University of Cumbria

Centre for Health Research & Practice Development

Final Report for the

Public Consultation on the "Closer to Home" proposals

for Cumbria Primary Care Trust

Dr Bob Carroll & Dr Ruth Balogh

April 2008

North Cumbria Primary Care Trust 'Closer to Home' Consultation

Responses from the public and organisations

Final Report

Contents

Acknowledgements

Thanks are due to Ruth Haigh, Gonzalo Araoz and Steve Balogh for help with the coding of the responses and to Mark Bennett and Nicola Duers of Cumbria PCT for their support.

1. **Introduction**

Cumbria Primary Care Trust has developed a strategy in consultation with key partners to provide health services closer to people's homes in North Cumbria. Proposals on the strategy have been subject to a consultation period of three months during which time the public and organisations have been asked to respond to the proposals through a questionnaire or through other form of feedback including a series of public meetings. A document containing relevant information about the proposals was made available to the public with the questionnaire in pull out form in the centre pages. It was also made available on a dedicated website. The consultation process was subject to scrutiny by the Health and Wellbeing Overview and Scrutiny Committee of Cumbria County Council.

The Centre for Health Research and Practice Development, University of Cumbria was commissioned to undertake the analysis of the responses to the consultation. The questionnaire was devised by the PCT not the University. The questionnaire data took the form of paper-based and web-based responses completed by the respondents. Some questionnaires were completed with the help of, or by, interviewers in GPs' surgeries. These often provided poor data responses and there were many questions not answered compared to the other responses. Personal details were masked in accordance with data protection requirements. The analysis took the form of highlighting and coding the main points in answers to the questions in the questionnaires and in other written responses and categorising these coded responses. Main themes cutting across the categories were then identified.

This report sets out the findings of the analysis of those responses and is divided as follows:

- Total numbers of responses for the questionnaires and other responses and distribution according to post codes and gender, and totals for the four agree/disagree questions.
- General comments on the consultation document. This includes observations on the document, questions and responses.
- Summary of responses from individuals to the specific questions on the questionnaire and from other responses with the categories of responses identified.
- Summary of responses from organisations; each organisation is shown separately.
- Major themes extracted from across all the responses and discussed in more detail.

2. **Totals**

The number of responses received

No. questionnaires from individuals	No. other responses from individuals	No. of responses from organisations	Total responses
676	390	85	1151

60 questionnaires were completed on line, 47 from individuals and 13 from organisations. 6 questionnaires were completed in Polish and translated. Some organisations completed a questionnaire as well as giving another written response. In total 25 organisations completed a questionnaire.

Post code areas of responses from individuals were divided into four main regions and totals of responses shown. West Cumbria includes Workington and South Copeland.

Carlisle & District	West Cumbria	Eden valley	Other	Not Known	total
116	620	185	115	30	1066

Gender of respondents

Male	Female	Not Known	Total
296	503	267	1066

There was no separate box for male/female so there are a large number in the not known category. Clearly many who gave initials only would have been male.

Totals of responses for the four 'Do you agree' questions were divided into the following categories: agree, agree with reservations, disagree, non committal, no reply. The first line is for individual responses, the second is for organisation responses.

Q.6. Do you agree that the Cumberland Infirmary Carlisle is the most appropriate place to handle major trauma in north Cumbria?

	Agree	Agree with	Disagree	Non	No reply	Totals

		reservations		committal		
Individuals	219	40	270	36	111	676
Organisations	4	6	1	6	25	25
Total	223	46	271	42	119	701

Q7. Do you agree with our proposed range of intermediate care beds both across the whole of North Cumbria and at each individual hospital?

	Agree	Agree with reservations	Disagree	Non committal	No reply	Total
Individuals	108	33	146	67	322	676
Organisations	1	3	2	3	3	25
Total	109	36	148	70	338	701

Q.9. Do you agree with the proposed range of services to be provided in the community hospitals?

	Agree	Agree with reservations	Disagree	Non committal	No reply	Total
Individuals	25	48	46	47	280	676
Organisations	7	7	1	5	5	25
Total	262	55	47	52	285	701

Q.10. Do you agree with our preferred option for acute hospital services in North Cumbria? Please explain why.

	Agree	Agree with	Disagree	Non	No reply	Total

		reservations		committal		
Individuals	126	68	68	12	440	676
Organisations	10	2	2	4	4	25
Total	136	35	70	16	444	701

There are a number of possible reasons for the very high 'no reply' totals, and include:

- difficulty of answering complex questions which refer to a range of changes.
- respondents not having read the document fully and feeling unable to answer the question.
- questionnaires were completed in the GP's surgery whilst waiting for an appointment and were short of time.
- some people who gave verbal responses to an interviewer in the GP's surgeries terminated the interview before completing all the questions.
- respondents felt that they did not have enough knowledge even after reading the document to answer the question.

1. General comments on the consultation document

Although the majority of responses came through the questionnaire, there were also responses in the form of letters and some provided several pages of detailed comments.

Some people and organisations responded in this way because they felt the questionnaire did not provide them with a suitable format for giving their views and comments and some responded with detailed comments and also completed the questionnaire. Some of the responses indicated that the respondent worked in the NHS and had very detailed and specialist knowledge of a certain area, and others indicated that the respondent or the family had experience of being a patient for lengthy treatment in or out of hospital, for example, cases of trauma and palliative care. Some organisations cited very specific interests because of their unique situation, such as Haverigg prison with its need to have escorts for prisoners. Others cited special interests because of their relationship with the PCT, for example, Cumbria County Council and its provision for social care and Eden Valley Hospice for its provision of palliative and end of life care. There were then some very well informed and detailed responses and examples from experience. Many people stated that they appreciated the opportunity to comment.

The Closer to Home consultation document itself was not always well received. For some, and particularly organisations and those who considered the document more carefully, there was not enough detailed information or enough evidence, 'more vision than fact' as one response suggested. Some statements in the document were queried in regard to the evidence on which they were based. One medical practitioner referred to papers in the British Medical Journal as support for his arguments. Respondents often posed questions of their own. It was also stated occasionally that questions were leading, that it was badly written and not user friendly. However, it was also clear from the responses that for many people the amount of information was perhaps enough or even too much to take in to answer the questions, since there was evidence that some people clearly had not read or remembered the information given, and some questions were clearly misunderstood, particularly Q5 about a single point of access. Many people had difficulty in answering the questions in a straight forward way. This was because there were a number of things to consider, for example, Q7 part 3 'intermediate care beds across the whole of Cumbria and in individual hospitals', and Q9 asks to consider a range of services in community hospitals without specifying precisely what will be available at each hospital. This makes it difficult to answer a simple 'yes' or 'no' to the 'do you agree?' questions. Some therefore answered 'yes and no' to the same question and many did not reply to these questions. People sometimes found it difficult to list the advantages without voicing their concerns and there was often a proviso or condition. Answers to a question often included answers to another question particularly when they had particular concerns, such as the downgrading of WCH. Responses were sometimes written in the margins and had to be related to questions by the researchers. All these points made analysis difficult.

2. Responses to the questions

The key categories are presented succinctly for ease in identifying the responses.

Our vision for the future

Q.1. We propose to provide more healthcare services in the community, closer to home.

What do you see as the advantages of providing care closer to home?

1. Access and travel: ease of access and travel, saving time and money for both patients and visitors, easier access has benefit of easing patients' tension, promoting relaxation and recovery.

2. Familiarity and local staff: familiarity with either home or local surroundings and environment and local staff aiding the wellbeing of patients, 'you're not just a number', responsive to local needs, strengthens communities.

3. Facilities: the extension of facilities in the community will benefit everyone and reduce travel.

4. In acute hospitals: shorter waiting times to see doctors/consultants/treatment, less time in hospital settings, reduction of bed blocking, and fewer visits to acute sector lessening the exposure to hospital infections, commitment to a new hospital in West Cumbria.

5. Other: positive environmental impact and reduces carbon footprint, costs less, cost effective, writes off historic debt. Acknowledges geography of Cumbria.

Do you have any concerns about providing care closer to home?

The main concerns revolved around facilities, staff, funding and care in the home.

1. WCH: the loss of facilities and downgrading of WCH.

2. Beds;: the number of beds and the reduction in the number of beds in acute and community hospitals resulting in shortage, risk of being sent home instead of being treated.

3. Facilities: the need to extend and upgrade facilities in community hospitals, inadequate waiting areas, difficult parking, administration arrangements, access so that walking is possible, services isolated from other services, doubts about whether the necessary changes could be achieved.

4. Staffing: concerns about pressure on staff, staff training, expertise, shortage of staff in both acute and community hospitals and local practices, GPs working hours and facilities.

5. Funding and resources: doubts about whether there would be sufficient funding to cover requirements, must not be seen as cost cutting exercise, costs not given for impact of accessibility of care, domiciliary care more expensive than convalescence

homes, difficult to gauge the level of resource required, based on economic outcome rather than clinical outcome and quantity rather than quality.

6. Care: communication between organisations, division of responsibility between social services and the PCT, availability of sufficient numbers of carers, 24 hour care, respite and palliative care, some want to be treated in hospital and feel isolated at home, and lack of awareness of support structures, standard and quality of care, discharge from hospital care without adequate care in their homes, about preparedness for the change.
7. Equality between areas, 'post code lottery', and rural and South Copeland issues.
8. Transport and access: extra transportation will be required, availability of other mechanised transport eg lifts, contraction of transport services, easy access to information, services and support.
9. Not taken wider environmental impact into consideration on biodiversity and landscapes of new build.
10. Idealistic, need pilot scheme and own comprehensive study.

Q.2. We propose that community services be planned locally in each of the four districts in North Cumbria (Allerdale, Carlisle, Copeland and Eden Valley).

What do you see as the advantages of local planning for community services?

Many people seemed to have missed the key concept of 'local planning' as their answers indicated they saw it as local treatment and gave answers accordingly.

1. The majority of answers revolved around knowing and meeting local needs, locally accountable, local voices, a greater sense of ownership over provision, strengthens the community.
2. Easier access to facilities and more appropriate care, benefits to intermediate care, local GPs' involvement.
3. More efficient, cost effective and informed decisions on the basis of local availability of beds and facilities, locally accountable staff work better, more options closer to home, flexibility, opportunity to forge links with between GPs and local communities and parishes, primary and secondary working as partners. Participatory budgeting should be considered as a model.

Do you have any concerns about planning local services in this way?

Most of the answers revolved around local committees and their decision making, the provision of local services and funding issues.

1. Local committees: how they are constituted and who sits on them, local people and professionals and their expertise for this type of work, doubts about effective decision making, local politics, administration over care, the district borders related to patient care, consultation with local people an especially those who find it hard to speak up for themselves, the need to pay attention to demographic profile of the area.

2. Services: local services competing against each other, fragmentation and lack of coordination, not taking an overall view of services, scope and quality of services and care, reductions in beds, role of local health centres, local GPs and staff knowledge and expertise (not enough), no details of what will be provided yet.

3. Areas; isolation, inequality between areas, 'postcode lottery', people on borders of localities, rural areas (Eden) sparse population may not attract funding to provide viable service, South Copeland not catered for adequately, Kirkby Stephen will need larger premises, more liaison with Parish and Town councils, transport links for accessibility. Are the selected local areas the best geography to plan services?

4. Funding: costs and efficiency issues, will there be adequate funding? Robustness of the financial agreements.

Q.3. Do you have any other ideas for how we could plan and deliver local community health services?

Many of the answers did not really consider 'plan and deliver' in their response.

Most of the answers related to community care, the range of services, involving local people and the local community, and transport. There was a suggestion of using private finance.

1. Community care: more care in people's own homes and in the community, using more community nurses and carers, work with social services. Community based nurses are under pressure and service understaffed so their numbers need increasing before reducing bed numbers.

2. Range of services: extend the range of services in community hospitals and in General Practices, increase consultants in local hospitals, have dedicated teams for chronic and long term illness, support home carers, extend local GPs work hours, improve services in rural areas and South Copeland, replace CUEDOC.

3. Local people and health workers: local health staff and users are key stakeholders and should be involved in planning and delivery, local people and health workers should be consulted and involved in the decision making, reduce layers of local bureaucracy between locality boards and PCT, involve acute services and local representatives in acute services planning, marketing campaign of changes to raise

awareness. Giving people support and skills to get involved is a critical factor. Robust complaints procedure needed.

4. Local community: links with local community organisations and voluntary sector, collaboration with faith sector for spiritual care, local businesses and services, healthcare managers to attend local council meetings, more liaison with Parish/Town Councils.

5. Transport: provide better transport, better ambulance service with paramedics, utilise paramedics more often.

6. Other: develop teaching hospital at WCH to attract staff, greater involvement in the consultation by Consultants and GPs, consider the size of older population and the support by a range of voluntary organisations.

Emergency care

Q.4. We propose providing emergency care services based on a three tier model with services available in community settings, hospital based emergency treatment centres and one centre in North Cumbria to handle major trauma.

What do you see as the advantages of providing emergency care in this way?

Most of the responses related to treatment time, travel issues, efficiency, and staff expertise.

1. Treatment time: reduce waiting, quicker treatment, more specialised treatment, appropriate level of care, saves lives, helps the take up of rehabilitation services, decrease in numbers waiting in A&E departments in acute hospitals, A&E in local setting, 24 hour consultant availability in WCH, availability of beds.

2. Travel: reduction in amount of travel, easier access to treatment, closer to home.

3. Efficient: financially beneficial, logical, efficient, less confusion, appropriate referrals and care.

4. Staff and facilities: concentration of staff expertise and appropriate facilities. Ideal for urban areas.

Do you have any concerns about providing emergency care in this way?

Most concerns revolved around the major hospitals, travel, the transfer of patients, staff and facilities.

1. Acute hospitals: only having one hospital for major trauma, loss of facilities at W.C.H., the number of beds and bed congestion, 24 hour service, hospital cleanliness and infections.

2. Travel and transport: difficulties of travel especially to Carlisle from West Cumbria and South Copeland, ambulance response times, transfer times, parking charges. Air transfer preferable in some cases.

3. Transfer of patients: the correct assessment in emergencies, prevalence of specific types of injury in different areas, not enough vehicles, communication between tiers about transfer, the movement of patients, ill patients surviving the journey, ability to transfer to appropriate tier at the right time, availability of beds, delays in accessing specialist services, ambulance service already overstretched.

4. Staff and facilities: inadequate numbers of staff, adequate staff training including paramedics, availability of up to date facilities and equipment, GPs' work hours, initial assessment and diagnosis, reduction of beds in community hospitals, consultation with emergency service staff and their agreement to the proposals.

5. Other: available funding, major disaster at Sellafield, need awareness campaign to avoid confusion by users. Would community hospitals be able to deal with violence in local A&E facilities?

Do you have other ideas for how we could provide emergency care?

Other ideas related to the categories of acute hospitals, travel and transport, community care.

1. Acute hospitals: having two major hospitals including all facilities available at WCH., provision at Penrith because of its central position and easy access, 24 hour availability, increase bed numbers and include 'fudge factors' related to new build hospital.

2. Travel and transport: better transport facilities, the upgrading of skills and vehicles in the ambulance service, ambulance service in Eden Valley needs improving, link with and funding for the air ambulance, mobile service to rural areas.

3. Community care: extend community care and facilities including GP's surgeries and 24 hour medical input and care, use paramedics, use St. Johns Ambulance, First Responders services, reinforce CUEDOC services, adequate services including emergency care in specific areas such as Millom and Eden Valley.

Q.5. We propose to set up a single point of access to emergency care services.

What do you see as the advantages of a single point of access to emergency care services?

This question was often misunderstood and not seen as referring to telephone access. Responses where this occurred are not included.

The advantages have been categorised into caller, operator and cost.

1. Caller: easier, quicker, dispels confusion for caller, CUEDOC takes too long.
2. Operator: has overall picture of requirements and availability of treatment centres, able to direct ambulances and make appropriate referrals.
3. Costs: more cost effective.

Do you have any concerns about a single point of access to emergency care services?

The main concerns fall into the following groups; call centre problems, operators, patients, other.

1. Call centre issues: number of lines available, waiting, slow service, adequacy of 24 hour staffing, automated service, avoid difficulties of NHS Direct, coping with the volume.
2. Operator:the operators who answer the phone and their knowledge and ability to direct callers appropriately, the training of operating staff, ensuring that diagnosis is not offered over the phone, operators' knowledge of districts in Cumbria and their ability to understand local accents.
3. Patients: not suitable for patients with special needs, e.g. oxygen, special treatments, may not be sensitive or specific enough for patient needs, might fail to recognise life threatening emergencies, the availability of treatment, how can deaf people use a single point of access? Elderly and their difficulty of remembering existing emergency numbers. Need for education and raising awareness of change.
4. Other: local service would be better, speak to a GP, need web access also. How does the proposal relate to 999and NHS Direct? Same as 999 call, duplication of CUEDOC.

Q.6. We propose that major trauma in North Cumbria will be treated at Cumberland Infirmary Carlisle.

Do you agree that the Cumberland Infirmary Carlisle is the most appropriate place to handle major trauma in north Cumbria?

Q.6. Do you agree that the Cumberland Infirmary Carlisle is the most appropriate place to handle major trauma in north Cumbria?

	Agree	Agree with reservations	Disagree	Non committal	No reply	Totals

Individuals	219	40	270	36	111	676
Organisations	4	6	1	6	25	25
Total	223	46	271	42	119	701

There were a number of reluctant agreements, with comments such as: providing it could not be done at Whitehaven; emergency surgery should still provided at WCH; need to upgrade services; 24 hour service required; the appearance that there is not much choice in the matter; major trauma needs to be defined; links required with South Cumbrian hospitals, such as Kendal for South Eden valley and Furness for South Copeland.

Sometimes comments were more positive such as, suitable access, staff expertise.

Many comments were made when they made disagreed or non committal responses. The main ones related to travel; the danger to life with serious injuries, the difficulties, parking problems, cost and time of travelling from West Cumbria, South Copeland, rural areas; and to bed spaces and the need for a major trauma at WCH, particularly with the Sellafield nuclear plant located in that area, the use of Furness General Hospital for some in South Copeland, the need to send patients to Newcastle for certain injuries.

Do you have any other ideas for where major trauma could be treated in North Cumbria?

Most of the replies suggested WCH, but there were a few supporting Penrith because of its central position and location near the motorway, and Cockermouth, Keswick, Kendal, Hexham and other unspecified centres. It was suggested that CIC services should be expanded to save sending to Newcastle, and a new hospital was proposed.

Do you have any other views on emergency care services in North Cumbria?

Most responses again supported the status quo at WCH. Other views included: utilisation of trained teams and paramedics which travel round the county as needed; more use of air ambulance, flying doctors, ambulance service and paramedics, CUEDOC, local GP's and services in emergencies; where is comprehensive strategy for a major emergency and how does it work alongside a nationwide disaster programme?; the training of staff in dealing with dementia and other mental health problems; consideration of all relevant published evidence and material before going ahead; travel costs to Carlisle for visitors paid for by the PCT.

Concerns were expressed about insufficient funding, beds and staff in acute hospitals, intermediate care beds, training for staff, and the ability of the ambulance service to cope.

Q7. We propose to provide intermediate care beds in hospitals, including community hospitals, and have set out proposals for a range of bed numbers both in total and at each hospital.

What do you see as the advantages of providing intermediate care in hospitals across North Cumbria?

1. Local access: easier access, less travel for patients and visitors, less stress for patients.
2. Makes sense, cheaper, more effective.
3. Acute assessment for the appropriate patients, freeing beds in acute hospitals, having special beds for elderly, containment of infection.
4. Patients: needed for patients unable to cope at home, appropriate care near home, more personal and less formal, support network for patients and family, involvement of local GPs.
5. Investment in hospitals, jobs in the local community, better use of cottage hospitals.

Do you have any concerns about providing intermediate care in hospitals across North Cumbria?

1. WCH, downgrading of WCH and the effects of this.
2. Travel: difficulties for those who do not live near the hospital, and for rural areas.
3. Staffing: 24 hour medical back up needed, number of adequately trained NHS and voluntary staff required and hours to be worked to deliver the service, trained rehabilitation staff, out of hours working for staff and GPs, and problems with GPs' working office hours, standard of care.
4. Beds: number of beds available, and the loss of beds, bed day savings may not be achieved safely.
5. Transfer of patients, and appropriate discharge time which should not be related to number of available beds, links between cottage hospitals and acute services must be strengthened to enable transfer, no evidence that case management of this group reduces morbidity or hospital admissions, hospital infections.
6. Funding issues, including working with and funding by social services, providing resources and facilities. Keswick is in Allerdale for social care, but Eden Valley funds the Cottage hospital.
7. Children are not mentioned in the document, what provision is being made?

8. Ageing and growing population, will need more beds, care and facilities.
9. Providing services at Keswick, Maryport, Alston and Penrith.

Q7. Do you agree with our proposed range of intermediate care beds both across the whole of North Cumbria and at each individual hospital?

	Agree	Agree with reservations	Disagree	Non committal	No reply	Total
Individuals	108	33	146	67	322	676
Organisations	1	3	2	3	3	25
Total	109	36	148	70	338	701

There were a number of non committal responses with comments about the number of beds and whether they were adequate, and the standard of care.

Some of the agree responses expressed reservations about staffing levels, number of beds and costs.

Most of the respondents who disagreed were concerned about the number of beds in acute hospitals generally and the number of intermediate care beds, and the standard of care. Some stated that details regarding the changes were limited.

Q8. Do you have any other comments on our proposed use of intermediate care beds in North Cumbria?

Many of the comments related to the number of available beds of all types at CIC, WCH, Community hospitals suggesting that these numbers were inadequate, and a need to upgrade WCH. Using spare beds in care homes was suggested.

Other concerns were about: adequate palliative care; transfer of patients and continuous intermediate care; the need for specialist staff for people with Alzheimer's who are difficult to deal with in a general setting; insufficient care and patients being unable to cope after discharge; coping with an emergency at Sellafield; provision in South Copeland; provision within 25 miles; sufficient funding and adequate staffing.

Community Hospital services

Q.9. We propose a menu of health services that could be provided at the community hospitals.

Do you agree with the proposed range of services to be provided in the community hospitals?

	Agree	Agree with reservations	Disagree	Non committal	No reply	Total
Individuals	255	48	46	47	280	676
Organisations	7	7	1	5	5	25
Total	262	55	47	52	285	701

There were some agree responses with reservations about staffing, funding, standard of care, transfer of patients, reducing waiting times, travel, 24/7 services and GP's hours, and lack of detail in the proposals.

Some respondents who disagreed or were non committal provided comments suggesting that services will suffer, number of beds would be inadequate, the need for or questions about specific services, and insufficient information about the services to make a conclusion.

Many people gave suggestions which were already in the Closer to Home menu, such as podiatry and dentistry, or about services which are currently available at some of the hospitals, for example, x-ray and physiotherapy. This may be because the document did not specify precisely what will be provided at each hospital, and because each hospital currently does not provide the same services. Concerns were expressed about the inequality between areas. Comments include:

1. Suggested services: x-ray, minor surgery, podiatry, audiology, breast care, speech therapy, physiotherapy, ME, diabetic care, alcoholism, palliative care, dialysis, mental health, respite care, stroke care, coronary care, orthotics, maternity, dentistry, radiotherapy, midwifery, allergies, ENT.

2. 24 hour care needed, increase in number of beds, upgrading of facilities, more consultants.

3. Community hospital friends and supporters groups, carers support groups, need for space for Adult Social care Team and Voluntary Sector to promote joint working.

4. Post office, shopping facilities, link up with existing facilities, leisure centres, schools. Co-location of other community services outside of health so they become a community resource.

Acute Hospitals

Q.10. We have set out three options for providing acute hospital services in North Cumbria in the future, including a preferred option.

Do you agree with our preferred option for acute hospital services in North Cumbria? Please explain why.

	Agree	Agree with reservations	Disagree	Non committal	No reply	Total
Individuals	126	68	68	12	440	676
Organisations	10	2	2	4	4	25
Total	136	35	70	16	444	701

Some respondents who agreed had reservations about staff and facilities, travel distances, links with Newcastle and Hexham. Some pointed out that they would not have agreed if they lived in West Cumbria. South Eden Valley links with Kendal and Lancaster. It was also suggested that new services in community settings should be operating fully before the option is implemented.

The respondents who disagreed commented about the downgrading of facilities at WCH, further impoverishment of the area, accidents in Sellafield, and in West Cumbria and South Copeland. There was support for options 2 and 3.

Q.11. Do you have other ideas for how we could organise acute services in Cumbria?

All the responses have occurred elsewhere.

1. WCH, the downgrading of facilities, losing out to CIC, 2 acute hospitals, also one acute at Kendal, strengthen links between acute and community. Some acute facilities in other areas, such as Kendal and Penrith.
2. Care, social services and partnerships.
3. More intensive care beds, development of specialist units.
4. Reduce management to save costs more funding.

Final Section Notes and Comments.

Hospitals and Health Services

1. WCH: retain services as now, downgrading will lead to downward spiral of facilities, recruitment of high quality staff and funding; increase the number of beds; loss of expertise, facilities and specialist units to CIC; retain palliative care bed; WCH needs highly qualified

A&E consultant, and should be a full teaching hospital. When building the new hospital the impact on local communities and local employment needs to be considered.

2. Beds: concern over reduction in beds and need to increase bed numbers at both acute hospitals, community hospitals provision is inadequate.

3. Staff: concerns about staff recruitment and training, staff morale and staff job losses, expectation of discussions with the trade unions about retraining and redeployment of staff, sufficient numbers of health visitors, nurses, midwives to cope with patients at home, suggestion to rotate staff to improve and distribute skills.

4. Specialists; specialist lead in each hospital, stroke specialists at both CIC & WCH, need specialist units and training in toxicity, ME/CFS and other specialisms, develop latest trauma unit and burns and plastic surgeons.

5. Baby unit should be upgraded to intensive care in order to save travel to Newcastle.

6. Children are not catered for in the document, and this needs to be stated. Potential increased provision for children at CIC means a place is needed where parents can stay in hospital with their children.

7. Signs; adequate signposting and information, to be put in all community hospitals, adequate car parking at hospitals.

8. Services being spread too thinly, GPs' out of hours services. Current pilot of night care service in Keswick is working well, but rehabilitation services are under resourced. Concern about Millom area and need for nursing home in Millom. More detail on support services is needed. Questions about the Cost of utilising Riever House.

9. Look at example in Scotland of 'Rural general Hospital' and 'Remote and Rural Medicine developed by Royal College of Physicians in Edinburgh.

Other organisations.

1. Reorganisation of community hospitals and care from home needs to be carried out with joined services and close working with Social Services, local councils, hospices, etc.

2. Link hospitals with University of Cumbria.

3. The proximity of HMP Haverigg which has 1000 prisoners and staff and a major disturbance there could cause many injuries.

Travel, transport and Ambulance service.

1. Difficulties of travel, congestion on roads, cost and time of travel from West Cumbria and South Copeland.

2. Hospital transport scheme should be set up to take patients to hospital, and between WCH and CIC. This could carry staff and supplies.

3. Agreement with ambulance service in Barrow for South Copeland residents, ambulance service in Alston is needed because of its location, preferred option will only work well if the ambulance service can deliver best possible service to rural communities. Concerns about funding the ambulance service.

4. Use air ambulance more.

General Comments.

1.People and consultation: need to inform people, consult people, empower people including hard to reach groups, and not treat them as a commodity, needs of older people to be considered, appeal system to receive help in home. The Consultation was poorly handled, information meetings rather than consultation meetings, Councils not engaged. Venues poorly chosen not well advertised and local communities not engaged. TV and local radio should have been used more. The PCT is too large and remote.

2. Closer to Home consultation document: badly written, presentation of information inadequate, lack of detail, lack of evidence and support for statements, not user friendly, publicity poor, NSF and NICE guidelines not considered. Web site very good but not everyone has access to computers or can use them.

3. Changes: proposals do not take into account environmental changes, carbon footprint, travel changes, tourist/holiday population and ageing population. Accusations that the proposals represent change for changes sake just to meet targets and justify existence of Boards. Does not provide evidence of how the proposed changes impact upon local communities, local economy and businesses.

Funding and services.

1. Changes will be expensive, will the funds be available? Problems in funding schemes (social and medical) organisations need to liaise on funding. Changes based on cost cutting rather than health reasons. Shift of cost from NHS to care sector. Impact of multi disciplinary assessments and appeals not considered.

2. Money that is spent on consultation, other initiatives, management (too much) should be spent on services. More money is required for healthcare system, hospitals and research.

3. Inequality between areas, postcode lottery.

4. Funding required for Air Ambulance and Hospice at Home services.

5. Training for First Responders in the new scheme.

5. Summary of responses from organisations.

Cumbria Health and Well-being Scrutiny Committee

The Committee drew attention to the importance of joint work with Cumbria County Council and the urgent need for the development of a joint business and financial plan to support the changes. They also suggest the need for an effective mechanism for ongoing community engagement and to check that alternative services are put in place to allow the changes to proceed safely and effectively. The Committee recommends that the PCT should proceed to plan and deliver changes to healthcare in North Cumbria on the basis of its consultation proposals including the revisions listed in the in a letter from the Clinical Leadership of the Acute hospitals and the PCT, provided that some issues are addressed.

> More health care in the community, commissioned in localities through clinical leadership.
> 3 tier model of emergency care with a single point of access, a major trauma centre in Carlisle and an Emergency Treatment centre in both Acute hospitals.
> Stepup/step down care beds on all hospital sites (both acute and community).
> Community hospitals on all current sites with modern services to meet patient needs.
> Acute hospital services provided from two hospitals, each with its range of services as described in option 1 in the document with revisions referred to above.

The issues which need to be addressed are too long to summarise here, but are contained on pages 7-10 of the Scrutiny Report. They are listed under the headings of (numbers refer to the number of issues):

Care Closer to Home (3); Emergency Care (4); Community services including Intermediate Care (2); Finance and joint planning (5); Care Streams and Client groups (3); West Cumberland Hospital (1); Other Service Considerations (2); The Consultation process (1); Implementation (8).

North Cumbria Acute Hospitals NHS Trust

The Trust welcomes the collaborative approach by the PCT throughout the development of its proposals and fully endorses the principles in Closer to Home and in particular the vision of the acute hospitals. During the consultation process a number of clinicians have expressed concerns about aspects of the proposals and intensive discussions were held. The outcomes of the debates are available in their in Appendix 2 and summarised on page 7 in their response. The Trust believes these need to be fed into the Closer to Home Proposals. The key issues and outcomes (summarised) are:

Emergency and complex surgery – continue to develop complex surgery service, provide surgical cover and orthopaedic surgery 24/7 at CIC and WCH.

Trauma services – significant trauma taken to the nearest ETC for stabilisation and initial treatment with senior clinical assessment available, patients needing immediate surgery should be transferred to the most appropriate place, such as, Newcastle.

Comprehensive geriatric assessment – agreement on principles of service development for older people across primary and secondary care.

Palliative care – specialist palliative care beds to be in acute hospitals, appropriate palliative care beds and services could be in community hospitals.

Bed numbers – revised inpatient bed numbers of 415 at CIC and 220 at WCH, the new WCH to be built with the contingency of a 30 bed expansion.

The Trust also completed the questionnaire. It expressed concerns about the lack of detail in the proposals for community services, about the possibility that local commissioning groups could become dominated by particular interests, and about a lack of coordination across the region. The Trust sees its commissioning relationship as being with the PCT and not individual localities. It urges the need for better working relationships between health and social care, and an integrated approach to commissioning across the localities.

There were the following responses from departments in the acute hospitals.

Family Care Stream Board welcomes the Closer to Home proposals but state that for the Family Care Stream it may prove a significant challenge in respect of quality, accessibility and sustainability criteria, and will be a particular challenge for the provision for pregnant women and the sick child. Investment in the preventative services delivered by midwives, health visitors and school nurses must be a priority. The Board points out that the balance between accessibility and quality reflects a problem for Paediatric and Obstetrics services and the two criteria tend to compromise each other.

At present the community hospitals play little part in delivering services to pregnant women and ill children so the acute and community services must be configured in a way that allows children and young people appropriate standards of care, and in the case of children as defined by the NSF. This relates to a suitable environment, including access to education and competences of staff and extending the Children's Community Nursing/Hospital at Home service. Local Service planning Groups must understand the unique needs of children and their families and must be held to account in a transparent way. If more children are to be transferred safely between sites, then considerable investment in training ambulance and hospital staff is required. Transfer does not make for good 'continuity of care'. The '48 hour unit' limit needs to be examined. There is also need for greater co-ordination with Cumbria Partnership trust to reduce the number of children admitted to hospitals.

The Board were disappointed that maternity care received little attention in the document and that it was vague over its provision. If the Special Care Baby Unit became nurse led in

WCH it would not save money and it would have a major impact on obstetric admission in both acute hospitals, and medical staffing and midwifery staffing would need to be examined. Full obstetric services should be considered as part of the 'premium' required to maintain services at the two acute hospitals.

The Board states that the Maternity Service Liaison Committee is a good example of public/professional partnership and suggests that this model should be used by locality teams and specialities to ensure that future plans are developed based on the needs of patients.

Obstetric and Gynaecology Dept.

Comments are included in the Family Care Stream Board's response above.

Supervisors of Midwives

Comments are included in the Family Care Stream Board's response above.

NCAH Midwives

Comments are included in the Family Care Stream Board's response above.

Consultant in Genitourinary Medicine states that the document does not include fathers in the parenting process. GU medicine and contraceptive care has clear areas of identified need. These include access to appropriately trained staff for provision of post-coital contraception, access to long term and hormonal contraceptive methods, access to appropriately trained staff for GU medicine and care, rapid turn- around of results of tests, the provision of HIV specialist care which is not mentioned in the document, the need to meet DOH targets particularly the 48 hour targets.

It was also pointed out that there is a need for financial investment, more information on palliative care, forensic medical services, and infertility care.

A&E Consultants WCH (2 separate responses)

These responses state that the document is weak on detail, uses crude data in some instances which must be treated with caution, indicates that the modelling for bed numbers is unexplained whilst having no modelling on the financial cost or clinical risk associated with increase journey times. There are concerns about provision in cardiology, about the management of the frail elderly with complex needs, about the needs of stroke patients, and the provision of Gastroenterology in the proposals. They suggest that there is no evidence that undertaking all major trauma at one centre would be good for patient care and it would be better to retain the status quo. Also orthopaedic emergencies and surgery, including out of hours surgery, should remain at WCH. They state that the document makes little reference to support services and raise a number of questions about 24 hour services.

A&E Consultant CIC states that some of the data in the submission with regard to Emergency Care at Carlisle are incorrect, and some inferences in relation to reports and consultations are contentious and are addressed in relation to Trauma/Emergency medicine.

The response supports concentration of more complex cases at CIC and the idea of a regional network which includes Newcastle and Middlesborough. CIC has a good reputation for training in general, and a concentration of more complex cases will improve training in this area. It is too difficult to provide the resources required, such as radiology and appropriate staffing, for complex cases on two sites and concentration on one site would lead to better and more cost effective provision of staff and resources.

The response voices the following concerns: assumptions related to the ability and willingness of Primary Care to take on extra work currently in Secondary Care; the transfer of some services currently provided in Acute A&E departments to other settings at the same quality and cost; the ECP service attached to the Ambulance service; the expertise related to minor injuries in Primary care.

Elderly Care Consultant WCH

Most of the points are covered in the following response.

Clinical Director Elderly Care WCH welcomes the opportunity to contribute but has some anxieties about the delivery of the proposals. There should be a move away from the emphasis on the amount of money to be saved to one of identifying the best forms of care for older people and suggests the following: rapid assessment and plans for treatment for older people; planning and implementing early supported discharges in certain cases; in-reach community teams with social workers and commissioning of care packages within 24 hours; enhanced old age psychiatry in patient services; 7/7 rehabilitation services and access to imaging to help with diagnosis; training for specialist nurses to take on extended roles. These would require more Geriatricians and adequate resources.

Consultant Dept. of Medicine for the Elderly CIC makes the following points; comprehensive geriatric care is central to the management of frail old people and the evidence is that this is most effective in specialised geriatric units; only about 20% of elderly acute admissions are suitable for community hospital care and community hospital care is more expensive; the data presented by Teamwork are flawed and examples are provided; small community hospitals of fewer than 12 beds are uneconomic; there are already community Parkinson's Disease clinics in 9 community hospitals; there is a massive need for training in specialist skills; moving patients earlier in their stay will have implications for the ambulance service.

Consultant Ophthalmologist WCH states that the high proportion of elderly patients in Cumbria has repercussions for opthalmology services because of age related diseases and multiple pathologies. The document does not appear to recognise these facts and does not mention opthalmology. It is suggested that the cut in bed numbers at WCH does not take into consideration the reality of ophthalmic medical care. A very detailed case is put for retaining ophthalmic services at both WCH and CIC and for relocation to one site at WCH rather than CIC. It is suggested that there is no evidence to support the idea that it is cheaper to locate to one site than have services at two as at present.

Clinical Director Ophthalmology (Directorate feedback) states the case for the relocation of ophthalmic units at CIC and WCH to a single site state of the art 'Centre of Excellence for Opthalmology' based at Penrith. It is believed that this would provide easier access for a regional centre, including South Cumbria and South West Scotland. It will provide the opportunity for in house education and training for staff with appropriate links to the University of Cumbria for nationally accredited research and education facilities.

Consultant and Sister Ophthalmology WCH suggests that the proposals to use Optometrists and GPs with special interests to provide some of the ophthalmic services in the community have major flaws. The case is made to concentrate ophthalmic services on one site at WCH

Orthopaedic Department responded with a focus on option 1 of the PCT consultation document. The department believes that that the only safe way to provide the service is with an 24 hour on call orthopaedic surgeon at WCH who would take responsibility for trauma admitted for surgery there the following day and who would also be key to deciding whether the patient should be transferred. If there is anaesthetic and theatre cover at WCH overnight, it would be preferable if these patients were treated at WCH, but if that is not the case then there would be significant increase in pressure on staff and infrastructure at CIC and investment will be required. Some patients will still require transfer to a tertiary referral centre. There is a very detailed description to underpin these views which cover the current configuration of services at WCH and CIC and key questions which needed to be clarified. These included defining complex elective and non elective surgery and out of hours, identifying responsibility for transfer, the number and type of cases for transfer, co-dependencies that may affect service delivery, risks, and resource implications. Further clarification of the document is required on what is meant by 'out of hours', facilities for emergency work out of hours, how other services which are required will be configured, and the continuance of spinal surgery in Cumbria.

WCH Medical Staff Committee has produced a clinical case to address the strategic proposals in Closer to Home. They also completed the questionnaire. The response acknowledges the strengths of the proposals but voices concerns over several issues, namely, the lack of detail in the document and failure to mention a number of specialist services, the lack of involvement of key stakeholders (local GP's, Consultants, the public) before the preferred option was announced, equity of access , robustness of financial plans,

the reduction of beds at WCH which provides 40% of acute care but would have only 30% of beds, the provision of general surgery; the transfer of patients in orthopaedic surgery and trauma cases, and case management of certain acute conditions (e.g. geriatric assessment, stroke) in the community. Modernisation has already been achieved in a number of conditions with the management taking place through outpatients.

Paediatric and Elderly Care Clinical Pharmacist WCH is very critical of the Closer to Home proposals and stating that major changes are proposed without providing evidence for these changes and suggesting that it is more about saving money than improving care. He is against the concentration of resources at CIC and the reduction in beds at WCH, and feels this may increase the death rate, and further states that WCH has demonstrated its excellence and innovation. There is no detail on community provision of the specialist services suggested in the menu.

Palliative Care Department pointed out that a model of joint working between NHS, Social Services and Voluntary Organisations where workers in each service attended certain meetings in the other organisations had existed in West Cumbria. The response focuses particularly on the need to consider the needs of people with dementia which does not appear to have been considered.

26 Consultants WCH applaud the wiping out of historic 'health debt' and the commitment to an acute hospital in West Cumbria and the philosophy of improving patient flow between primary and secondary care. However, they have grave concerns about key components of the strategy including the reductions in beds at WCH, the 'Best Practice efficiency savings' data and methodology, the management of elderly patients with complex needs in the community, movement of all major trauma to Carlisle, the number of hours each day of available emergency services at WCH, and the inadequacy of communication channels between NCAT and the PCT. Closer to Home is not a consensus view with the full involvement of clinicians from primary and secondary care and they cannot support the proposals as they stand.

Consultant in Rehabilitation Medicine CIC gives a negative response to the proposals**.** He states that the proposals regarding neurological disability and rehabilitation are unclear and that it might mean the withdrawal of a unit from an acute hospital. The response supports NRU in both acute hospitals and early supported discharge for neurological disability and a 'post acute unit' for the mobile, intellectually impaired who need a neuropsychological approach and are at currently managed out of the county or cared for by relatives. He argues that to construct a mixed physical disability and behavioural change unit on a single community site would create an expensive and ineffectual unit and be too far from home for the majority. He supports his case through 12 pages of information, 13 concerns about the clarity of the proposals, and proposals about what should be done and how to proceed.

Consultant neurologist CIC makes the case for one major hospital in North Cumbria on the grounds that it is necessary to provide and recruit specialist teams of the highest standards and that Cumbria's population size will not support two major hospitals. An advantage will be that fewer patients will be sent to tertiary centres. WCH must develop as an acute, efficient and effective hospital for general common simple emergencies.

Stroke and Rehabilitation Therapy Services Staff, CIC suggest that at present stroke and neurological services are fragmented and inconsistently provided across the county and emphasise that services should be based on closely coordinated multi disciplinary teams which specialise in the care of people with these conditions. A list of the services which should be provided and have appeared in national policy documents is included. It points out the drawbacks of a Closer to Home approach for these services, and proposes a model of a single acute plus community neurological service in North East Cumbria.

Consultant Dept of Emergency Medicine WCH does not support the proposal to have one major trauma unit based in Carlisle as the longer journey times for patients from West Cumbria would have an adverse effect on patients and lead to an increase in mortality rates, and certain cases still have to be sent to a tertiary centre in the new proposals.

Professor, author of NCEPOD Major Trauma Report stresses the importance of initial care in cases in emergency and major trauma, and the NCEPOD report shows that current initial care is not of high enough quality to allow any increase in journey times. Planning must consider this issue, and also how initial airway management is dealt with in long transportation times. The management of major trauma needs to be considered within a regional context.

Dermatology Department suggests the most appropriate model for Dermatology is to have a strong base with three consultants at CIC with provision for many services in WCH. It envisages a strong academic and research base with high quality equipment and care at CIC, and would also support the expansion of local services in an integrated way. There is a detailed case made in this response for these developments.

Other Health Service organisations

North Cumbria Maternity Services Liaison Committee

NCMSLC stated that there are general concerns regarding the consultation and the document and more specific ones related to maternity services, which they suggested should be noted for future consultations. NCMSLC had not been involved in pre consultation despite seeking a dialogue and this could have clarified inconsistencies. They had expected more detailed proposals in regard to maternity services particularly midwifery services. It would have liked to have seen a statement about their services similar to the one in the Closer to Home Feasibility Study.

The committee welcomes the PCT's commitment to maintain consultant led maternity services in WCH and provided evidence from the West Cumbria Community Maternity Survey to show the support from the public. They state that there is an inequity for patients in pain relief between Carlisle and WCH, as epidurals are not available in CIC. The committee state that the midwifery service was understaffed in 2006 and there has been no recruitment to rectify this. MSLC would like to have dialogue about the midwifery and health visitor roles.

NCMSLC would like further clarification in a number of areas, namely, diagnostic services, Special Care Baby Unit, Anaesthetics, 24 hour emergency services, perinatal mental health issues, maternity bed numbers, and models of maternity care. MSLC state that in 'Maternity Matters' (Dept. Of Health, 2007) recommends that it should have a role in service commissioning at strategic and local levels but this is not happening at present, and it has no relationship with the PCT Family Care Stream Board.

The Stroke Association.

The main points made by the Association were that: the recommendations of the National Stroke Strategy should be given serious consideration; the stroke facilities at WCH and CIC need further investment to meet the Strategy; the different diagnostic tests needed for stroke may not be available in community hospitals; longer term rehabilitation requires the skills and expertise of a multidisciplinary team available in specialist units; resources, expertise and equipment must be available for those transferred to community hospitals or discharged.; an individual care plan is required for each patient; coordinated partnership between health social care and other services is required.

The Association wishes to be directly involved in the development of stroke networks and would welcome the opportunity to work with the PCT.

Multiple Sclerosis Society Allerdale branch

The Society sees advantages of Closer to Home in providing temporary intervention, eg saline drip for people with long term disability or acute infections, but concerns were expressed about respite care, working with and lack of communication with Social Services, and the need to expand community services first.

Intermediate care teams working in the community have been successful, but concerns were expressed about existing medical and support services which exist, and the number of beds in each hospital.

The Society pointed out that neurological rehabilitation and rehabilitation does not figure in the PCT's plans for WCH yet the Neurological and the Young Disabled Unit is a Centre of Excellence and supports local teams.

The Society does not support commercial outlets in community hospitals.

The League of Friends of Mary Hewetson Hospital were concerned about the bed numbers and how they were calculated, the elderly population and their needs in rural areas, and the large number of visitors/tourists to Keswick and their need for medical attention and the necessity for the PCT to cope with this in addition to those of the local population.

The League of Friends of Brampton and District War Memorial Hospital welcomes the Closer to Home proposals but has concerns about the reduction in the number of community hospital beds, the funding and staffing levels for care at home, and out of hours care in emergencies. It supports the proposed Health Campus for Brampton.

The Joint League of Friends of the Community Hospitals of North Cumbria completed the questionnaire. They have concerns about equity between local areas, funding, care in isolated communities, burden on cares, and adaptation of ambulance services. They feel that the experience of charities and voluntary groups such as Age Concern and Hospice At Home should be sought and joint working encouraged. The important role of BASICs teams and First Responders should be recognised and included in emergency service planning. The number of beds should not be reduced in community hospitals and a wide range of services provided including some forms of surgery. Full cooperation of GPs is needed.

Eden Valley Hospice noted that End of Life care was not mentioned in the document and would like the opportunity to contribute to palliative healthcare when restructuring is confirmed. Consideration should be given to more integrated working between hospice organisations and acute services. They also state that there is a lack of understanding of palliative care and expressed concerns about the service at CIC. EVH would like to develop in a specialist role in North Cumbria by increasing outwith services and integrating 'hospice at home' provision. Concerns about the provision of social care at present were stated, and that the barriers between health and social care should be removed. They agreed with the preferred option for acute hospitals.

Hospice at Home West Cumbria has serious concerns that the voluntary basis of their service is not fully understood by the PCT and that the implications of the proposals for the community workload with its limited local funding is not appreciated. It is felt that certain services (eg,lymphoedema) cannot be sustained without additional NHS funding. They would like more equitable funding (compared to the rest of Cumbria) for the palliative care service and will need extra NHS funding to meet the proposals on community care.

Hospice at Home Carlisle feels that the thrust of the proposals is in line with their philosophy and that they will continue to play a role in palliative care in community settings, but that they have financial and human resource implications for them, and therefore they would welcome involvement at an early stage in order to develop their business plans.

Cumberland Infirmary IBD Patient Panel praised the IBD service at CIC and is concerned that proposals should not weaken the service. There is no model for the treatment,

management and support for these conditions based in the community. They would like to discuss these matters with the PCT as part of the consultation, which they have requested before and were disappointed not to have received a reply.

Cumbria Partnership NHS Foundation Trust believes the proposals are on the right lines but may not go far enough to address financial and service sustainability issues. They have a number of questions about the feasibility study and the proposals particularly about costs.

The Trust proposes developing other services in community hospitals, mental health team bases, rehabilitative allied professions, disability services. It has clinical partnerships with NHCNHS Trust, ie, dementia, challenging behaviours, drug and alcohol addictions and A&E mental health needs and feels these should have been mentioned in the document and the Trust needs to be reassured that they will continue.

Save Our Services West Cumbria recognises the attempt of the proposals to meet the challenges of providing healthcare in North Cumbria. SOS feels that the proposals fail to recognise the centrality of WCH in the provision of healthcare to the community. They are unhappy at the downgrading of WCH and propose that it remains a DGH, increase the number of beds, that no change should be made regarding major trauma, retain emergency surgery, retain elderly medicine beds because of the complexity of medical needs of this group, retain palliative care, adequate services in Haematology, chemical Pathology, Microbiology and Radiology.

West Cumbria Carers welcome the concept of Closer to Home, but are concerned that there is a lack of detail in the community based proposals and in particular the proposed health and social care teams. They state that the wording of many of the proposals, such as the use of ‘could include’, suggests there is a degree of uncertainty about the services. They would like clarification and further information on a number of issues, such as bed numbers, respite care, the delivery of specialist services in community hospitals, health and social care teams, the composition of locality planning teams, the single point of access, rehabilitation services, and staff training.

North Cumbria Acute Hospital Patient and Public Involvement Forum completed the Questionnaire but in addition had a long list of concerns and questions. These include concerns about the consultation process and the document, Community and Acute Hospital facilities, the treatment of major trauma, maternity services at WCH, Palliative Care beds.

Cumbria PCT Patient and Public Involvement Cumbria Forums

Cumbria PPI Forums commend the PTC for the work in the proposals and agree in principle with the ethos of Closer to Home. They have concerns over the document and website, and stated that it was not possible to comment constructively on most of the proposals as too much has to be taken on trust. They suggest that locally elected representatives including local councillors, and people with ‘no political clout’ should be actively involved in planning

local services. They feel that telemedicine, which would allow a consultant to be available remotely, should be employed, and that a helicopter service and First Responders should be funded. The Forum states that palliative care patients with complex needs require the specialist services at WCH. It has concerns about the source of adequately trained staff in every area and the inconsistency and inequity which may arise, the reductions in the funding of acute and local beds, and bed planning which used 90% occupancy. The forum feels that improved health outcomes must be the priority rather than cost effectiveness

Cumbria Patient and Public involvement joint consultative committee

Although PPI forums have submitted responses independently as above, a joint response has been submitted in order to raise the profile of certain common themes in the responses.
Transport issues: will there be enough adequately trained staff and properly equipped vehicles to cope with the demand for movement of patients?; the poor quality of cross county public transport system.
Community services: lack of detail around delivery of community services; problems with the Choose and Book targets not being reached in Community hospitals; the ability of Social Services to deliver a supportive service; the need to plan for rural issues; equity of services across the County; better methods of gathering the views of minority groups.
Bed numbers; concerns about loss of beds and lack of clarity about bed numbers.
Emergency planning; concerns about the emergency and ambulance services being able to cope; consideration of air ambulance in rural transport issues; more information on the 'single point of access'.
GPs commitment: concerns about GP's commitment and involvement in the new proposals.
Process of consultation: the Forums expressed their concerns about; their lack of involvement and input into the proposals, drop in meetings were not well advertised and not in very accessible venues, the document contained insufficient detail to base judgements, and terminology was of concern; website information was good but only available to those with time, ability and facility to access a computer.

Public Forum for North West Ambulance Service states that they were not given an opportunity to discuss the proposals prior to the consultation. The document provides little information on the ambulance services and that there is a lack of substance to the future delivery of services by the NWAS Trust. Concerns were raised about the location, publicity and timing of public meetings and lack of NWAS Trust representatives at those meetings.

There is concern about financial issues for the NWAS, what services it has to provide and what part Locality Groups will play in commissioning their services. It was also noted that some PTS vehicles currently on operation will not be suitable for carrying some patients in step up/step down transfers and that the proposals will probably increase the out of hours patient transport needs. There are concerns about the impact on the ambulance services and require more details are required on the role of the NWAS Trust.

It is not clear how many major trauma patients will be transferred but the NWAS Trust feels that protocols should be drawn up and agreed between the Trusts as to the skill levels required by the staff who accompany these patients whilst in transit. Apart from the task of transporting patients in emergency there is no detail about how NWAS will be utilised in the proposals for emergency care.

Cumbria Action for Health completed the questionnaire and had particular concerns about the provision of Palliative Care, the reduction of services at WCH, the reduction in bed numbers, increased pressure on carers, community transport, rehabilitation and stroke services.

Royal College of Nursing completed the questionnaire and notes that the proposals will require some staff retraining and redeployment and it expects an ongoing discussion with trade unions about these issues.

Penrith Day Hospice Team completed the questionnaire and has particular concerns about the provision of staffing, of palliative care and services at Penrith hospital**.**

Eden and Keswick Alzheimer's Society completed the questionnaire, but was disappointed that the document did not recognise the needs for the growing numbers of people with dementia and suggested there was a need for better training of staff to deal with this condition.

Unison Northern Region feels that the PCT has not adequately involved the staff associations, and that the proposals for acute and emergency services will lead to a poorer service for West Cumbria. They "insist that before any proposals are implemented the staff side organisations are fully consulted and involved."

Unions Cumbria PCT suggests that there is 'no meat on the bone' yet, no specific detail as to how each community hospital will develop and expresses concern that acute services in West Cumbria will be reduced. They state that only certain staff have been consulted and that nurses, AHP's and support staff have not been involved. They would like reassurances that staff currently employed by the Trusts in the NHS will remain and that services will not be divested to the private sector. They wish to see meaningful dialogue between management and the staff side as a matter of urgency.

Community Groups

Brampton Community Association completed the questionnaire and was particularly supportive of the idea of bringing together health and community services under one roof. The closer working relationship would help the Association to reach all the community and promote services and healthy living agendas and lists some 'localisation benefit scenarios.'

Residents of Rural North East Cumbria supports greater localisation of health services and suggests using community centres for health information and advice, training courses

'Dealing with Illness for the general public' (which has been initiated elsewhere) and for Health trainers and Health Support Workers. 'Northumberland Fishnets' provides an example of PCT support for community health initiatives.

Whitehaven Methodist Fairtrade Circuit expressed unease at the Closer to Home proposals, particularly at the loss of facilities departments and beds at WCH.

The Parish of Whitehaven Parochial Church Council requires more detail to comment on the advantages of the proposals, and would like to know where the funding and resources are coming from to implement the proposals. Consideration should be given to the significance of the deprivation index of West Cumbria and hence the greater impact of a reduction in services in this region. They feel there are no advantages to providing emergency care in the proposed way to West Cumbria, and there should be two equally resourced hospitals. Palliative care and paediatric services should be retained in WCH. They feel CIC will not be able to cope with the proposed arrangements.

West Cumbria Strategic Partnership partially completed the questionnaire. Among its main concerns were the chosen localities. They questioned whether these were the areas which people identified with and were best for planning of services, and whether the PCT had fully considered the impact of change on environmental issues and on the local economy and local businesses and urged the PCT to do so.

Churches Together in Cumbria completed the questionnaire**.**

Age Concern Carlisle and District completed the questionnaire**.**

West Cumbria Rape Crisis Ltd completed the questionnaire**.**

Age Concern South Lakeland and Barrow completed the questionnaire and are awaiting with interest for the South Cumbrian proposals.

Carlisle partnership HCOP Group completed the questionnaire. They pointed out there was insufficient information to answer some of the questions.

South Workington Neighbourhood Management

The main points made by SWNM were: health services in South Workington were not adequate, eg, lack of clinical services and suiting the needs of the provider rather than the user as they often do at present; access to care at home will require a seamless multi-agency approach and insufficient information is given on how this will be provided; they do not support the loss of any facilities at WCH or the reduction of beds at Workington Community hospital; they support the mainstreaming of air ambulance service, the 'BASICs' and 'First Responders' schemes; the proposals appear to place an added burden on the Third Sector.

Rotary Club of Bassenthwaite suggests that there is little evidence that sufficient provision and investment will be made including that for social services. Their main concern is over the reduction of services at WCH and its viability as a major acute hospital, and that Option 1 has not been explored enough including patient dis-benefits.

Cumbria Children's Trust is concerned on two main counts; that the needs of children are not adequately acknowledged, and how changes to community based specialist nursing services may affect PCT resources. They point out that there was a proposal to cut £2 million from the budget in Cumbria: A Whole A System Review: Feasibility Study. It argues that the PCT should take into account strategies in the Children and Young People's Plan for Cumbria and ensure that they do not compromise services to children, young people and their carers.

Connexions Cumbria supports the Cumbria Children's Trust response and adds that lifestyle issues should be linked to the document 'Risk Taking Behaviour Strategy for Young People'. They also point to the greater impact of travel and transport problems on children and young people as they are not independently mobile and may not have access to support.

People First (a voice for people with learning difficulties) welcomed the Closer to Home proposals with some comments from individuals. They wanted improved support and breaks for carers.

Councils

Cumbria County Council

CCC stated that they are reviewing their social care facilities and beds. They want to be a full partner in planning the appropriate provision and to break down any barriers that exist and take forward proposals on health and social care teams. Concerns expressed include where cost improvements may be achieved, eg, Cumbria Whole System Review: Feasibility Study suggested a £2million budget reduction for community based specialist nursing including health visitors. CCC feel that the document is adult focused and the opportunity exists to reshape services for children and young people and sees the opportunity around the agenda 'Every Child Matters'. CCC has already developed local joint management teams and this provides an opportunity to work with the PCT and Health services in local management teams.

CCC completed the questionnaire. The CCC welcomes the flexibility and responsiveness to local needs, and would like to see the integration of planning for services in community health and social care. Access to services should be equitable and not become a post code lottery.

Emergency Treatment Centres must be staffed and resourced adequately as well as major trauma centres. The needs of West Cumbria must be taken into account bearing in mind

travel difficulties. The CCC wish to see the expansion and support of air ambulance services. Option 1 is the best option but reassurance is needed that the bed numbers in acute hospitals is adequate.

CCC is seeking to be a full partner in community schemes. There is a need for coordination of the different transport services and for the CCC, the PCT and the Transport Authority to work together.

Carlisle City Council completed the questionnaire. Their main concerns were the adequacy of capacity and resource, funding (rural proof funding), and reduction of bed numbers in community hospitals.

Allerdale Borough Council gave a detailed response and completed the questionnaire. ABC welcomes the concept but have reservations about the proposals. They wish to see the barriers between primary and secondary broken down and joined-up community care. They are in favour of a bottom-up approach to change. They state there is a lack of clarity, detail and evidence for the proposals in some parts. They are concerned about the dependency on the bid for £80 million of fundingand 'no plan B' in the event that it is not secured.

They have concerns about the bed modelling used in both acute and community hospitals and the reduction in bed numbers. They are concerned about the down-grade of WCH, the loss of palliative care at WCH, and about the demographics not being taken into account, the catchment area and deprivation, and visitor numbers at Keswick. ABC point out that CIC does not have a neurosurgery unit and major trauma cases often have to be taken to Newcastle for neurosurgery.

Copeland Borough Council was generally disappointed with the consultation document and felt it contained inadequate information to enable a full response.

CBC favours the retention of the specialised stroke unit at WCH, the bed numbers in that unit, the palliative care service unit at WCH with the same bed numbers, the same level of ambulance service, the Young Disabled Unit, the consultant led maternity unit and paediatrics, the retention of major trauma and emergency treatment unit, and support services such as pathology and microbiology.

CBC feel it is necessary to gain the support of local GP's and put in place the necessary support structure before changes take place, and note the impact on social care services. There are concerns about funding and the absence of a 'fall back' position.

Eden District Council completed the questionnaire**.**

Caldbeck Parish Council completed the questionnaire and wanted to know whether Caldbeck Surgery and Wigton hospital would need to provide more space and clinics.

Ennerdale and Kinniside Parish Council completed the questionnaire. They were critical of the consultation process and thought that it was poorly handled, the document difficult to obtain, Parish Councils and local communities not engaged and venues were poorly chosen and advertised.

Lamplugh Parish Council suggest that the Community Hospitals should not become the 'cinderellas' of the Trust, and query what will happen to the money being saved and how it will be used.

Papcastle Parish Council thought there was not information to be able to give reasoned answers. 'Too much vision and not enough fact'. Concern was expressed about the number of beds and the lack of information on social care bed provision, and about facilities at WCH.

Patterdale Parish Council objects to the proposed reduction in beds at Penrith hospital and would like to know the figures for occupancy levels.

Langwathby Parish Council is concerned about the reduction of bed numbers at Penrith hospital.

Haile and Wilton Parish Council is concerned about the loss of facilities and beds and the downgrading of WCH which threaten its viability. The Council has doubts over whether the Closer to Home proposals can be implemented and about the staffing and funding provision.

Great Strickland Parish Council is concerned about the distance to the acute hospitals and feels that more services and beds should be available at Penrith Community Hospital.

Gosforth Parish Council feels the presentation of data in the document is confusing and some of the terminology needs more detailed definition or examples. It pointed out that people living south of Egremont do not regard themselves as North Cumbrian. Although it accepts that option 1 is the only viable one of those offered it is extremely concerned about the needs of people in West Cumbria and South Copeland, and the downgrading of WCH. A recent journey from South of Whitehaven to Carlisle took 2hours 20minutes, and a traffic accident South of Calderbridge requires a 100 miles detour to get to Carlisle.

They have concerns over removal of Palliative Care and long term rehabilitation to CIC, and about waiting times, administration including links with WCH services and parking at CIC. Also concerns were expressed about cooperation with social services and availability of support services.

The system is dependant on skills of 'first attenders' and resources and training for paramedics and ambulance staff must reflect that.

St Bees Parish Council welcome the opportunity to comment on the proposals. However they do have a number of concerns and have raised 33 questions which they would like the PCT to answer, and invite a representative from the PCT to attend a Parish Council meeting

to answer them. The lack of detail in the proposals make it hard to make judgements on them, and appear to be a cost cutting exercise based on short term objectives. The Council submitted detailed arguments and supporting statements from medical journals.

They are concerned about the reduction of bed numbers in both the acute sector and community hospitals and about the model that it is based on and feel it does not take into account possible disasters noting that it has Sellafield in the area. They have added concerns about critical care beds and believe that the maintenance of ITU/HDUs are essential at both acute hospitals, and about the transfer of patients in major trauma and emergencies. Further concerns were raised about the loss of the Pathology Unit at WCH, and the lack of consultation with the ambulance service and GPs.

Cockermouth Town Council is against the reduction of beds and the plans related to Youth Disability Unit and Stroke Unit at WCH but are in favour of increasing the number of beds at Cockermouth Hospital and of step up/step down beds.

Kirkby Stephen Town Council completed the questionnaire. The Council is concerned that the geography of Kirkby Stephen is not taken into sufficient consideration, and that people in the area need improved access to facilities and links with South Cumbrian hospitals. It would like clarification on the provision of maternity and midwifery services.

Millom Town Council feels that the document is lacking in robust evidence to support much of the business case recommended. Rurality and transport difficulties are a feature of the Millom area and MTC supports the idea that Millom Community Hospital be redesigned and refurbished to provide a 'Hospital Village'. MTC has concerns about service becoming a postcode lottery, the provision of out of hours medical services, providing enough ambulances with trained crews, recruiting community nursing staff in rural areas, about adequate funding for rural communities, and at WCH the future of the stroke unit bed numbers, microbiology, pathology, mental health care, and also confusion about transfer of Millom area patients to hospital (Furness, Lancaster, WCH, CIC).

MTC state that extensive changes will be required for inter agency working with social services, and that services provided by partners (air ambulance, First Responders, BASICs) should be centrally funded and not have to rely on public donations.

Workington Town Council is supportive of the principle of Closer to Home, but wants the maximum number of bed numbers retained. It feels that there the need to determine how much of £80 million can be obtained, and is unhappy with trauma patients going to Carlisle from West Cumbria.

Other Organisations

Haverigg Prison welcomes the proposals, but the need for escorts to go with prisoners for medical appointments presents staffing issues. They feel that they need a better healthcare

facility nearer the prison and that Millom Hospital should be upgraded and offer more services and facilities.

University of Cumbria, Faculty of Health, Medical Sciences and Social Care is fully supportive of the aims of Closer to Home. The Faculty is developing its curricula to meet the needs of education and training for the NHS and community care through its full and part time CPD provision, and is reviewing its provision in collaboration with NHS and Social Care providers.

6. **Major Themes**

Access, travel and transport

The difficulties of travel in Cumbria were noted in the consultation document and were of major concern in the responses.

The main advantage of receiving treatment closer to home was seen to offer patterns of service that would reduce travel, saving time and money for patients and visitors, resulting in less strain for patients and visitors, and aiding recovery. The increase use of community hospitals was generally welcomed for these reasons.

However, the people of West Cumbria and South Copeland were particularly concerned about extra travelling to Carlisle with the downgrading of WCH and loss of major trauma and several specialist units. The document states that the journey from Whitehaven to Carlisle is 39 miles and takes 68 minutes. Respondents suggested that accidents were not uncommon on that road resulting in the road being blocked for several hours with detours of up to 100 miles being required. Some people pointed out the difficulties on that particular route and the length of travel times they have experienced and these have often been longer than the suggested time, and then encountering parking difficulties at CIC on arrival. Other people who had not always got access to a car stated that public transport by bus and train was not necessarily available at convenient times for appointments or visiting and was time consuming. One person gave the example of the unavailability of public transport for a return journey and resulting in a £70 in taxi fare. Concern was expressed about journey times for emergency treatment by ambulances and that people's lives were being put in danger and that the situation would become worse if major trauma services were only provided at CIC.

People also suggested that there was a need for the provision of better public transport, better coordination and links with County Council and transport providers, more links and funding for the ambulance service and the air ambulance service, and a NHS transport link between CIC and WCH for the public, staff and supplies.

Hospitals

WCH

There was strong opposition to the downgrading of WCH. This was not just about increase in travel for some people who would have to go to Carlisle. There was concern about a single major trauma unit for Cumbria in Carlisle, and that the loss of facilities, specialist units, beds and expertise was going to cause staff recruitment problems for consultants, doctors and nurses and lead to a further downward spiral for WCH. It was pointed out that it was often difficult to recruit and attract suitably qualified staff to this area. Some people suggested that major trauma and full emergency facilities should be retained because of the closeness

of Sellafield nuclear plants and its potential for serious accidents and incidents, and for sea and mountain rescues. WCH status and certain units, such as Palliative Care, the Stroke Unit and Young Disabled Unit, and supporting units of Microbiology and Pathology should be retained at WCH. These units were highly praised by some respondents and it was pointed out that they would be a significant loss and that relocation at CIC would cause families a lot of stress. There was a very strong feeling about the Palliative Care Unit with one letter which containing 18 signatures against its possible closure. Likewise there were at least 372 objections to the closure of the Stroke Unit, Ullswater Ward and Younger Disabled Unit. These units were seen as Centres of Excellence and there is a fear that patients will not receive the same level of care in acute or community hospitals elsewhere. People suggested that politics and finance were driving the changes and closures at the expense of the patient.

CIC

Whilst many people agreed that, if there was to be only one major trauma unit, then CIC was the best option to concentrate facilities and expertise, it was pointed out that Carlisle was situated in the far north of the county and was not easy to access for people from West Cumbria and many rural areas at the area bordering South Cumbria. The preference was for two major trauma hospitals and WCH was the only viable second location. Concerns were expressed about emergency and ambulance response and travel times to CIC and the possibility that patients might suffer as a result. There were also major concerns about treatment and the number of beds at CIC. People cited problems and illustrated them with personal examples, such as having to wait in corridors and cancellations because there were no beds available. Public transport and parking problems have been noted above under the heading ‘access and travel’. It was noted by medical staff that the CIC did not have a neurosurgery unit and that some patients will still have to go to Newcastle or elsewhere.

Furness General Hospital and Kendal Hospital

Some people in South Copeland could not understand why South Cumbria was not included in the consultation and why FGH was not included. Some people in the area thought FGH should have been included and that emergency treatment would be sought there as it was nearer and more accessible. People in South Eden valley noted that Kendal was nearer than Carlisle and should have acute facilities and be available to them.

Community Hospitals

Whilst many agreed with the concept of increasing the facilities and usage at community hospitals for reasons relating to local access, travel, familiarity, local staff, and benefiting both patients and visitors, there were concerns expressed about staffing, facilities and funding. There would have to be a major upgrading of facilities if extra services were to be provided, and doubts were expressed as to whether the funds would be available and the

plans achieved. The document lists services which are currently provided at each hospital and a list which could be provided. However, there was a lack of detail about the exact nature of the services which could be provided, in particular the specialist units. People were uncertain about what would be available at their local hospital including the number of beds. There were many services suggested, some of which were listed but others include audiology, ME, dialysis, dietetics, disability services. There was concern over whether enough staff of the appropriate levels of skill would be available, such as the provision of consultants and doctors rather than nurses for particular cases. Concern was also expressed about GPs' involvement and whether they had been consulted, their hours of work and about the availability of 24 hour medical care. For some people the issue of inequality between areas and hospitals and a 'post code lottery' was a concern. One person suggested exploring the concept of 'Rural General Hospitals' which was now established in Scotland with specialist training available in a Scottish medical school.

Beds

The number and availability of beds in both acute and community hospitals was one of the biggest concerns. People were unsure how many beds would be available and whether the step up/step down number would be part of the current number or added to it. Many people noted a decrease in the total number of beds in the two acute hospitals and community hospitals. They were against a reduction and thought that more beds would be needed in the future because of the proposed closer to home proposals and the aging population. Although the idea on intermediate care in community hospitals was favoured, and respondents thought it would free up beds in the acute hospitals, it was thought that more beds would be needed. Concern was expressed about the transfer and discharge of patients and the possibility that it could be driven by the number of available beds rather than to appropriate level of care and treatment.

Working with other organisations

Many of the responses acknowledged the need for close links and joined up services between organisations, the most frequently mentioned being social services and voluntary services involved in care for elderly patients. Some individuals and organisations that undertake this work stated that the partnership needed to be improved and better than it had been so far been and others doubted whether this would happen to the extent that is needed. Some people have said they have encountered difficulties dealing with social services and there have been funding issues.

Funding

Some organisations congratulated the PCT on obtaining NHS Northwest funding to remove the 'historic debt'. However some are concerned about the dependency on a £80 million bid and the lack of alternative plans if this does not materialise. There is also concern expressed

at the proposal in the Cumbria Whole Service Review Feasibility Study to cut £2 million from the community based nursing and health visiting funds. This seems to contradict the proposals for Closer to Home and investment in local community services, work with social care and through health visitors. Whilst some people commented that the Closer to Home proposals would be more efficient and cost effective, there were equally many people who thought that a large investment in community facilities and services would be required to carry out the proposals, that changes would be more costly, such as, community and home health support and care. Many doubted that the PCT would have sufficient funds to carry out the proposals to the required standards. There were accusations of cost cutting at the expense of healthcare, merely to reach targets and cost savings, and of shifting the cost burden to Social Services in some cases. There were concerns that it would lead to inequality between areas, to a 'postcode lottery' with rural areas hit hardest. There were calls for joint funding with other organisations such as Social Care providers, for more funding for already financially stretched Voluntary Organisations involved in providing health services such as Hospice Organisations and First Responders. The ambulance service, air ambulance and transport services also needed more funding because of the nature of the geography in Cumbria. It was pointed out that some of the cost cutting measures to save money did not add up in terms of future demands as they did not take into consideration the ageing population, the tourist and holiday population and type of activities undertaken. Many people indicated that it was important to put in place adequate community services and joint working with organisations before there was any reduction in the acute services. This would be likely to put a strain on finances.