Cumbria Primary Care Trust consultation paper "Closer to Home"

Lead Member: Mrs Y R T Clarkson

Lead Officer: N White

Recommendation: that Cumbria Primary Care Trust and Cumbria County Council Health and Wellbeing Scrutiny Committee be advised that in respect of the "Closer to Home" Consultation proposals this Council considers that:

In respect of Introduction part of the consultation document - The Council would like to comment that it was generally disappointed in the consultation document itself, and were bemused how such a document could go out for consultation with the obvious lack of support from consultants, GP's and others.

The Council welcomed the time extension for the response but still feel there is inadequate information and detail to allow a full response to be made. The Council would therefore reserve the right at a further date to make further comments if and when information becomes available.

There will have been a lot of people and organisations responding to this consultation that deserve a response to their comments.

In respect of Change – The Council recognises that a change is needed but that change has to be in the best interests of this local community and we have yet to be convinced that this is what Closer to Homes will deliver,

In respect of Vision – The vision in principle is fine, but to deliver it will need the time, finances and support from a lot of organisations, and the Council is not convinced that this support is there at this time. The theory to deliver services closer to home is good but in Copeland this is rather more difficult considering we only have two community hospitals compared to the 10 in the rest of North Cumbria. It is also worth noting that accessibility is judged as an essential criteria, therefore this emphasises the need to keep hospital services in Copeland.

In respect of the consultation questions the Council has the following reservations in achieving the delivery of the proposals that it would wish to see addressed:

(A) as the national evidence on the benefits of a specialised stroke unit is overwhelming the PCT is asked to confirm that the improvement in stroke care it recently announced includes:

1) the retention of a specialised stroke unit at West Cumberland Hospital,

2) whether this unit will be in its own ward or part of another ward,

3) no reduction in the numbers of acute beds or rehabilitation beds in that unit, and

4) the continuance of the necessary equipment and staff to support the rehabilitation of stroke victims at West Cumberland Hospital.

(B) that the nationally recognised palliative care service unit remain at West Cumberland Hospital with at least the same number of beds that currently exist to enable members of the public to be able to choose to have their care at the Hospital if they so wish.

(C) that Cumbria PCT and the North West Ambulance Services Trust agree on a service model that ensures that at least the same level of ambulance service is available under Closer to Home that currently exists, and

(D) Cumbria PCT confirms that it will provide sufficient funding to ensure that the service model is maintained.

(E) that the support of local GP's is crucial in ensuring the success of the Closer to Home and the PCT is urged to seek and resolve any necessary issues so that all GP's in Cumbria can support the proposals.

(F) the PCT be thanked for agreeing to increase the proposed numbers of beds at West Cumberland Hospital to 220 with the possibility of increasing this to 250.

(G) this Council supports the retention of the young disabled unit, the consultant led maternity unit and paediatrics and asks the PCT to publicly announce as soon as possible the proposed number of beds per service for all the services that will be provided at West Cumberland Hospital.

(H) The PCT be requested to regularly review the number of beds and provide the Council with its analysis.

(I) The Council through its Overview and Scrutiny Committee would wish to continue to monitor the progress and may ask the PCT to come to its meetings at appropriate times to explain the current position.

(J) This council notes and strongly endorses the view of several Consultants at West Cumberland Hospital that the original wording of the consultation document as affecting major trauma - proposing that "major trauma services for the whole of North Cumbria to be located at

the Cumberland Infirmary in Carlisle" was unworkable and unacceptable.

This council welcomes the fact that the Trusts have moved forward from that position and now recognise that patients with significant trauma would be taken to the nearest Emergency Treatment Centre for stabilisation. A clinical decision would then need to be made on the best approach and that a number of patients would require and receive immediate surgery at West Cumberland Hospital.

This council would like to see a clear statement of policy about the treatment of patients with significant trauma agreed between the trusts and the consultants as a matter of urgency and published.

(K) This council remains concerned that the West Cumberland Hospital needs a base of support services such as pathology and microbiology if it is to provide the safe and sustainable care which patients need, and urges the trusts to continue to address this issue.

(L) The development of community facilities and the necessary support infrastructure should be put into place before the reduction in acute beds is started. The Council would not look favourably at any reduction in service at West Cumberland Hospital without a sufficient level of service and care being available for the people of West Cumbria.

(M) There is some concern over the funding of the community care proposals and what happens if the Community Venture Funding is not awarded.

(N) The lack of a fall back position if the necessary savings are not achieved is also of concern particularly any affect on the proposed new build for the West Cumberland Hospital.

(O) The PCT is urged to continue to listen to the concerns of the public as it develops its proposals and continues to be willing to change its proposals to reflect those concerns.

(P) that Cumbria County Council carefully reassess the financial implications from the Closer to Home proposals as the increases in the early discharging of patients from hospitals could have profound effects on the social care service it provides. It will be very difficult to provide an acceptable level of service without additional funding or greater integration between health and social care.

1. BACKGROUND

The Children, Young People and Healthy Communities Overview and Scrutiny Committee held a special meeting on 21 November 2007 to consider how the Council should respond to the NHS public consultation on the "Closer to Home" proposals.

The Committee agreed that there was much more information needed before it could make a reasoned judgement on the proposals. In light of this it agreed that a further meeting be held to call witnesses to go through the necessary evidence.

The Committee held that meeting on 17 January 2008 and heard evidence from:

Mrs Alison Hunter – Hon Secretary, Stroke Link West Cumbria and
Louise Shaw - Assistant Regional Manager for North West Stroke Association

Janet Ferguson - Cumbria Palliative Care Lead Nurse, Workington Community Hospital on Community Hospitals

Salman Desai - Head of Service Development and Performance Management and Andrew Kirchin - Communications Manager, North West Ambulance NHS Trust

Keith Opie - Service Delivery Manager, Allerdale and Copeland Area Office, Cumbria Fire and Rescue Service

Paul Mavin – Company Secretary, North Cumbria Acute Hospitals Trust

John Critchley – Director of Resources, Graham Shipp – Turnaround Director Cumbria Primary Care Trust and Dave Rodgers – Lead GP for Copeland

Nick Smith – County Manager Service Development, Older People Cumbria County Council Adult Social Care

It also considered written evidence from the 'Save Our Services' Response to Cumbria NHS Primary Care Trust 'Closer To Home' (An NHS consultation on providing more healthcare in the community in North Cumbria).

2. EVIDENCE CONSIDERED

A. Stroke Unit

The Committee were informed that there were 4 acute beds and 18 rehabilitation beds for stroke victims at West Cumberland Hospital. 96% of hospitals in England have a stroke/rehabilitation unit with an average number of 10 acute beds and 24 rehabilitation beds.

The PCT had recently confirmed that a Stroke Unit would remain and be improved at West Cumberland however it was unclear what the exact details of this would be.

Stroke was a complex illness that required support services from a number of different specialisms as well as considerable support and stress on the family of the victim.

Cumbria PCT was aiming for the top 25% quartile of performance for the discharge of patients and this equated to 7 days for the discharge of stroke victims with the majority being discharged within 21 days. The complexity of the illness made this difficult to achieve as well as the need for ongoing medical support.

A third of the 130,000 (approx) people per year who suffer a stroke die within the first 3 months of having the stroke. Of the remaining two thirds – a third will make a good recovery, a third will be left with some form of disability and a third will be left with communication problems.

There was a real concern that the right level of diagnostic equipment and specialist staff would not be available at the community hospitals. Local GPs who might not have the necessary specialist knowledge would monitor rehabilitation. It was also likely that the beds would be in generic wards rather than specialist units and the specialist staff would be dispersed and not as effective.

The House of Commons Committee of Public Accounts in 2006 had found that by increasing the proportion of stroke patients who spend the majority of their time in hospital on a stroke unit by 25%, around 550 deaths per year could be prevented.

There was currently acute rehabilitation at West Cumberland beyond the first 72 hours post stroke but it was unclear whether this would remain.

The national service framework for Older People stated that rehabilitation on a stroke unit should be supported by a stroke –skilled multidisciplinary team, which includes a range of, allied health professionals and has strong links to social care. This would ensure that staff on rehabilitation units have the appropriate competencies to deal with the complex issues that patients present. Furthermore the Cochrane review of stroke units trials showed that not only did stroke rehabilitation units benefit all patients irrespective of age and severity but that those with more severe stroke gained most. Other settings such as generic I intermediate care needs may not be as effective at improving outcomes.

The New Strategy for Stroke 2007 – 10 point plan for action states that – stroke unit quality: stroke unit care is the single biggest factor that can improve a person's outcomes following a stroke. Successful stroke units are built around a stroke skilled multidisciplinary team that is able to meet the needs of the individuals.

RECOMMENDED – as the national evidence on the benefits of a specialised stroke unit is overwhelming the PCT is asked to confirm that the improvement in stroke care it recently announced includes:

(1) the retention of a specialised stroke unit at West Cumberland Hospital,

(2) whether this unit will be in its own ward or part of another ward,

(3) no reduction in the numbers of acute beds or rehabilitation beds in that unit, and

(4) the continuance of the necessary equipment and a stroke –skilled multidisciplinary team to support the rehabilitation of stroke victims beyond the first 72 hours post stroke at West Cumberland Hospital.

B. Community Hospitals

The Committee was informed that in order to continue to provide general palliative and end of life care the community hospitals would need to have sufficient well-trained staff.

There needed to be enough beds to offer beds for respite and palliative care at the time they are needed. Rebuilding of community hospitals should ensure that there were single rooms for patients who were dying as well as facilities for family and carers to stay with the patients.

There needed to be expert identified staff for the specialist palliative care unit at West Cumberland Hospital and the Community Hospitals would need sufficient staff to support patient care.

Rehabilitation was an important area for palliative care patients to ensure they were able to do as much as possible within the limits of their condition and illness. Access to allied health professionals such as physiotherapy and occupational therapy could be improved for palliative patients.

Existing staff had the necessary skills within their settings. Good provision of general palliative care within community hospitals would mean appropriate support and education for the specialist palliative care team. There would need to be sufficient staff capacity to release staff for training.

In respect of community beds in Millom it was unusual for there not be sufficient beds but if there was a patient would be likely to be transferred to South Cumbria/Barrow rather than North Cumbria.

The Committee noted that the palliative care service in West Cumbria had been recognised nationally at palliative care conferences.

RECOMMENDED – that the nationally recognised palliative care service unit remain at West Cumberland Hospital with at least the same number of

beds that currently exist to enable members of the public to be able to choose to have their care at the Hospital if they so wish.

C. Ambulance Services and Cumbria Fire and Rescue Service

The Committee was informed that there were 2 Ambulances in Copeland that were 24/7. There was also a Rapid Response vehicle available for 12 hours a day as well as vehicles that could be called from adjoining areas and the Sellafield Ambulance Service

In the last six months there had been 4,957 ambulance journeys to West Cumberland Hospital and 7,642 to Carlisle. However it was not clear how many of those journeys to Carlisle were from West Cumbria.

In the last six months there had been 96 journeys to Newcastle. It was important to note that there were three different types of journey by ambulance – emergency, intermediate and other patient travel and these may not have all been emergency journeys.

The trust confirmed that the current response time for category A calls was 8 minutes across Cumbria.

In respect of the Golden Hour for trauma patients this started from the first moment of impact. Getting treatment in this hour was critical in improving the chances of survival for victims.

The Fire and Rescue Service target, which they were currently meeting, was to reach 95% of accidents within 15 minutes. The priority was to initially stabilise the patient and the Fire and Rescue Service would immediately undertake any work to clear the victim to enable the ambulance service to take the lead.

Whilst the Fire and Rescue service at Whitehaven was a 24 hour service in the rural areas the service was often a part time volunteer service but still managed to meet this target.

It was noted that the claim that mortality rates increase by one per cent for every extra six miles travelled by victims to a trauma Centre came from a Department of Health study from 1997 to 2001. This was before major improvements were made in Accident and Emergency services.

The costs of the additional ambulance services that were needed as a result of the closer to home proposals were yet to be worked out. The Ambulance Trust would need to work out a service model with the PCT.

The Ambulance Trust considered that the delivery of care was more important than the speed that could be provided through the use of estate ambulances. The same level of care was not possible in estate ambulances compared to normal

ambulances. There was also a rapid response vehicle in Copeland where urgent circumstances necessitated its use.

Whilst air ambulances also reduced travel times there were often circumstances where such ambulances were not available. However, there were potentially two ambulances in Cumbria as the North East air ambulance could be called if needed. It was also worth noting that Air Ambulance service received charitable status and was not controlled by the NHS.

It was noted Cumbria had a significantly higher number of road casualties than the national average. However the number of people who had died or had been severely injured in road accidents in 2007 had reduced in greater numbers than the target set by the government. There had been a similar reduction of children dying or being severely injured in road accidents beyond the government target.

This had been due to not only improvements in equipment and training but also a targeted approach to educate those groups most likely to be involved in serious road accidents.

Whilst the level of risk of a terrorist attack to Sellafield was classified there had been a parliamentary briefing that had clarified the situation. There were regular exercises for all the emergency services that would be involved in an incident and Cumbria had been fortunate in receiving resources for the specialised equipment and vehicles that would be needed.

It was noted that the recent changes of NHS services in Blackburn and Burnley and the problems that it had caused for the ambulance service in that area would give the ambulance trust a better idea of the required service model in Cumbria to overcome some of those problems.

RECOMMENDED – that Cumbria PCT and the North West Ambulance Services Trust agree on a service model that ensures that at least the same level of ambulance service is available under Closer to Home that currently exists, and

RECOMMENDED - Cumbria PCT confirms that it will provide sufficient funding to ensure that the service model is maintained.

D. Lead GP for Copeland

The Committee was informed that the Closer to Home proposals would require a different way of working for GP's. The recent movement by the trusts on a number of issues had made GP's happier with the proposals but there still remained a number of details to be worked out as well as the impact on patients

It was noted that not all GP's were in favour of the proposals and monthly meetings were being held with the practise manager and a GP. It was intended to go round all the practises in Copeland to check on all the doctors' issues with the proposals.

The proposals should see greater involvement in the local communities but the practicalities had yet to be sorted out. It may be a case of seeing things happen before everyone will believe in the proposals.

In respect of whether there was pressure put on GP's to send patients to Carlisle it could well be the case that this was due to the Government targets on waiting times. For some services it was quicker to go to Carlisle and would enable the treatment to take place within the target.

There were no plans to increase the amount of minor surgery undertaken by GP's in Copeland under the Closer to Home proposals. There was already surgery undertaken for "bumps and bruises".

The purpose of Closer to Home was to reduce the number of people in hospital and provide an alternative service. It was also about getting people out of hospital quicker and community support teams would need to provide the right quality of care.

The proposals had seen the start of discussions between primary and secondary care clinicians about the clinical pathways and the right clinical care for patients. These discussions would now continue as in the long term the distinction between primary and secondary care would become blurred.

RECOMMENDED – that the support of local GP's is crucial in ensuring the success of the Closer to Home and the PCT is urged to seek and resolve any necessary issues so that all GP's in Cumbria can support the proposals.

E. North Cumbria Acute Hospitals Trust and Cumbria Primary Care Trust

The Committee was informed that in May 2007 the PCT had a historic debt of £37 million with an £18 million recurrent debt. A 3-year programme for financial recovery along with an overall 5-year financial plan had been put in place.

The Department of Health and the Strategic Health Authority had been confident enough with this plan to wipe off £28 million of the debt. In house efficiency savings meant that the PCT would make £8.3 savings this year enabling the debt to be cleared. Good financial management would also enable the loans to service the debt to be paid off by the end of the year.

This meant that £19 million could be invested in community services over the next 5 years. £10 million of this would go towards patient services and £9.2 million towards Community Ventures. £2.7 million in interest payments would also be released for patient services.
The financial viability of the PCT was dependent on Closer to Home. There was a premium to run 2 hospital sites in North Cumbria. As soon as it can the PCT

needed to invest in community services. £14 million had been set aside as transition funds over the next three years to enable the change to community based services.

Cumbria was one of 9 areas bidding for the Government Community Ventures Fund of £80 million and a business case was being put together for this bid. More details would be available from the Department of Health in April.

The PCT was now putting money into locality boards that would enable GP's to spend the money locally, as they want. The locality boards consisted of GP's, lay people and social care representatives. The boards were charged with setting priorities and being more responsive to local needs. This was the start of a journey to allow GP's to take control of the local service.

The community services were being pump primed in this way as it was not sustainable to have dual running. There was sufficient capacity in the community hospitals at the moment and patients needed to be discharged more quickly from hospital to a community hospital or their home.

The PCT considered that it was not efficient to provide rehabilitation in acute beds and it was more effective and cheaper in the community.

The bed modelling exercise that had been undertaken for the PCT as part of these proposals had looked at the health care services by proportion at patient levels through five-year age bands. Increased usage in acute activity for elderly patients in Cumbria had been based on the anticipated population changes and the proposed bed numbers took this into account.

The PCT had confirmed that the number of acute beds at West Cumberland Hospital would be 200 with 20 community beds making a total of 220. There would be sufficient flexibility to increase this number to 250 total beds if circumstances permit. There was no breakdown of the number of beds per service available yet.

The current level of out of hours surgery at West Cumberland was around 600 cases a year. Out of hours will be considered as after 9pm on a weekday and probably after 6pm at weekends.

Much of the complex planned (elective) surgery for North Cumbria was currently undertaken in Carlisle. The intention was to continue to develop services for complex surgery and other complicated procedures at Carlisle. The Acute Trust was confident that safe surgical cover out of normal working hours could be provided at both hospitals. Some out of hours cover for emergency general surgery would be provided by a first on call consultant in Carlisle with a second on standby for life threatening emergencies (fewer than 5 cases a year).

As elective complex surgery would be mainly carried out in Carlisle some patients in West Cumbria would be transferred to Carlisle if they needed emergency complex surgery. This would only occur if they have been stabilised

to allow safe transfer, if not then the surgeon would come to West Cumberland Hospital.

Patients with significant trauma would be taken to the nearest Emergency Treatment Centre for stabilisation. A clinical decision would then need to be made on the best approach and a small number of patients around two to three a year would require immediate surgery. Most could be stabilised and transferred to the most appropriate place (Newcastle, South tees or Carlisle) for ongoing best clinical care.

It was not true that the reduction in beds at West Cumberland would leave that hospital with 42% of the acute work but only 28% of the acute beds. What was needed was a change in working practise that took patients out of acute beds.

No work had been done at this stage to assess whether there were some specialisms that could be safely and sustainably concentrated in West Cumbria. It could happen although Carlisle was closer to the tertiary centres.

The trim point in patient care is where the PCT starts to pay extra for the patient care as beyond this point is seen as excess bed days. The main reasons for excess bed days was the inability to discharge patients as there were no community facilities available and Doctors practise not to release patients.

The PCT was aiming for the top 25% in performance not the best practise figures for the discharging of patients from hospital. For hip replacements this meant being released within 7 days from the hospital. At the moment the PCT was not at the top 25% and it was seeking to reduce the number of excess bed days in Cumbria that was above the national average through better community facilities and being more efficient in discharging patients.

The primary care assessment centres would be put into 5 locality areas in Cumbria with one covering Allerdale and Copeland. Governance would be given to the locality boards so that financial responsibility could be given to local patients. The idea behind these centres was to provide a nurse led diagnostic based centre that would enable patients to be seen and dealt with quickly for minor accidents enabling the A & E Department to deal with the serious cases.

The CATS proposals had now being stopped however the benefits of the system were being looked at by the Acute Trust. There was some merit in the CATS model for the clinical pathways as it gave choice to patients.

The Committee expressed concern about the need for a micro biology and pathology unit at West Cumberland Hospital and there was currently an unacceptable delay for cancer results on follow-ups. The acute trust commented that whilst this wasn’t acceptable it was part of a national problem.

In terms of funding for additional ambulance services that would be required as a result of the Closer to Home proposals the PCT would be looking for improvements in efficiency from the Ambulance Trust.

The PCT considered that there was no need for a fall back position under the Closer to Home proposals. There would only be an increase in the number of acute beds at West Cumberland Hospital if the financial resources were available. If the proposals did not generate the estimated savings and the Trust ran up debt again it could have implications for a new build of West Cumberland Hospital.

The funding for the new hospital had still to be determined and a business case would need to be made which would include the right location for the hospital.

The Committee noted the concern of the staff at West Cumberland Hospital that they did not feel that they had been consulted sufficiently on their views on the Closer to Home proposals.

RECOMMENDED – that the PCT be thanked for agreeing to increase the proposed numbers of beds at West Cumberland Hospital to 220 with the possibility of increasing this to 250,

RECOMMENDED - this Council supports the retention of the young disabled unit, the consultant led maternity unit and paediatrics and asks the PCT to publicly announce as soon as possible the proposed number of beds per service for all the services that will be provided at West Cumberland Hospital,

RECOMMENDED - The PCT be requested to regularly review the number of beds and provide the Council with its analysis,

RECOMMENDED - The Council through its Overview and Scrutiny Committee would wish to continue to monitor the progress and may ask the PCT to come to its meetings at appropriate times to explain the current position.

RECOMMENDED - This council notes and strongly endorses the view of several Consultants at West Cumberland Hospital that the original wording of the consultation document as affecting major trauma - proposing that "major trauma services for the whole of North Cumbria to be located at the Cumberland Infimary in Carlisle" was unworkable and unacceptable.

This council welcomes the fact that the Trusts have moved forward from that position and now recognise that patients with significant trauma would be taken to the nearest Emergency Treatment Centre for stabilisation. A clinical decision would then need to be made on the best approach and that a number of patients would require and receive immediate surgery at West Cumberland Hospital.

This council would like to see a clear statement of policy about the treatment of patients with significant trauma agreed between the trusts and the consultants as a matter of urgency and published.

RECOMMENDED - This council remains concerned that the West Cumberland Hospital needs a base of support services such as pathology and microbiology if it is to provide the safe and sustainable care which patients need, and urges the trusts to continue to address this issue.

RECOMMENDED - The development of community facilities and the necessary support infrastructure should be put into place before the reduction in acute beds is started. The Council would not look favourably at any reduction in service at West Cumberland Hospital without a sufficient level of service and care being available for the people of West Cumbria.

RECOMMENDED - There is some concern over the funding of the community care proposals and what happens if the Community Venture Funding is not awarded.

RECOMMENDED - The lack of a fall back position if the necessary savings are not achieved is also of concern particularly any affect on the proposed new build for the West Cumberland Hospital.

RECOMMENDED - The PCT is urged to continue to listen to the concerns of the public as it develops its proposals and continues to be willing to change its proposals to reflect those concerns.

F. County Council Adult Social Care

The Committee was informed that a major redesign of service such as Closer to Home would have implications for Adult Social Care as well as Health services. Neither the County Council nor the Trusts could meet the targets alone and needed to work together.

The County Council had been engaged with the PCT on the proposals so that there was no surprise in the implications. In fact the direction of travel concurred with the priorities of the County Council. Whilst there was risk in change no change was not an option.

Any decrease in bed numbers would be felt by Adult Social Care and it was important that the right infrastructure and services to support early discharge from hospital was put in place.

The major implication was a greater focus and shift in resources from the NHS and the County Council on combined social/health care in people's homes.

A greater integration of Health and Social Care had already started at a strategic level on the Health and Well-Being Board with jointly commissioned services.

It was now intended that there would only need to be one visitor to someone's home. Rather than having a social worker and a community nurse visiting the home community nurses and social workers received common induction packs so that the community nurses could ask the relevant questions and request home care.

This greater integration had been tried for the last 10 years with mixed success and Closer to Home was a good opportunity to push forward and embed the integration so that it became more beneficial for the public.

There was funding being provided toward intermediate care that would allow a change of emphasis for the County Council to having people in step up/down beds rather than residential care homes.

Pooling of health care and social care resources had led to generic home care that covered a range of auxiliary care. This had run in Copeland over the last 5/6 years and had given considerable experience in how to manage this process successfully.

In respect of when the means tested element kicked in for social care services this was carefully explained to the member of the public before the care was started and social care unlike health care was not free.

The County Council considered that the future of community hospitals needed to be reshaped into community villages. This required a shared approach with potential sites for health and social care being provided at the same site in the form of a "one stop shop". The PCT was applying for funding for this through the Government's community ventures fund.

The residential care homes in the county were aging and the County Council did not have the funds to rebuild 33 care homes. Partners were being sought to remodel the community hospitals and the community villages would provide a win/win solution for the County Council, the NHS and the community.

Whilst this idea was a new one the approach in Cumbria was different to other parts of the country and it was hoped this would make it more attractive for Government funding.

The County Council would be supporting the Closer to Home proposals and its cabinet was to submit a formal response on the proposals.

There was to be no additional funding provided by the County Council as a result of the Closer to Home proposals as it did not anticipate additional costs.

In respect of the possible need for additional social workers there was no funding available in the immediate future and the County Council was running a scheme that would enable unqualified social workers to train to become qualified workers. However the recruitment and retention of social workers in some parts of the county had proved problematic.

There was a degree of nervousness for the County Council about the financial plans and the necessary investment in the community. Savings would need to be made to free up community investment. There would also be the geographical problems that currently exist across Cumbria that could not be solved overnight.

RECOMMENDED – that Cumbria County Council carefully reassess the financial implications from the Closer to Home proposals as the increases in the early discharging of patients from hospitals could have profound effects on the social care service it provides. It will be very difficult to provide an acceptable level of service without additional funding or greater integration between health and social care.

G. Other Comments

There is also link needed in the proposals to other organisations such as registered social landlords and the use of local authorities disability facility grants. To stop bed blocking it was sometimes necessary to provide adaptations to be made to houses. There are many examples where people are kept in hospital longer than they need to be simply because their home adaptation is not a priority for the Registered Social Landlord.

Consideration also needs to given within the proposals over the provision of public transport. Accessibility to services is one of the criteria in the proposals and for the community hospitals to flourish access to these hospitals through a better public transport service was needed.

3. CORPORATE PLAN

There are five applicable actions in the Council's Corporate Plan.

Action	Outcomes (measurable)	Target date
Lobby for accessible primary health care facilities for the people of the Borough	Every resident will have access to primary care services within 20 minutes drive time of their homes	Annually from 2007
Challenge any proposed reduction in the nature and quality of health care services in the borough through links with the West Cumbria Partnership and County Council Health Scrutiny	Health Services safeguarded or replaced by equivalent or better provision	2007 onwards
Encourage people to participate in active lifestyles	Number of Parks Friends groups Number of health related cultural activities	To 2012

	Increase in use of Council supported leisure facilities, especially by target groups (young, elderly, women and disadvantaged)	
Develop policies and actions to improve the health of Copeland Borough Council's employees	Absence and accident reduction. Opportunities to learn about healthy lifestyles. Improved occupational health. Reduced work related stress.	2007 2008 2008 2010
Support partnership working to reduce health inequalities	Achievement of Cumbria Agreement targets.	2010

4. CONCLUSION

It is recommended that the Council makes its response to the Closer to Home proposals by commenting on the sections titled Introduction, Change and Vision within the consultation document as follows:

In respect of **Introduction** - The Council would like to comment that it was generally disappointed in the consultation document itself, and were bemused how such a document could go out for consultation with the obvious lack of support from consultants, GP's and others. We welcomed the time extension for the response but still feel there is inadequate information and detail to allow a full response to be made. The Council would therefore reserve the right at a further date to make further comments if and when information becomes available.

There will have been a lot of people and organisations responding to this consultation that deserve a response to their comments.

In respect of **Change** – The Council recognises that a change is needed but that change has to be in the best interests of this local community and we have yet to be convinced that this is what Closer to Homes will deliver.

In respect of **Vision** – The vision in principle is fine, but to deliver it will need the time, finances and support from a lot of organisations, and the Council is not convinced that this support is there at this time. The theory to deliver services closer to home is good but in Copeland this is rather more difficult considering we only have two community hospitals compared to the 10 in the rest of North Cumbria. It is also worth noting that accessibility is judged as an essential criteria, therefore this emphasises the need to keep hospital services in Copeland.

It is then recommended that the Council respond to the consultation questions in the consultation document on the basis of the recommendations of the Children, Young People and Healthy Communities Overview and Scrutiny Committee at the head of this report. These recommendations highlight the detailed concerns on the proposals that were examined through the witness sessions undertaken by the Committee.

Council is invited to consider these recommendations and agree or amend them as appropriate.

It is also recommended that the Council sends its response to the Cumbria County Council Health and Wellbeing Scrutiny Committee as it has a formal role in the consultation process. The Primary Care Trust has to consider and respond to any recommendations made by this Scrutiny Committee and to try to reach agreement with them over the issues they raise. The Scrutiny Committee has powers to refer the consultation to the Secretary of State for Health if it remains dissatisfied with the proposals or with how it has been consulted.

List of Appendices:

None

List of Background Documents:

None