 1. He then provided an overview of the findings of the consultation highlighting the following:-

- much of the qualitative feedback related to the safety of young patients as well as the impact on family members and carers – again location and distance from services were a major factor
- the view from the public that uncertainty around service provision had undermined recruitment, concerns expressed around the deterioration of children being transferred from West Cumberland Hospital to Cumberland Infirmary Carlisle and the impact of having to travel could have on some families
- organisations, clinicians and professional bodies felt there was a need for ongoing public and clinical engagement, a need to adhere to national policy/clinical guidelines, and there was a mixed response on the sustainability of current services

The Chief Executive explained why the current service model did not present an attractive option to newly qualified Paediatricians. He felt that there needed to be a pathway for Paediatricians to come to Cumbria that included training in specialised areas. In addition he advised that if there was a commitment to encourage people to apply for jobs in the west of the County then there needed to be a network put in place that would allow them to bring their families and to fully commit to the area.

The Chair invited members to ask questions or make comments on the proposals.

Members asked if children would automatically be transferred to Carlisle if they presented to the West Cumberland Hospital after 10pm.

Dr Harpin replied that by and large this was what was proposed, however, if paediatric attention was necessary then a paediatric consultant would be 'on call'.

Members asked if children would be subject to night time transfers. In response the Director of Strategy at North Cumbria University Hospital Trust replied under normal circumstances night time transfers would be avoided wherever possible.

One of the members asked how the deprivation of liberty applied to vulnerable children who could not have their parents with them. The Medical Director explained that the deprivation of liberty laws around vulnerable children doesn't

apply unless under special circumstances. If there were special circumstances then the NHS already had procedures in place to deal with this.

Members were deeply concerned about the impact transferring this service to the Cumberland Infirmary would have on the North West Ambulance Service and whether they would have sufficient capacity to deal with the extra transfers.

The Chief Operating Officer from the CCG confirmed that modelling had been undertaken and additional capacity, based on this, would be implemented.

The Director of Operations from the North West Ambulance Trust explained that a strong recruitment process was taking place to match staff to the requirements of the service going forward. Dedicated ambulances would be used for transfers for both children's services and maternity services, and contingency plans would also be in place if additional services were needed, such as private providers.

Scrutiny Panel members were concerned to hear that the dedicated ambulances would be a shared service between children's services and maternity services, as this was not what they had been led to believe.

The Chief Executive of NCUHT explained that the use of a dedicated ambulance shared between children's services and maternity services did not apply in the case of maternity Option 1, which was the preferred option.

Members asked whether the private providers would be fully trained and whether the vehicles would be sufficiently stocked. The Director of Operations said all private providers would be CQC registered, and the vehicles would carry a full stock of provisions. He emphasised to members that the private providers would only ever be used in emergency situations.

Members had a number of concerns about children being 40 miles away from their families, not least, that this may prove to be an extremely costly service. When children were poorly surely the need was greater for them to be near their families.

The Director of Strategy at North Cumbria University Hospital Trust explained that work had started with colleagues in Healthwatch to look at possible solutions to this issue, such as shuttle buses, and help with accommodation, or even help into other services.

The Chief Executive of NCUHT reminded members that the service being scrutinised was only the service for acutely ill children and the need for the correct systems to be in place when needed. There were already a number of transfers taking place between West Cumberland Hospital and the Cumberland Infirmary, and also the Cumberland Infirmary and Newcastle.

Members asked why no impact assessment had been carried out for public transport services.

Health colleagues explained that a comprehensive baseline assessment had been carried out for non emergency options, but there were still some gaps for emergency options. An Action Plan was being developed to take this forward, however, she reminded the committee that the NHS was not responsible for public transport gaps.

Members also had concerns about the affect of the proposals on the Ambulance Service. If there was no A&E service available this may result in many parents simply calling for an ambulance instead of visiting the A&E department. This needed to be carefully considered as part of the impact assessment.

Members proposed that this should be referred to the Secretary of State for health on the grounds that the changes proposed are not in the best interests of the health service in the area.

This was **PROPOSED** by Mrs Wharrier and **SECONDED** by Mr Gill.

The meeting was then adjourned for 10 minutes.

The meeting reconvened and the proposer outlined why members should refer this substantial variation to the Secretary of State for health on the grounds that the changes proposed are not in the best interests of the health service in the area. Particularly:

- The committee think that the travel impact assessment does not sufficiently reflect the geography of the area.
- The impact assessment did not adequately reflect the shift in demand caused by an increase in ambulance call-outs.
- The proposals for a dedicated ambulance are not sufficient to provide an adequate safe service.

This was then put to a vote, the results of which were:-

FOR - 8
AGAINST - 3
ABSTAIN – None

(C) Maternity Services

The Chief Executive of Cumbria Clinical Commissioning Group stated that the preferred option in the Consultation Document for Maternity Services had been option 2, 'The consolidation of a consultant led unit at Cumberland Infirmary, Carlisle (CIC) and the establishment of a midwifery led unit at West Cumberland Hospital (WCH)'.

However, the lack of support from the public and West Cumbria GPs for Option 2, was carefully taken into account, and considered alongside the support for this option from the professional bodies, NHS organisations and some consultants. There were concerns about the long term deliverability of Option 1, however, it was acknowledged that it was the strong preference of both the public and GPs. The Clinical Workshop advised system leaders to take further opportunities for transformational change that would support Option 1, but to be in a position to implement Option 2 or 3 should Option 1 not prove possible to sustain. In addition Option 1 should proceed on the basis of a collaborative, 'co-production' model, akin to that suggested by West Cumbria Voices.

The Chief Executive of the CCG said the NHS had listened to the public concerns raised for Option 2 and there was a firm commitment to ensure Option 1 was sustainable.

The Chair asked who would decide after the 12 month period whether the option was actually sustainable. The Chief Executive of the CCG said and Independent Review Panel would determine whether the criteria had been met for Option 1, but that ultimately it would be decision for the CCG Governing Body to take.

Members of the Cumbria Health Scrutiny Committee sought assurance that there was a real commitment from all partners to test the viability of this option over the proposed 12 month period. They were concerned that 12 months was not long enough to work through actions supporting the recommendations.

In response, the Chief Executive advised that there would need to be a genuine recognition of what could be done in terms of recruitment, this would need to be undertaken in an open and transparent process through the Co-production Steering Committee which would determine the criteria to achieve this.

Members asked whether it would be possible for an elected member to join the Co-Production Group. The Chief Operating Officer of the CCG said this was still work in progress but that the group was keen to engage with members and other interested stakeholders on this. However, there was a genuine wish for the process to be seen as open and transparent, and members would not be excluded from this.

Members had concerns that if after 3 months Option 1 was proving not to be sustainable that the CCG would just move to Option 2 without consulting partners/stakeholders about this.

The Chief Executive of the CCG said the criteria and milestones would be devised with the Independent Chair and the Independent Review Panel. However, everyone concerned wanted to ensure that Option 1, the preferred option, remained viable.

Members felt that one of the crucial factors to the success of this option would be the extensive difficulty the Health Service had in recruiting staff to west Cumbria. They asked how the NHS was proposing to resolve this.

The Chief Executive of North Cumbria University Hospitals Trust said that the vision set out for rural and remote care was excellent, but the challenge now was around attracting young professionals and families to live, work and stay in the area. This would be crucial to the success of the sustainability of Option 1. The Chief Executive outlined a number of possible solutions to this, including:-

- Permanent contracts
- Less reliance on temporary/agency staff

Members understood the issues and the need to review the situation carefully after the 12 months period had elapsed, but they wondered if the substantial variation was agreed now, whether they would then get the chance to reassess this decision in 12 months time, if the decision was to implement Option 2 or 3.

The Chief Operating Officer for the CCG said that if after the 12 month period it was deemed that Option 1 was not a success the discussions about the implementation

of Option 2 would be brought to the Health Scrutiny Committee for discussion. However, he could not confirm whether this would be treated as a substantial variation.

On the basis that the CCG could not confirm this would be treated as an additional substantial variation it was proposed that this be referred to Secretary of State for health.

This was **PROPOSED** by Mrs Troughton and **SECONDED** by Mr Gill.

The meeting was then adjourned for 10 minutes.

The meeting reconvened and the proposer outlined why members should refer this substantial variation to the Secretary of State for health on the grounds that the changes proposed are not in the best interests of the health service in the area. Particularly:

- The Committee were not given sufficient reassurance that the Committee would be able to have formal input into the Co-production Steering Committee and Independent Review Panel in developing the success criteria and its final recommendation as to whether option 1 is sustainable.
- The Committee wanted to see but were not given a commitment that if the judgement is made that option 1 is not sustainable and option 2 or 3 were implemented after the 12 month period, this should be considered to be a different substantial variation and treated accordingly.
- The committee does not think that the travel impact assessment sufficiently reflected the geography of the area.
- The impact assessment did not adequately reflect the shift in demand caused by an increase in ambulance call-outs.
- The proposals for a dedicated ambulance were not sufficient to provide an adequate safe service.

This was then put to a vote, the results of which were:-

FOR - 10
AGAINST - 1
ABSTAIN – 0

The Committee then adjourned for lunch.

(D) Community Hospitals

The meeting reconvened and the Chief Executive of the CCG outlined the key themes that had emerged from the consultation feedback, which included:-

- accessibility and patient safety;
- resourcing and quality of care;
- a clear case made for retaining the community hospitals, and
- concerns of a financial, economic and social nature

He explained the overall consideration of the options in light of the consultation feedback and referred to the following:-

- the major challenge in recruiting and retaining staff
- the limited prospects for staff in small isolated units
- the operational difficulties when trying to rota small numbers of staff, and
- the challenge of meeting clinical standards as set out by the National Institute for Health and Care Excellence.

Therefore the Success regime considered it important to have in-patient units with at least 16 beds where possible.

The Chief Executive confirmed that although the primary focus of the communities had been to defend bed closures, there had been some very innovative proposals for the future roles of community hospitals and differing services they could provide. These had been co-produced by Cumbria Partnership NHS Foundation Trust working with the public stakeholder groups such as the Hospital League of Friends and the local GP practices in each of Maryport, Wigton and Alston.

Members reminded health colleagues of the need to be mindful that community hospitals were considered an integral part of their community and removing them would be seen as diminishing those communities.

The Chief Executive made members aware that the workforce position in Community Hospitals, and especially in Alston, was very fragile and that it may become necessary for bed closures even in the shorter term due to difficulties in sustaining safe staffing levels. He also acknowledged that bed closures were likely to continue happening on an un-planned basis because of the on-going staff recruitment and retention challenges.

The Deputy Chief Executive of Cumbria Partnership Foundation Trust said Cumbria County Council had been engaging and was keen to work with stakeholders on the development of business cases for the proposals from Alston, Maryport and Wigton.

The Director of Service Improvement from NCUHT outlined the work that had been undertaken in Maryport. He had facilitated the co-production work there and there were some really exciting and innovative ideas coming through. There were 3 main proposals that had come forward from this group and a business case for these had already been produced. However, further work was still needed for Alston and Wigton.
Members referred to page 87 of the document pack where it stated that the conversation had moved from community hospital beds in Alston to finding a sustainable, affordable health and care model for the most remote town in England. This would imply that there were 2 equal partners in these discussions but members did not feel this was the case. They asked for clarity of the evidence in recommendation for the community hospital bed base and how would the impact for the removal of the beds be assessed.

The Director of Strategy from NCUHT said although the removal of the beds did have an important impact the real issue was about how we could create a sustainable healthcare model for the future of Alston.

Members asked if the proposed solution would include a number of medical beds.

The Director said the medical model for beds in Alston, Wigton and Maryport would be removed but that alternative models of delivering would need to be developed.

One of the members asked about dignified end of life care in Maryport, and how this would be delivered based on the fact that there were no nursing homes in Maryport. She also had concerns abut respite medical care and asked what the proposals would be for this based on the reduced bed status.

Members felt there was a lack of alternative nursing care provision and a new model of increased home-care support may not be appropriate or safe for patients currently supported in community hospitals particularly for end of life care.

The Director said hospital beds should not generally be used for respite medical care. In the past year 185 people had died in Maryport, but 86% of these did not die in hospital. The preference of most people would be to stay at home for end of life care and wide consultation was being carried out currently on the options for this.

Members asked about whether rural proofing had been applied to the proposals for community hospitals. They felt there would need to be some imaginative solutions to resolve the issues in Alston, where the issues of economies of scale would need to be addressed.

The Director of Strategy said the 16 beds in Alston would not meet the criteria and that the situation with recruitment of staff in Alston was reaching a crisis point. The model was extremely fragile and the NHS was working hard to try to find a solution to this.

Members asked why there was no Independent Review carried out for Alston, similar to the one carried out for maternity in West Cumbria, before the decision was made.

The Chief Operating Officer from the CCG said an external audit was carried out, which considered issues such as:-

- Reducing the length of stays
- Reducing admission numbers
- Buildings – fit for purpose
- Sustainable nursing levels
- Recruitment
- Geography

He also said that the majority of admissions to Alston hospital were not for people who lived in the area. The average distance patients travelled was 12.5 miles.

Health colleagues felt that in the majority of cases the patients using the community hospital beds actually needed adult social care services rather than hospital services and that innovative thinking would be needed to resolve this issue. However, he reassured members that none of the hospital beds would close until alternative forms of care were available and it was safe to do so. Transition would need to be carefully managed.

The Deputy Chief Executive said in Maryport a Health Alliance had been established and had proposed a number of alternative models to resolve the issues including:-

- Developing the community hospitals as a 'hub'
- Recycling the nursing teams
- Closing the public health gap

Members felt there was no denying that changes were required to make services fit for purpose, and that innovative alternative solutions were needed. However, some of the solutions would require the expansion of adult social care services, in the current climate of austerity this would be very challenging.

Members had concerns about the ability of members and also the public to scrutinise the decisions of the Success Regime going forward, and wondered if there were any plans for future scrutiny.

The Chief Executive of CCG explained that due to pre election period guidance some of the information had been restricted and could not yet be shared. However, in relation to the development of the Integrated Care Community Programme the Success Regime would be interested in engaging, both the members of the public, and also scrutiny members on this.

The Chair of Healthwatch asked the Success Regime whether they would be willing to engage with Healthwatch on Integrated Care. The Chief Executive confirmed they would be willing to engage with Healthwatch.

Members felt that one of the major issues to be addressed to ensure these services were improved going forward was around IT. The Deputy Chief Executive agreed with this. There were also plans in place for future and improved engagement with the third sector to take this forward.

On conclusion of the discussion members proposed that this be referred to Secretary of State for health.

This was **PROPOSED** by Ms Taylor and **SECONDED** by Mr Hughes.

The meeting was then adjourned for 10 minutes.

The meeting reconvened and the proposer outlined why members should refer this to Secretary of State for health on the grounds that the changes proposed are not in the best interests of the health service in the area. Particularly:

- There is a lack of alternative nursing care provision a new model of increased home-care support may not be appropriate or safe for patients currently supported in community hospitals particularly for end of life care.
- Insufficient consideration of the interdependencies of the community hospitals to the health and care services in the areas
- Insufficient consideration of rural proofing issues.
- Lack of an independent review of Community Hospitals to inform the proposals.

- Decision of the CCG to close medical beds have limited the options for developing further proposals within the next twelve months, as part of the plans to implement Integrated Care Communities.
- Details of how the further proposals might be funded are not clear, and until that can be clarified no medical beds should be closed
- Potential negative impact on Delayed Transfer of Care.
- The committee think that the community hospital travel impact assessment does not sufficiently reflect the geography of the area, particularly around public transport provision.

This was then put to a vote, the results of which were:-

FOR - 10
AGAINST - None
ABSTAIN – 1

(E) Emergency and Acute Care

The Chief Executive of Cumbria Clinical Commissioning Group advised that section 10 of the Decision Making document sets out the options consulted upon with Option 1 being the preferred option.

He stated the consultation also heard public concerns regarding early access to critical care, how uncertainty and low morale were affecting recruitment, the desire to retain an intensive therapy unit at West Cumberland Hospital and the need for a full risk analysis to be undertaken.

Themes arising from organisations, clinicians and professional bodies included the need for ongoing public and clinical engagement, the need to adhere to national policy and clinical guidelines, and some concerns about medical training in the context of a composite workforce.

During the consultation North West Ambulance Service raised concerns around transfers and operating protocols but had subsequently confirmed the deliverability of the preferred option.

The Chief Executive explained the reasons as to why the status quo was not put forward as an option. Those reasons included:-

- the risk of stretching a medical team over two sites;
- difficulties with supervision, training and maintaining skills;
- difficulties in meeting health regulations and performance standards; and
- the challenge to recruitment presented by the geographical location.

The Chief Executive of North Cumbria University Hospital Trust said that NCUH NHS Trust had made significant progress in improving emergency care at both Cumberland Infirmary Carlisle and West Cumberland Hospital, but that further improvement was still required.

The programme had benefited from external support from the Clinical Senate in developing an innovative workforce solution. It was felt that the preferred model actually addressed many of the concerns raised during consultation, principally because the vast majority of care would continue to be delivered locally.

RESOLVED that this decision not be referred to the Secretary of State for Health

(F) Hyper-Acute Stroke Services

The Chief Executive of Cumbria Clinical Commissioning Group advised that section 11 of the Decision Making document provided an overview of the options consulted on and that Option 2 was the preferred option.

Responses from the public included some recognition of the benefits of a Hyper-Acute Stroke Unit and delivery of rehabilitation as close to home as possible. Concerns about early access to services (and reference to a 'Golden Hour') and the need for a full risk analysis had been raised.

The themes from organisations, clinicians and professional bodies included:-

- need for ongoing public and clinical engagement;
- adherence to national policy and guidance; and
- mixed views about sustainability and possible alternative proposals for West Cumberland Hospital

The Chief Executive advised that some stakeholders suggested that initial diagnosis and treatment would be undertaken at West Cumberland Hospital before transferring to Cumberland Infirmary Carlisle.

He confirmed that NHS organisations strongly supported Option 2 and following the close of the consultation, North West Ambulance Service had confirmed deliverability of the preferred option but in the context of additional capacity required.

The Chief Executive asked members to note that the key measure of access for a stroke was not the 'Golden Hour' but to receive thrombolysis within 3 – 4 hours. This standard was deliverable in terms of travel time for all parts of West, North and East Cumbria.

The Chief Operating Officer from the Cumbria Clinical Commissioning Group explained that the clinical evidence showed that a Hyper Acute Stroke Unit would improve outcomes for everyone. This included patients who do not receive, but would have benefitted from, thrombolysis. This was due to the presence of specialist Physicians, Nurses, and Therapists working in a single unit seven days a week, providing highly skilled specialist care. He also explained that current thrombolysis rates at both West Cumberland Hospital and Cumberland Infirmary Carlisle were very low.

Although members welcomed the introduction of a seven days a week service they again had concerns about the ability of the Ambulance Service to cope with the additional services being placed upon it, especially as target levels for ambulances were already below average in West Cumbria.

RESOLVED that this decision not be referred to the Secretary of State for Health

(G) Emergency Surgery, Trauma and Orthopaedic Services

The Chief Executive of North Cumbria University Hospital Trust described the proposal in the consultation to make permanent the interim changes previously made on safety grounds. The consultation included the proposal to return some emergency surgery and trauma care to return to West Cumberland Hospital.

During the consultation an alternative model was proposed which entailed 24 hour emergency care, excluding major trauma, at West Cumberland Hospital with consultant led care 8 till 8, 7 days a week for medicine, surgery, trauma and orthopaedics and gynaecology.

The Chief Executive advised that the alternative model was considered, and that a number of issues arose indicating the challenge of maintaining two surgical teams, with low volumes of activity, safety, viability and sustainability concerns.

He assured members that the Trust was committed to the repatriation of services to West Cumberland Hospital, and that to date over 2,000 more procedures had been undertaken at West Cumberland Hospital, of which around 700 to 750 had been emergency procedures.

Members again had concerns about the capacity of the Ambulance Service to be able to continue to provide these services.

The Director of Operations from North West Ambulance Service said an independent survey had been undertaken for this service and he was confident the right number of vehicles would be matched to need.

RESOLVED that this decision not be referred to the Secretary of State for Health

(H) Consultation Implementation

The Senior Manager – Health and Wellbeing confirmed to members that this decision did not qualify as referring decision that could be referred to the Secretary of State for Health, on the basis that this had already been addressed at meetings of the Health Scrutiny Committee held on 13 April 2016, 16 May 2016 and 13 October 2016.

Health Scrutiny Committee members had serious concerns about the ability of the Cumberland Infirmary to cope with all the service being transferred from West Cumbria. The hospital was struggling now with capacity issues and his would only be exacerbated once the additional services were transferred over.

The Chief Executive of NCUHT accepted that the Cumberland Infirmary was not currently fit for purpose, and he outlined the proposed plans to address this, including the creation of an ‘emergency floor’.

Members also had concerns about the capacity of the North West Ambulance Service to cope with all the additional journeys, and sought assurance that the cumulative impact of these changes had been fully considered and that funding was in place to deal with capacity issues.

Health colleagues confirmed this was the case.

RESOLVED, that members agree that the implementation would not be considered as a substantial variation.

The Chair thanked the Health Scrutiny Members and Success Regime colleagues for the informed discussions. He then explained that the variation protocol sets out the requirement for a resolution procedure if the committee decided to refer a decision to the Secretary of State. With the agreement of the CCG, if necessary the resolution procedure would be undertaken within an adjournment once all the decisions had been considered.

The Lead Health Scrutiny Members and the Clinical Commissioning Group would meet separately to discuss the disagreement in further detail. The Committee would then reconvene immediately after this on the 22nd to consider the outcome of the resolution process and then make a further decision about whether to refer the decision to the Secretary of State.

The Chair reminded all members of the process and asked them to stay.

The meeting was then adjourned.

The meeting reconvened with the following members present, Mr N Hughes, Mr J Lister, Ms J Riddle, Ms V Taylor, Mr A Toole, Mrs G Troughton, Mrs C Wharrier and the Chief Executive of the Cumbria Clinical Commissioning responded back following the dispute resolution as follows:-

68b) Children's Services/Paediatrics

The Chief Executive confirmed that the CCG would commit to work actively on these three areas (travel, shift in demand and safety of the Dedicated Ambulance Vehicle) to better understand the implications for travel with a view to acting to mitigate any adverse impact.

Members had concerns that if they chose not to refer this at this stage to give time for the CCG to mitigate any adverse impact then the opportunity would be lost.

The Chief Executive asked members if there was anything the CCG could do to prevent the referral as they wanted to try to mitigate any further delays to the development of this service.

Members had specific concerns about the provision of the consultant on call, the transfer of children out of hours and the safety of the children during travel without access to a paediatric professional.

The Chief Executive said the CCG would extend the scope of the MLU audit to include the changes to children's services as determined by Option 1)

Some of the members had reflected on the proposals from the CCG and felt that they would be content not to refer this based on the reassurances from the Chief Executive. However, not all members were in agreement with this.

The decision to proceed with this referral was then voted upon,

FOR - 2
AGAINST - 5
ABSTAIN – 0

RESOLVED that members agree not to refer this substantial variation to the Secretary of State for Health.

68c) Maternity Services

The Chief Executive of the CCG gave members assurance that the output of the Co-production Steering Committee and Independent Review Panel would be fed back into the Health Scrutiny Committee.

There would be transparency of the work of the 2 groups.

The Co-production Steering Committee would decide if a member from the Health Scrutiny Committee could have a seat on the group. The Chief Executive pointed out that there may however, be a potential conflict of interest of a member taking this seat

The Chief Executive said the CCG recognised that there were still unresolved differences in relation to the maternity option.

Members reiterated their concerns that on the basis that the CCG could not confirm this would be treated as an additional substantial variation it was proposed that this be referred to Secretary of State for health.
The decision to proceed with this referral was then voted upon,

FOR - 6
AGAINST - 1
ABSTAIN – 0

RESOLVED that the substantial variation for Maternity Services be referred to the Secretary of State for Health on the grounds that the changes proposed were not in the best interests of the health service in the area.

d) Community Hospitals

The Chief Executive confirmed that medical beds would not close until the alternative models were in place (albeit there may need to be temporary closures for operational reasons in the meantime). The Health Scrutiny Committee members recognised this.

The Pre-Consultation Business Case had within it a very significant shift of resources to support these developments.

The CCG re-iterated the strong support for these alternative models, which would have a significant positive impact on delayed transfers of care.

The Chief Executive gave members assurance that the CCG would continue to work closely with the council, respecting the governance arrangements around integrated commissioning that were already in place.

Members specifically asked for details on the proposals for the alternative to the medical beds, and what plans were being developed for this.

The Deputy Chief Executive of the Cumbria Partnership Foundation Trust outlined the proposals in more detail, including:-

- Additional prevention for those with frailty issues
- Recycling money and people
- Public health issues – looking to free up investment to resolve issues such as obesity

Members were concerned about the difficulties with recruiting nurses at Alston Hospital, as the nurses would be crucial to the success of this.

The Chief Executive outlined the role the co-production group would play in this. He felt that way in which decisions were taken to manage the community services effectively needed to be taken collectively.

Members asked how carers in the communities would be sourced in remote locations such as Alston. The Deputy Chief Executive accepted that this would be challenging to achieve.

However, he felt that there was a real exciting opportunity to try to resolve these issues together, in partnership. If the decision on Community Hospitals was delayed there was a very real possibility that enthusiastic people would be lost to the alliances.

Members asked for the terms to be put in writing and sent to Health Scrutiny Members. The Chief Executive of the CCG AGREED to action this.

The decision to proceed with this referral was then voted upon,

FOR - 3
AGAINST - 4
ABSTAIN – 0

RESOLVED that members agree not to refer this substantial variation to the Secretary of State for Health.

69 DATE OF FUTURE MEETING

The next meeting will be held on Wednesday 24 May 2017 in County Offices, Kendal at 10.30 am.

The meeting ended at 6.20 pm

CUMBRIA HEALTH SCRUTINY COMMITTEE

Notes of the Health Scrutiny Resolution Meeting held on Wednesday 22 March 2017 at Cumbria House, Carlisle at 5.30pm.

PRESENT:

Mr H Hughes (Chair)	-	Cumbria County Council – Lead Health Member
Mr J Lister	-	Cumbria County Council – Lead Health Member
Mr S Childs	-	Chief Executive Cumbria Clinical Commissioning Group
Mr S Eames	-	Chief Executive North Cumbria University Hospital Trust
Dr J Howarth	-	Deputy Chief Executive – North Cumbria University Hospital Trust
Dr D Rogers	-	Medical Director – Cumbria Clinical Commissioning Group
Mr D Houston	-	Senior Manager – Health and Integration Cumbria County Council
Mrs J Currie	-	Senior Democratic Services Officer Cumbria County Council

The Chair welcomed everyone to the dispute resolution meeting, and explained that the variation protocol set out the requirement for a resolution procedure if the committee decided to refer a decision to the Secretary of State, to discuss the disagreement in further detail.

He said the Committee would reconvene immediately after this to consider the outcome of the resolution process and then make a further decision about whether to refer the decision to the Secretary of State.

1 REFERRAL NO 1 - CHILDREN'S SERVICES

The Chief Executive of NCUHT said he understood the concerns about the travel impact and wondered if there was anything else the CCG could offer in order to avoid the referral. He suggested the CCG could offer to do a much more substantial travel assessment, and ask whether this would satisfy the members that CCG would do its utmost to mitigate the effect of this.

The Chair said Health Scrutiny Members also had concerns about the shift in services and the impact these would have on the Ambulance Service. The Chief Executive of Cumbria Clinical Commissioning Group felt that the effect on the Ambulance Service would be much smaller now that the decision had been made to implement Option 1 for Maternity Services which did not include the introduction of a maternity ambulance service.

The Chief Executive said the CCG would commit to work actively on these three areas (travel, shift in demand and safety of the Dedicated Ambulance Vehicle) to better understand the implications for travel with a view to acting to mitigate adverse impacts where possible.

Concerns were expressed that members may say that it was too late to carry out a travel impact assessment after the decision as they would see its purpose as informing their decision. Dr Howarth said he felt it would be much better to implement modelling to assess this.

It was proposed that the CCG should put their offer to the committee and let them assess whether this would be enough for the HSC to withdraw the referral. This was **AGREED**.

2 REFERRAL NO 2 - MATERNITY SERVICES

The Chief Executive of the Cumbria Clinical Commissioning Group said the first bullet point in the referral could be easily resolved but he had concerns that this could prove to be a conflict of interest for local authority members being involved in the decision making process and the Scrutiny Process.

He said there would be absolute transparency of the work of the Co-production Panel and the Independent Review Panel. It was suggested that a member of the Heath Scrutiny Committee could sit on the Co-production Panel. The Chief Executive **AGREED** to take this suggestion back to the Co-production Group as the decision would be for this group to make, not the CCG officers.

In summary, the Chief Executive said the CCG would give assurance that the output of the Co-production Steering Committee and Independent Review Panel would be fed back into the Health Scrutiny Committee. There would be transparency of the work of the 2 groups. The Co-production Steering Committee would decide if a member from the Health Scrutiny Committee could have a seat, but expressed concerns that this may lead to a conflict of interest for members.

In relation to the second bullet point the Chief Executive felt that the CCG was unable to give a firm commitment that if after the 12 month period, it was deemed that Option 1 was not a success, the discussions about the implementation of Option 2 would be treated as a new substantial variation.

The CCG's Medical Director said the CCG desperately wanted this to be a success but they did not want to have to go through a further protracted process of substantial variation if Option 1 proved to be unsuccessful

The Lead Health members thanked the CCG for meeting to explore the possibility of obtaining a firm commitment but had not been able to reach agreement on this. It was **AGREED** that this would be fed back to the meeting, however, they felt that if this commitment was not made then the wish of the HSC would be for the referral to stand.

3 REFERRAL NO 3 - COMMUNITY HOSPITALS

The Deputy Chief Executive of CPFT said that there had been so much effective and innovative work done to resolve this that he was worried that all the progress would be lost and that all the good work would be lost.

It was asked if it would be possible to give an assurance that medical beds would not be removed until alternative plans were in place

The Chief Executive of Cumbria CCG said the Pre-Consultation Business Case had within it a very significant shift of resources to support these developments, and he re-iterated the strong support for these alternative models, which would have a significant positive impact on delayed transfers of care.

In summary the Chief Executive of North Cumbria University Hospital Trust said he would reassure the HSC that medical beds would not close until the alternative models were in place - albeit there may need to be temporary closures for operational reasons in the meantime. This had already been recognised by the HSC members.

The Chief Executive of Cumbria CCG said the Pre-Consultation Business Case had within it a very significant shift of resources to support these developments, and he re-iterated the strong support for these alternative models, which would have a significant positive impact on delayed transfers of care.

Finally the Chief Executive of Cumbria CCG gave assurance that the CCG would continue to work closely with the council, respecting the governance arrangements around integrated commissioning that were already in place.

It was **AGREED** that the CCG should relay these reassurances to the committee.

The meeting ended at 6.10 pm

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CUMBRIA HEALTH SCRUTINY COMMITTEE

Meeting date: 24 July 2017

From: Policy and Scrutiny Team

CUMBRIA HEALTH SCRUTINY VARIATION SUB-COMMITTEE

1.0 PURPOSE OF REPORT

1.1 This report concerns the membership of the Variation Sub-Committee.

2.0 ISSUES FOR SCRUTINY

2.1 The Cumbria Health Scrutiny Committee is asked to nominate and agree the membership of the Cumbria Health Scrutiny Variation Sub-Committee.

3.0 BACKGROUND AND CONTEXT

3.1 The Committee has an agreed protocol in place to deal with Substantial Variations of Health Services.

3.2 The protocol has been developed to facilitate a common approach between NHS Organisations and the Health Scrutiny Committee of Cumbria County Council as to what constitutes a 'substantial variation or development' of health services.

3.3 It is intended to promote early discussions on potential substantial variations as they are initially considered, prior to any formal consultation, so as to facilitate a more collaborative and joined up approach to substantial variations. The protocol is about working together, within the legal framework, to improve the experience of patients.

3.4 The protocol was developed with advice and significant input from the Council's Legal Services Team.

3.5 The Committee established the Variation Sub-Committee and delegated Stage 1 of the protocol to the Sub-Committee.

3.6 The Sub-Committee shall be made up of a representative drawn from the membership of the Cumbria Health Scrutiny Committee from each of the following areas, which may be a District or County Council Member of the Committee for that area, previous membership:

- Barrow – Michael Cassells
- Eden - Neil Hughes
- Allerdale – Carni McCarron-Holmes (Vice-Chair)
- Copeland – Gillian Troughton
- Carlisle – Jo Williams
- South Lakeland – Mark Wilson (Chair)

July *2017*

Appendices

Appendix 1 Cumbria Health Scrutiny Variation Sub-Committee Terms of Reference
Appendix 2 Cumbria Health Scrutiny Variation Protocol

Contact: David Stephens, Strategic Policy and Scrutiny Adviser
david.stephens@cumbria.gov.uk Tel: 07900698361

APPENDIX 1

Terms of Reference: Cumbria Health Scrutiny Sub-Committee

Functions

To discharge the functions of the Cumbria Health Scrutiny Committee in relation to Stage One of the Substantial Variation protocol:

- Reviewing documentation provided by the NHS Organisation on service variations and developments submitted to the Cumbria Health Scrutiny Committee;
- Determining whether the service variation or development constitutes a substantial variation or development taking into account all relevant guidance and representations by the NHS Organisation.

Membership

The Sub-Committee shall be made up of a representative drawn from each of the following areas, which may be a District or County Council Member for that area:

- Allerdale
- Copeland
- Eden
- Carlisle
- South Lakeland
- Barrow

Chair and Vice Chair

The Chair shall be drawn from the County Council members and shall be elected annually only by those members appointed by the County Council.

The Vice-Chair shall be drawn from the District Council members and shall be elected annually only by those members appointed by the district councils.

Voting

Each of the representatives on the Committee shall have equal voting rights.

Quorum

A quorum shall comprise 2 members of the Sub-Committee, of whom at least one was appointed to the Cumbria Health Scrutiny Committee by Cumbria County Council and one by a District Council.

Substitutes

Substitution shall be permitted from the existing pool of Cumbria Health Scrutiny Committee Substitutes

Frequency of meetings

The Sub-Committee shall meet in public to consider variations and shall be timed to ensure their recommendations can go to the quarterly Health Scrutiny meetings.

Appendix 2

Substantial Variation Protocol

Introduction

This protocol has been developed to facilitate a common approach between NHS Organisations and the Health Scrutiny Committee of Cumbria County Council as to what constitutes a 'substantial variation or development' of health services.

It is intended to promote early discussions on potential substantial variations as they are initially considered, prior to any formal consultation, so as to facilitate a more collaborative and joined up approach to substantial variations. The protocol is about working together, within the legal framework, to improve the experience of patients. Whilst concentrating on substantial variations or developments of health services, a recurrent theme is the need for the NHS Organisations and the Health Scrutiny Committee of Cumbria . and opportunities to improve their care

It is not intended that this protocol shall prejudice, conflict with or affect the exercise of the statutory functions, powers, rights, duties, responsibilities or obligations arising or imposed under any legislative provision enactment, bye-law or regulation whatsoever, nor shall it fetter the exercise of any discretion the Council or any NHS Organisation may have.

Legislative & Constitutional Context

Section 244 of the National Health Service Act 2006 authorises the Secretary of State to make regulations in relation to health scrutiny.

Regulation 23 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 (The Regulations) place an obligation on NHS Organisations to consult with the Council where they are considering any proposal for substantial developments or substantial variations to health services other than where a decision must be made as a result of the risk to safety or welfare of patients or staff.

The Council may issue a report to the Secretary of State where:

a. the Council is not satisfied that consultation on any proposal has been adequate in relation to content or time allowed;
b. the Council is not satisfied that the reasons given by the NHS Organisation not to consult are adequate; or
c. the Council considers that the proposal would not be in the interests of the health service in its area.

Other than in relation to the University Hospitals of Morecambe Bay NHS Foundation Trust the Council has delegated its role in relation to the above regulations to Cumbria Health Scrutiny Committee (CHSC). This Protocol shall not apply in relation to the University Hospitals of Morecambe Bay NHS Foundation Trust whose substantial variations shall be addressed in accordance with the Council's Constitution.

Stage 1 - Substantial variation determination procedure

There is no definition within the Regulations of what constitutes a substantial variation or development and as a result proposals for service change should be discussed with the CHSC at an early stage to attempt to reach a common position between the NHS Organisation and CHSC where possible.

Without limiting the previous paragraph the parties will, where appropriate, use the following procedure:

1. When an NHS Organisation develops or is made aware of a proposed variation which may be substantial it shall advise the CHSC as soon as possible.

2. The NHS Organisation shall, as soon as reasonably practicable, provide the CHSC with such information as is reasonably necessary to allow it to form a view on whether a change is substantial.

3. Both parties shall then attempt to form a common position on whether the variation is substantial. In deciding whether a change is a substantial variation the NHS Organisation and the CHSC will consider:
   - Whether there is a major change to services experienced by patients and future patients;
   - the impact of the change upon patients, carers, the community, other services and the public who use a service, or may use it in the future;
   - whether the majority of patients using the service would experience a significant material change in how they receive that service, particularly in terms of access or location

4. Where, following the parties assessment, the NHS Organisation notifies the CHSC that it considers that the variation not to be substantial, but the Council considers the variation is substantial the parties shall follow the resolution procedure below with a view to resolving the disagreement.

Relevant factors

The NHS Organisations and CHSC have agreed that the following factors may be relevant in determining the nature of a variation:

Characteristics likely to diminish defining proposals as substantial	**Characteristics likely to increase defining proposals as substantial**
Where questions are about quality	
• Area of proven practice with robust clinical governance and risk assessment arrangements	• Proposal not tried and tested • Conflict or disagreement Ethical issues • Where issues of quality, or choice vs. access need to be balanced
Groups affected and nature of impact	
• Patients do not consider proposals significant • Proposals will have positive impact on patients and carers • Proposals to increase capacity/access/address any adverse travel implications • Proposal is for a short or temporary duration • Small number of patients / or low proportion of a particular group affected	• Patients consider proposals significant • Proposals will have varying impact on different constituencies • Proposals increase inequalities in access to services • Proposal is for a permanent change to the service • Large number of patients affected, or all/most of a particular group of patients affected. Wider implications: • Adverse impact on patients groups • Lack of cohesion with other NHS or • community strategies • Widening of inequalities • Cumulative effect • Effect on wider community
Climate of opinion	
• Clinical support for proposal • Support from community and patients through robust community and stakeholder engagement at all stages • Proposals specifically address concerns e.g. transport provision and home support for day surgery • Proposal based on need for change and agreement on way forward	• Lack of clinical consensus • High level of opposition, especially from patients and public, concerns not addressed, inadequate community engagement • Rationale for proposal not clear

<u>Stage 2 -Substantial Variation Implementation Procedure</u>

Where the parties agree that a proposed variation is substantial the NHS Organisation shall produce a draft variation plan which it shall submit to the CHSC for consideration. The CHSC will provide comments to the NHS Organisation which will then consider the comments and go out to consultation formally with the relevant stakeholders in accordance with the relevant legislation.

The timetable for consideration of the drafts shall, unless otherwise agreed, be:

Action	Timing
Submission of draft variation plan to the Council	As soon as possible following determination that the change is substantial, but in any event within [2] weeks.
Consideration and initial comments by the Council	Comments & recommendations to be provided within [4] weeks of submission of plans.
NHS Organisation to review comments and recommendations and provide feedback on changes	Feedback to the Council on comments and recommendations within [2] weeks of receipt of comments.

In certain instances the NHS Organisation may request the proposed variation be implemented on a temporary basis whilst consultation is undertaken, if this is agreed by the Committee this should be for a maximum of 6 months with any proposal to make the variation permanent to come back to the Committee before the end of that period.

Where the NHS Organisation chooses not to implement a recommendation or comment on the adequacy of the proposed consultation by the CHSC the parties shall follow the resolution procedure set out below.

Stage 3 – Consultation on the Substantial Variation

The NHS Organisation will carry out it's public consultation providing details to the CHSC to allow for appropriate engagement by the Committee. Once the consultation has been completed the NHS Organisation will report the results of the consultation back to the CHSC with its response and proposed next steps.

Ifat this stage the CHSC feel that the proposal would not be in the interests of the health service in its area the parties shall follow the resolution procedure set out below.

Resolution procedure

This section sets out the process which the NHS Organisation and CHSC will go through in order to resolve disagreements over whether a change is substantial and over changes recommended and comments made by the CHSC on draft variation plans.

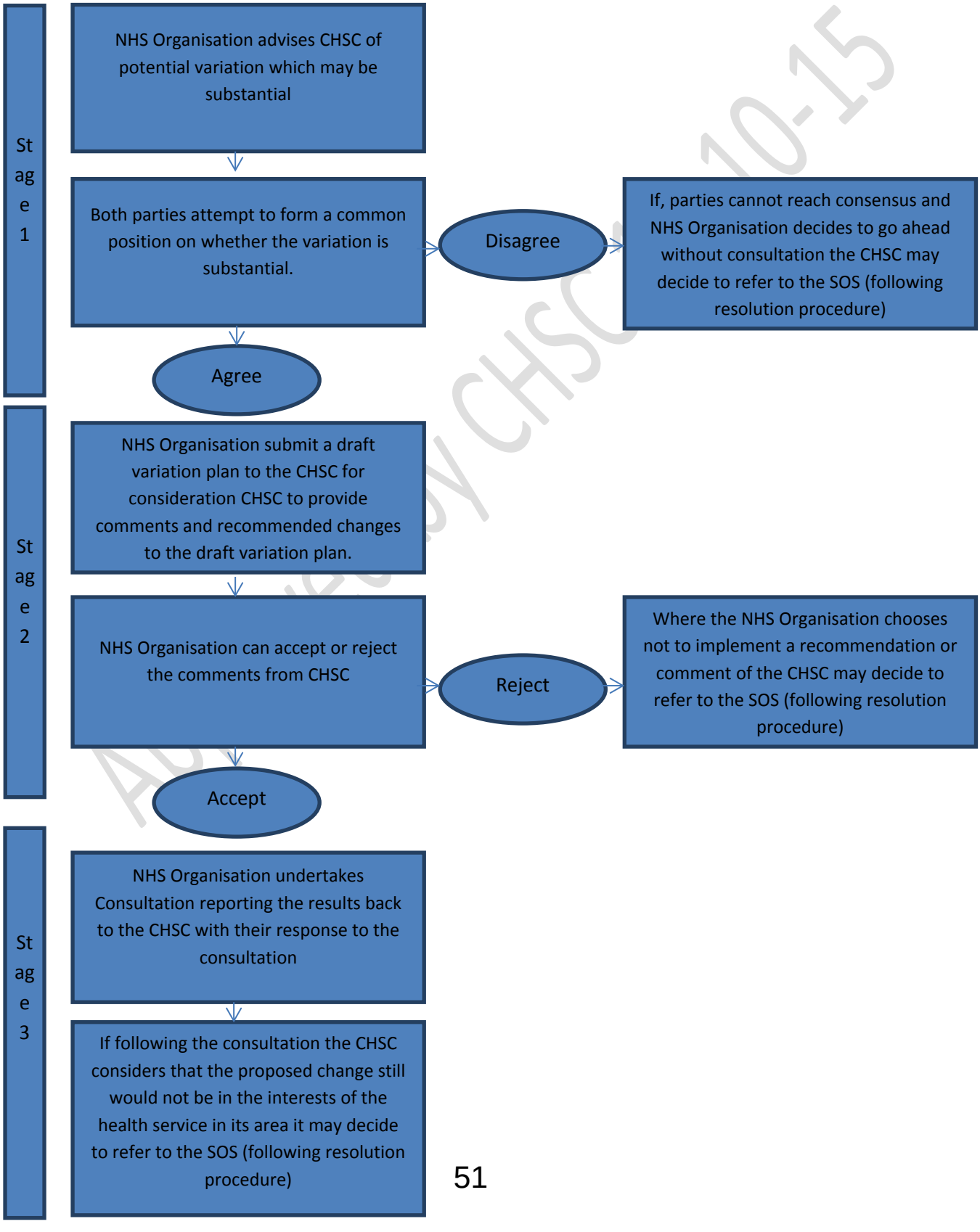
Should the NHS Organisation and the CHSC fail to reach agreement on any of the matters discussed above either party may:

1. Send to the other a [form/letter] setting out the area of disagreement and that party's position in relation to it. The [form/letter] shall propose not less than three dates for a meeting to discuss the dispute with the other party.

2. The Chair of the CHSC and the relevant senior officer of the NHS Organisation shall meet within 28 days of the receipt of the [form/letter] to discuss the disagreement in further detail.

3. Should an agreed position not be reached within 7 days of the meeting referred to at paragraph 2, above, the parties may make proposals for further negotiations or, if no proposals are received or accepted, this protocol will be considered exhausted and the NHS Organisation may take a decision on how to proceed. The CHSC will then make a decision on whether or not to refer the matter to the Secretary of State.

The parties shall agree minutes of dispute meetings which may be disclosed to the Secretary of State, other competent bodies or in accordance with any other obligation to disclose by either party.



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CUMBRIA HEALTH SCRUTINY COMMITTEE

Meeting date: 24 July 2017

From: Policy and Scrutiny Team

COMMITTEE BRIEFING REPORT

1.0 PURPOSE OF REPORT

1.1 This report updates the Committee on developments in health scrutiny, the Committee's Work Programme and monitoring of actions not covered elsewhere on the Committee's agenda.

2.0 ISSUES FOR SCRUTINY

The Committee are asked to:

(i) Review the existing Work Programme.

(ii) Propose additional activity to be included within the Work Programme

3.0 UPDATES

3.1 **Health & Care Integration Task Group**

As reported previously to the Committee the Scrutiny Task Group established jointly by the Cumbria Scrutiny Committee and the Adults Scrutiny Board included a number of recommendations which were made to the Success Regime Programme Board and the Bay Partners Board. Progress against these recommendations and the implementation of Integrated Care Communities will continue to be monitored.

Variation Sub Committee

3.2 The Variation Sub Committee will convene as required to consider proposed changes to Health Services as per the first stage of the Committee's Variation Protocol.

Scrutinising the Better Care Together Programme.

3.3 The Better Care Together quarterly report will be issued two weeks in advance of the Cumbria Health Scrutiny Committee meeting – this will be circulated to Members via email.

3.4 Better Care Together will attend the Cumbria Health Scrutiny Committee meeting at least once a year by invitation to give updates on key health projects and challenges.

3.5 The Joint Cumbria and Lancashire Health Scrutiny Committee will only convene if there is a planned service change that is considered a "substantial variation" e.g. any changes to elective surgery.

4.0 WORK PROGRAMME

4.1 The Committee's work programme is attached at Appendix 1 for the Committee to consider and review.

July 2017

Appendices

Appendix 1 - Work Programme

Contact: David Stephens, Strategic Policy and Scrutiny Adviser,
david.stephens@cumbria.gov.uk

APPENDIX 1

WORK PROGRAMME 2017-18

	Issue	Notes	Timeline
Task Groups & Development Sessions	Self-Care	Seminar on self-care principles and practice across health and social care.	To be confirmed
	Implementation of Public Health Services For 0-19 Year Olds	Special Joint Children's and Health Scrutiny Committee meeting on the 14 September 2016 recommended that a Task and Finish Group be established to look at the implementation of the proposals in September 2017. The Group would report to Scrutiny Management Board any concerns they have about the new service and recommendations.	September 2017
Items for Future Board Meetings	HealthCare for the Future of WNE	Ongoing monitoring of implementation of changes, and the Audit's being undertaken and the Co-production Steering Committee and Independent Review Panel.	Ongoing
	In Patient Mental Health Strategy	Three parts, overarching strategy, operating model agreed by CCG and CPFT but Commissioning Plan has not been seen. Item deferred from the 2016-17 work programme and should be seen as a high priority	To be confirmed
	Sustainability and Transformation Plans	A further update to be provided on the delivery of both STPs in Cumbria	October 2017
	Update from Integrated Care Communities Clinical Leads	Agreed at the 28th February Committee meeting that an update be provided in 12 months, this was specific to the ICCs in Morecambe Bay area but could also include representations from North Cumbria ICCs	February 2018
	Better Care Together	Annual update from the BCT Programme	February 2018
	Helme Chase Midwife Led Maternity Unit	Committee to receive a further report from the CCG on the performance of the Unit and an assessment on how the new model is operating.	February 2018
	NWAS CQC Improvement Plan	Agreed at the 28th February Committee meeting that an update be provided in 12 months on progress made by NWAS in meeting the requirements of the CQC	February 2018
	Quality Accounts	The Committee reviews and responds to the annual quality accounts for each Trust: NCUHT, CPFT, UHMBT & NWAS	April May 2018

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