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