The Future of Healthcare
in West, North & East Cumbria

Public Consultation Document

Response from Copeland Borough Council

14 December 2016

PART ONE

The Borough of Copeland includes the following postcode areas:

CA12, CA13, CA14, CA18, CA19, CA20, CA21, CA22, CA23, CA24, CA25, CA26, CA27, CA28, LA16, LA17, LA18, LA19, LA20 and LA22.

CBC response to the Success Regime proposals

To prepare our response, we have undertaken a six week process of gathering evidence and talking to witnesses to understand the proposals and their implications for Copeland and its residents. We address each of the proposals in our comments and provide some overarching issues within this preamble to frame our comments and response. Our approach has been to consider what is needed from the Success Regime and not to just tick boxes in support of any of your proposed options.

- Firstly, we accept there has to be change to cope with advances in medicine. We expect best medical practise in services to our area alongside ensuring the best level of care for Copeland residents. However, please note that we have a lack of confidence in the document particularly due to the core assumptions used throughout including averaging data when we are clear that our residents are not average in distance, access and health inequality and that need data is based on past data sets and not on future and potential growth for Copeland specifically.

- Our investigations highlight that West Cumberland Hospital, Whitehaven (WCH) is as good if not better performing on some of the services being proposed to move to Cumberland Infirmary, Carlisle (CIC) than CIC current performance.

- Rurality and transport evidence highlight very clearly that Copeland will experience disadvantage and marginalisation from equal access to services in comparison to the rest of Cumbria and England. The mitigations summarised in the option will not address this disadvantage. (We are concerned that mitigation includes volunteer mountain rescue and air ambulance which from our evidence gathering we understand that no direct consultation or agreement was sought from these sources to be an official mitigation arrangement.) We strongly comment that this disadvantage to our residents is unacceptable and would be better addressed through a stronger rural proofing exercise.

- Deprivation statistics and issues in our (Copeland) area are well recognised by the evidence and medical people we spoke to in our investigations. This has not been adequately factored into the requirement for service options and is a strong case for maintaining maternity, children's and minor trauma and emergency operations at WCH.

- Growth plans for the Copeland area are unprecedented within the UK and have not been adequately factored in. The proposals are based on demand statistics from the past and without stronger data sets on future need projections potentially leave West Cumbria and Copeland losing current resources which when demand increases in relation to this growth, cannot and will not be provided leaving our residents marginalised from core health services within an acceptable distance expected by national residents.

- The road infrastructure and transport issues in Copeland have not been adequately assessed with average transfer times not offering a true reflection for Copeland residents accessing services through the Success Regime's proposals. The Acute Hospitals Travel Impact Analysis does not include the time taken for an ambulance to get to the patient only transfer times. We found it disappointing and surprising that there was no available data on deaths and births during ambulance transfer to help us understand risk and follow up on local concerns.

- As community leaders in Copeland we would argue that you have not sought to address the issues and feelings in the local area through your proposals. The evidence supports our resident's feelings of unfairness and being marginalised and disadvantaged against other resident and community areas in Cumbria.

- We recognise that the Success Regime is about financial resource management but would clearly state that West Cumbria, particularly Copeland, is unique. We have had a relationship with Government that has recognised the unique national role the area has. We require the Cumbria Clinical Commissioning Group and the Success Regime to work effectively in partnership with each other and with government to deliver against the existing and planned economic and rurality issues not experienced elsewhere, to ensure the Centre of Nuclear Excellence located in West Cumbria is matched by a strong and maintained good health provision with strong access for local residents to ensure they are not disadvantaged through hosting nuclear waste and sector growth which many other areas of Cumbria and the country will not support. We are looking to the Success Regime to work with us locally to ensure the national significance and special case for economic growth, nuclear and tourism in West Cumbria is used to ensure WCH continues to be able to deliver and develop its services effectively, without disadvantage and marginalisation of health care to a whole community of Copeland and South Allerdale.

Summary of our proposals

1 Maternity Services:

We note the Success Regime's Preferred Option is Option 2 but do not agree with this preference, or any of your options. We encourage you to consider an amended version of Option 1 as the proposed action. That is,

"The provision of a consultant led maternity unit at both Cumberland Infirmary Carlisle and at West Cumberland Hospital, an alongside midwife-led maternity unit at both sites and the continued option of giving birth at the Penrith Birthing Unit or at home. There would be a special care baby unit at both Cumberland Infirmary Carlisle and West Cumberland Hospital."

2 Children's Services:

We do not agree with any of the options set out in the Success Regime proposals. Our proposal would be in line with elements of the preferred Option 1 but would look to ensure 24 hour inpatient arrangements at a short stay paediatric unit at West Cumberland Hospital along with overnight beds for children with both less acute, low risk illnesses and more acute requirements recognising that transfers to Carlisle and specialist care at hospitals outside of Cumbria will be required.

3 Community Hospital Inpatient Beds

We do not favour any of the Success Regime Preferred Options. We would expect to see no reduction in beds as proposed recognising that if any of the other options continue we will require transition beds within our communities. Most importantly, we do not feel able to comment effectively as we have no experience of the proposed Integrated Care Communities (ICC) pilots in our area and recognise the importance of these ICCs to ensure any proposals in this area can be effective in offering effective support to our residents. We do note that WCH is effectively our community hospital as we have no other arrangement for our borough's area.

4 Emergency and Acute Care

We are in support of Option 1 and in particular the 24/7 Accident & Emergency (A&E) at West Cumberland Hospital along with acute medical inpatient services and rehabilitation. The proposal for an intensive care unit is essential in line with our resident needs and growth expectations.

OPTION 1:

Involves a 24/7 A&E at Cumberland Infirmary Carlisle along with acute medical inpatient services, including for the most complex cases. There would be assessment and inpatient beds for the frail elderly, as well as specialist rehabilitation. The number of intensive care beds currently on site would increase slightly, as would the number of emergency assessment unit beds.

There would also be a 24/7 A&E at West Cumberland Hospital along with acute medical inpatient services and rehabilitation. There would also be a small intensive

care unit but some of the most seriously ill patients would be transferred to Carlisle if it was felt they would benefit from the extra support available there.

5 Hyper-Acute Stroke Services

We have no formal view on the Success Regime Options proposed on the basis that our evidence gathering has led us to conclude that the decision has already been made to centralise on to one site as set out in option 2. On this area we consider consultation on this subject is meaningless.

6 Emergency Surgery, Trauma and Orthopaedic Services

We support the proposal for additional emergency surgery and trauma care to take place at West Cumberland Hospital and welcome the transfer and return of surgery to West Cumberland. We would encourage the Success Regime to maintain this direction of development to best use the resources available at the WCH. Our major request within the proposals is to ensure the WCH is used for more than minor surgery and care. Our key message is to ensure an effective emergency surgery and trauma facility within Copeland, able to service the local residents and growth plans into the future.

7 Strategy and Vision

Copeland Council support the need for change in principle but have major concerns regarding elements of the strategy and vision.

Question 1 - Maternity Services

We note the Success Regime's Preferred Option is Option 2 but do not agree with this preference or any of your options. We encourage you to consider an amended version of Option 1 as the proposed action.

"The provision of a consultant led maternity unit at both Cumberland Infirmary Carlisle and at West Cumberland Hospital, an alongside midwife-led maternity unit at both sites and the continued option of giving birth at the Penrith Birthing Unit or at home. There would be a special care baby unit at both Cumberland Infirmary Carlisle and West Cumberland Hospital."

Our Reason and Evidence is set out below:

a) Our evidence is that option 1 is the preferred option of local midwives and obstetricians. The report from November 2014 of the Options Appraisal for the reconfiguration of Obstetric and Maternity Services in Cumbria by the Royal College of Obstetricians and Gynaecologists highlighted published information that amongst a remote and rural population women preferred consultant led care and was associated with their risk status during pregnancy and labour. This report also set out in the options that a Midwife Led Unit (MLU) could be considered at WCH if appropriate and with time. They highlight the importance of working with local women to ensure that the local community would support a MLU. As community leaders we have clear messages from our community that there is not collective support for a stand-alone MLU.

b) Our evidence found that the existing medical providers and the Success Regime were clear of the multiple disadvantage and health issues experienced in the Copeland area which underpins our concern that pregnant women and new babies from our area are more likely to be higher risk care needs. We have concluded that our existing provision of a consultant led unit offers the best service to local residents of Copeland particularly in the knowledge that WCH currently has all the relevant resources and expertise with the exception of neo natal paediatrics. In our investigations we found that GPs would like a consultant led maternity service at WCH and CIC but it must have a neo natal paediatrician.

c) Our conclusion is that the maternity proposal is more for financial reasons than to provide a safe service where evidence would highlight that the current service which is more akin to option 1 is seen as safe at WCH as at CIC. The proposals do not demonstrate that option 1 is more unsafe than option 2. We would urge the Success Regime to re-consider their position in line with the proposals for the children's service which will ensure paediatric provision and overnight stays where the opportunity to enable neo natal paediatric care within this option to integrate with the maternity services requirements and offer a fuller opportunity for paediatric staff to experience and train.

d) One major concern underpinning our request for not implementing option 2 is the transfer times for patients both between the two hospitals and in the journey times from our deep rural neighbourhoods to WCH and CIC. Our gathered evidence shows that the risk to mothers and babies from travelling, that would not happen currently, is unacceptable for our residents and community. The consultation document sets out average travel times, incorporating closer neighbourhoods than Copeland neighbourhoods within the data mix, as minutes. In our evidence gathering we have received information from the North West Ambulance Service that the average emergency transfer time from WCH to CIC is 57 minutes and for bed to bed transfer of 1 hour and 40 minutes. No ambulance would have an incubator on board, this would need to have been assessed at start of transfer and put on the ambulance at this time. We assert that the option proposed on maternity by the Success Regime has not taken into account adequately enough the geography and existing and anticipated transport concerns. Our strong view is that these times are, and will increasingly be negatively impacted by the growth plans for the borough of Copeland and by the poor transport and road infrastructure. Construction traffic on the already inadequate roads during the building period will increase ambulance times. This leaves us to conclude that there is an evidenced potential for regular risks and unsafe transfer times to mother and babies with option 2.

e) As laypeople we have looked at understanding the definitions of risk with maternity and have received mixed information on all first births risk categorisation. We also understand from our evidence gathering that all caesarean sections are major operations and thereby we expect caesarean do not fit with the model of low risk to remain at WCH and therefore under option 2 are most likely to move to CIC even for planned. We have received verbal responses that this would not necessarily be the case but to ensure our Copeland residents are not disadvantaged compared to any other area of Cumbria affected by these proposals option 2 does from the evidence we have on the patient issues and levels of disadvantage and general health mean that considerably less women will be considered low risk on caesarians and first births than would be the average for the north, west and east Cumbria area.

f) Our evidence highlights a bed to bed transfer between WCH and CIC takes 1 hour and 40 minutes whereas unplanned and emergency caesarean section, which is potentially life threatening, needs to be performed within 30 minutes of being agreed. A transfer at this point from WCH to CIC would not meet the stated intent of the Success Regime to use these proposals to increase safety of patients. We would support the opinion from our midwives input that the last person to be moved should be the mother, with rotation of consultants and anaesthetists being more preferable. We do understand from the information we have received that no births have been made in an ambulance in the past year and would question that the stats and evidence lead us to conclude that moving all non-low risk births to CIC would change that statistic. The availability under option 2 of any specialist staff to accompany a maternity transfer would need to be supplied by WCH and this would

not be specialist consultants as they will not be located there. If two transfers are needed within the same time frame you would use 999 with potentially no specialist staff available. This leaves our residents at more risk than those women closer to CIC from other boroughs and we believe this is unfair and not acceptable.

g) The report suggests that premature babies will be taken to CIC, however we would question the Success Regime on the emergency and speed of some deliveries which would impact on this. Taking the evidence of anticipated transfer times we state our concern and position that maintaining a consultant led maternity service at WCH would reduce risks to such new born babies whilst still maintaining the ability to travel to specialist facilities outside of the county for appropriate care or for specialist care to be transferred in.

h) The proposals for option 2 from the investigations we have made put much, we would propose too much, responsibility on midwives to make decisions. This leads us to conclude that this will result in decisions to ensure 'safety' for the midwife led unit and the patient for transfer to Carlisle in significantly more cases where a consultant led unit will be able to take other decisions on risk and transfer. The proposals highlight the difficulties with recruiting qualified staff and have received verbal evidence that option 2 and the shadow over the future of maternity services at the hospital are impacting morale and the ability to retain and recruit midwives. Our investigations highlight a real concern on viability of staffing option 2 as this approach could result in losing qualified midwives and associated staff contributing further to the issues the proposals are aiming to address and reducing the service and safeness of a maternity service at WCH.

i) Access for mothers with disabilities is best at WCH and poor at CIC. How will option 2 enable required and expected access. A further concern from the evidence that the existing good service provision at WCH is being taken from our local residents for a poorer service at CIC.

j) Evidence gathered has shown that capacity at CIC is a major issue with bed occupancy being consistently over the 85% safe guidelines.

k) We note that no consultation has been undertaken with women in Copeland who are most impacted by these proposals to help inform the proposals, particularly in understanding the additional medical and social impact of option 2 which will affect the health and wellbeing of many mothers.

In summary the key issues our response highlights above will only be addressed effectively by a variation of the option 1 you set out. That is

"The provision of a consultant led maternity unit at both Cumberland Infirmary, Carlisle and at West Cumberland Hospital, an alongside midwife-led maternity unit at both sites and the continued option of giving birth at the Penrith Birthing Unit or at home. There would be a special care baby unit at both Cumberland Infirmary Carlisle and West Cumberland Hospital."

Question 2 - Children's Services

Similar to Maternity Services we do not agree with any of the options set out in the Success Regime proposals. Our proposal would be in line with elements of the preferred Option 1 but would look to ensure 24 hour inpatient arrangements at a paediatric unit at West Cumberland Hospital along with overnight beds for children with both less acute, low risk illnesses and more acute requirements recognising that transfers to Carlisle and specialist care at hospitals outside of Cumbria will be required.

Our Reason and Evidence is set out below:

We do not feel the options adequately ensure families and children from Copeland have been given the same access to higher risk care and support than other parts of Cumbria. We are in support of the option to maintain a paediatric assessment unit and overnight beds at WCH we would urge the success regime to consider the following issues:

a) including an integrated approach with the neo natal paediatric requirement needed to maintain and build a safe and fair maternity service to assist the range of opportunities for any paediatrics within the unit and ensure fair access to care for our residents.

b) In line with the transfer times concerns already set out in the maternity comments we believe there is a case for providing in-patient admissions and emergency admissions and assessments between 8pm and 8am. We have not received enough evidence and clarity on existing transfers of children and risk categorisation to fully understand the implications of transferring all non low risk children. We would request that the Success Regime be clear, that residents being served by WCH will not be getting the same service without additional stress and travel, which makes our children at higher risk and stress from transfer and access to the needed higher risk care than other Cumbrian residents located closer to CIC.

c) Has the option been considered to move the paediatric staff as required to WCH for clinics rather than move the children and families, patient first approach, which would still work to "reduce the risk of temporary closure or reduction in service due to the lack of staff". The current inpatient balance of 58% at CIC to 42% at WCH will be due to a range of factors and to us illustrates that the case for change is primarily motivated by financial savings. On existing stats and in line with the very rural nature of Cumbria, children surely would be safest with the two facilities continuing with specialists moving between sites rather than the 42% patients moving to a riskier and potentially unsafe access in line with the other points we raise here. All the options you set out here offer no choice and will disproportionately impact on our rural Copeland resident causing ongoing stress and travel risk to our families and children requiring medical care.

d) Needing to resolve transport issues and additional ambulance capacity to ensure our Copeland residents can get fair and equal access to children's services at Carlisle for your preferred option, does not offer confidence to potential patients and families in Copeland. Our evidence to date has been on the maternity dedicated ambulance which requires 11 staff for a 24/7 resource. It would appear this may be the same requirement here and we would restate the maternity arguments and concerns re bed to bed transfer times, availability, how would the skilled and specialist be provided if the high risk experience has been moved to CIC and what happens when there is an emergency that cannot medically manage the transfer. We are concerned that these proposals will disadvantage disproportionately Copeland residents over other Cumbrian residents and this is not acceptable.

e) The option of keeping even a low risk day unit and some overnight beds is stated as "dependent on the successful recruitment of doctors and the training and development of advanced paediatric nurse practitioners" and our evidence gathering with medical professionals highlights the importance of ensuring that WCH is not downgraded or requiring less medical opportunities which in turn would be less attractive to new recruits. Ensuring a neo natal opportunity and the ability for more in patients and assessments and care at WCH appears to us to be a better option to meet our residents fair access and confidence needs and ensure best recruitment and less reliance on expensive locums.

f) Finally, we have used the standards review by the Royal College of Paediatrics and Child Health document from 2015 to assist us. Recognising that the UK performs poorly on child mortality it highlights a range of issues which we see as relevant to Copeland resident's situation in quality and safety standards for small and remote paediatric units. It raises the issue of mitigating risks associated with distance from specialist services and we believe your options do not mitigate but increase the potential and existing risks. The report mentions the opportunity of remote units using effective IT and electronic means for ***minimising the need for patients (in this instance children and their families) to travel*** to central units. It also sets out the opportunities for units with low admission numbers and relative infrequency of children being admitted out of hours and not necessarily necessitate a resident senior paediatrician, but rather be managed via range trained personnel including registered children's nurse and expanding GPs trained in this area. The proposals do not highlight how this might work, linking to the UCLAN medical centre and ensuring sufficient staff across all rotas to deliver and keep a 24 hour paediatric unit at WCH. We would urge this be provided to ensure our residents are not disadvantaged by the proposals and are fairly treated as other Cumbrian residents and national residents.

Question 3 - Community Hospital Inpatient Beds

We do not favour any of the Success Regime Preferred Options. We would expect to see no reduction in beds and hence do not agree with this core principle of the proposal recognising that if any of the other options continue we will require transition beds within our communities. Most importantly we do not feel able to comment effectively as we have no experience of the proposed Integrated Care Communities pilots in our area and recognise the importance of these ICCs to ensure any proposals in this area can be effective in offering effective support to our residents. We do note that WCH is effectively our community hospital as we have no other arrangement for our borough area.

Our Reason and Evidence is set out below:

a) From the evidence obtained, the reasoning behind the Success Regime's preferred option can be understood, however, at the present time No option can be supported until the Integrated Care Communities scheme is in place and has been operating successfully in the Copeland area.

b) We are supportive of the Integrated Care Communities concept, but due to Copeland's unique geography, ageing population, above average levels of obesity and areas of deprivation feel that 'One size does not fit all'. The balance of Community Hospital Inpatient Beds and the number of Home Visitors (District Nurses) needs to be right. It is important that we recognise the transition and 'step down' role of the community hospital beds and do not reduce these as proposed until the ICC for Copeland is working effectively.

c) We are concerned that at the same time that the Success Regime proposals are being considered, a consultation is also underway looking at the potential loss of Residential Care Beds in the Copeland area. We would urge your proposals to take account of the impact and issues from this.

Question 4 - Emergency and Acute Care

We are in support of Option 1 and in particular the 24/7 A&E at West Cumberland Hospital along with acute medical inpatient services and rehabilitation. The proposal for an intensive care unit is essential in line with our resident needs and growth expectations.

OPTION 1:

Involves a 24/7 A&E at Cumberland Infirmary Carlisle along with acute medical inpatient services, including for the most complex cases. There would be assessment and inpatient beds for the frail elderly, as well as specialist rehabilitation. The number of intensive care beds currently on site would increase slightly, as would the number of emergency assessment unit beds.

There would also be a 24/7 A&E at West Cumberland Hospital along with acute medical inpatient services and rehabilitation. There would also be a small intensive care unit but some of the most seriously ill patients would be transferred to Carlisle if it was felt they would benefit from the extra support available there.

Our Reason and Evidence is set out below:

a) With the proposed major developments in West Cumbria due to take place in the next few years (NuGen, National Grid Coast Connection, West Cumbria mining), it is essential that the West Cumberland Hospital, Whitehaven retains a 24/7 Accident & Emergency department. We feel not enough emphasis has been given to the expected growth in population numbers in West Cumbria.

b) We believe that whichever option is decided upon, it is essential that the Integrated Care Communities system is fully supported and implemented. There is no evidence to suggest that Integrated Care Communities will reduce the number of patient visits to the Accident and Emergency department

c) During a recent visit to the A&E department at the West Cumberland Hospital, we were very impressed with the state of the art facilities and would like to see them utilised to their full potential. We were also impressed with the professionalism and dedication of the staff we met who obviously cared passionately about the hospital.

d) Finally, we are greatly encouraged by the creation of a new workforce model for the WCH and how this will work with UCLAN and the Medical Centre development.

Question 5 - Hyper-Acute Stroke Services

We have no formal view on the Success Regime Options proposed on the basis that our evidence gathering has led us to conclude that the decision has already been made to centralise on to one site as set out in option 2. On this area we consider consultation on this subject is meaningless.

Our Reason and Evidence is set out below:

a) Following a visit by the Northern England Strategic Clinical Network to North Cumbria University hospitals NHS Trust in November 2014, their report states:

*"The Trust reported that **the decision had already been made** to centralise the hyper-acute stroke services on to one site and agreed that the site choice will be the CIC due to its proximity to Neurosciences Services at Newcastle".*

b) We identified a major concern in the delay in diagnosing a stroke, initial CT scan and appropriate treatment if a patient is transferred to Carlisle.

Figures provided by the North West Ambulance Service show the average transfer time by ambulance on a blue light from Whitehaven (WCH) to Carlisle (CIC) to be 57 minutes.

c) Figures obtained from the Royal College of Physicians, Sentinal Stroke National Audit Programme (SSNAP) show that the West Cumberland Hospital is consistently achieving better results (Level C) than Cumberland Infirmary Carlisle (Level D) and Royal Lancaster Infirmary (Level D). (We do recognise Level D is the poorest level of service).

If stroke services are to be centralised it is recommended that this be at the West Cumberland Hospital in Whitehaven and the good practice be built on.

d) Concern remains that the Cumberland Infirmary Carlisle has the capacity to deal with increased numbers of patients from West Cumbria. We repeat the recent national statistics which highlight that all hospitals in England are outside the 85% beds occupation in wards open overnight. There appears to have been a significant increase in the last year with Quarter 2 2015/16 occupation at 87% to 89% occupation in Quarter 2 2016/17. This evidence causes concern on capacity.

e) It was noted that an 'Early Supported Stroke Discharge Scheme' was currently not operating at West Cumberland Hospital, Whitehaven or Cumberland Infirmary, Carlisle and it is strongly recommended that this scheme be extended to West Cumbria.

Question 6 - Emergency Surgery, Trauma and Orthopaedic Services

We support the proposal for additional emergency surgery and trauma care to take place at West Cumberland Hospital and welcome the transfer and return of surgery to West Cumberland and would encourage the success regime to maintain this direction of development to best use the resources available at the WCH. Our major request within the proposals is to ensure the WCH is used for more than minor surgery and care. Our key message is to ensure an effective emergency surgery and trauma facility at Copeland able to service the local residents and growth plans into the future.

Our Reason and Evidence is set out below:

a) We concur with the evidence we gathered through our preparations for this response that whilst we welcome the new facilities at the WCH and an increase in operations at the hospital the proposed reduction to minor trauma and transfer to CIC does not seem to fit with the local context and requirements.

b) Copeland is recognised through our evidence gathering as a challenging area. We are host to the largest industrial site in Europe and on the edge of the largest visitor economy in the UK. When discussed with key representatives their response highlighted the ability of the trust to meet the additional demand provided by tourists into Cumbria and the Lake District. We argue that the evidence of the type of activities undertaken by the tourism visitors to that of nuclear sector contractors, particularly construction related, is very different and would potentially demand a different response in service and capacity. We know that conversations are taking place between the Success Regime and nuclear partners but strongly feedback in this consultation that the impact of Copeland Economic Growth and plans have not been accounted for adequately. The opportunity of the new medical centre collaboration with UCLAN is greatly welcomed but we would expect minor trauma and emergency surgery to be provided at WCH close to Copeland industrial and construction sites and in support of the ability to recruit surgeons.

c) We would also make links back to the need for emergency capacity and capability to be strong in support of the proposals you make including specifically maternity, where emergency surgery at WCH is an important mitigation when faced with long transfer times and uncertainty of road traffic conditions during construction and growth. Our evidence highlights that WCH staff believe in WCH and that CIC has moved status on trauma to 'below average' where WCH is average. The case for only one facility for trauma and emergency would by context and existing performance lead to a conclusion that maybe WCH should be the primary site. We do understand that capacity, particularly bed numbers, is challenged for this area at CIC and the underpinning proposal to reduce numbers of bed by the success proposals does not provide local confidence in Copeland that capacity will be available for future potential demand for trauma and emergencies arising from growth and the impact of these proposals.

d) Our gathered evidence highlights that moving to minor injuries only greatly reduces capacity to deal with emergencies, further compounds recruitment difficulties and will not strengthen the potential of the new medical centre. It has been suggested to us by some medical witnesses that our residents are marginalised by these proposals and will, if implemented, be getting an unequal service compared to any other part of Cumbria and we recognise and agree with this analysis.

e) We welcome the approach of transferring some surgery from CIC to WCH particularly for patients requiring high technology diagnostics and neurology related care in line with the good provision of equipment now at the WCH.

f) In line with some of the other sections we are concerned from the evidence that CIC will not be able to cope with the additional demand on beds and resources.

g) We have set out elsewhere in our response the deep rural nature of Copeland and for emergency and trauma the impact of our poor road infrastructure is important to restate. We do recognise and support our residents getting the best treatment from specialist units but do require a confidence that our local hospital is not able to deliver minor trauma and emergency surgery adequately to mitigate against the unsafe travel times.

h) We are concerned that the target time to put in an airway is 45 minutes from point of injury which cannot be achieved even if the expected, no traffic problems, transfer from Whitehaven to CIC of 57 minutes, more for all other parts of Copeland. We do recognise where a paramedic or doctor is in attendance this will be done at the site of the injury but expect this to be for major incidents only. We are re-assured that the WCH has an important role in preparing patients for travel and transfer using the good facilities now on offer.

Question 7 - Strategy and Vision

Our Views, Reason and Evidence findings are set out below:

Copeland Council support the need for change in principle but have major concerns regarding the following elements of the strategy and vision.

1 You set out on page 15 that the overall strategy is designed to "bring more care closer to home". Our experience and the evidence gathered lead us to be very concerned about the Integrated Care Communities ability to effectively deliver to ensure the success proposals can work for our residents. Whilst we all support the intention, the move to implement any changes in advance of the ICC being set up and embedded first, runs a genuine and real risk to Copeland residents. We are most disadvantaged by the proposals in terms of travel and transfer risk, loss of existing services in maternity, stroke, minor trauma and children's services which once lost will not be re provided locally. This will have very serious impacts on our communities.

2 We do not support reducing beds until the ICC is fully embedded in line with the concerns we picked up across our evidence gathering on the ability of the ICC to deliver what is needed for the Success Regime proposals to work. We have local knowledge that a reduction in beds is likely to impact our residents by exposing some recovering patients in poor condition homes to hazards that are detrimental to their recovery, which may result in them needing to go back into a hospital bed. We work in partnership with the better care fund and would expect the Success Regime to look at this issue carefully in line with our statutory stock condition survey outcomes.

3 We note the proposal to develop WCH as a centre of excellence and welcome this approach but would argue that the shift of services such as maternity, children's, stroke, minor trauma to CIC whose performance from the stats we have seen appears to be less than WCH and with existing capacity and bed use at greater than 85%, does not seem logical.

4 The deep rural nature of the Copeland area and that not enough attention has been paid to this in the proposals. Serious danger of negative rural impact and disadvantaging Copeland residents against other Cumbrian residents.

5 Experience has been highlighted that previous attempts to work on a more integrated basis to deliver in the community have not been as successful as planned or expected. The assumption regarding ICC being able to deliver effectively and in an integrative manner is throughout the document and in evidence when questioning representatives. Our concerns are not enough resources for the public and community based elements of an ICC, difficulties in the practicalities of making this work, time it takes to bed in such arrangements

6 Will quality be maintained?

7 No guarantees that the success regime proposals will get people safely to the right place for treatment

8 Beds availability in Carlisle – currently over 85% recommended level. How will the success regime be assured and ensure our residents can be confident that this strategy of using CIC more will be met when capacity is already above recommended levels.

9 Recruitment issues are clearly a key driver and our observation from the scrutiny evidence gathered is that the preferred options will not assist in supporting the necessary recruitment. Specifically there are opportunities for more medical delivery at WCH and as with Maternity and emergency surgery, options can be chosen which maintain and expand the skills and experience needed rather than reduce the opportunity for individual development which in turn will make the WCH even less attractive. The emerging medical school does appear to be a major opportunity to assist the attractiveness of WCH to new recruits.

10 Mental health strategy – recognise importance of interaction of success regime proposals with this planned strategy – not seen detail as yet but want to understand how ICC will engage and integrate mental health within the success proposals.

11 All partners with focus.

Question 8

We provide the following additional comment on the ideas described in the consultation document.

Responses prepared by the Council indicate a widespread dissatisfaction, both with the process and the proposed outcomes. Significant concern is noted regarding key safety aspects within the proposals which may lead to serious or even fatal consequences. The downgrading of services within WCH has been a cause for local concern over many years with the continued transfer of switching key treatment areas to CIC.

This consultation document appears to be drawing together a range of options which at the present time will downgrade the hospital, thus exacerbating the worry and the distrust that exists within the West of the County. The proposals appear to ignore the unique nature of the geography of the area, as noted earlier. However, this uniqueness is important and known by central government for local support of the planned expansion of crucial national Nuclear facilities directly within the area and the subsequent population expansion that we as a Council are being asked to plan for. Indications given by key health personnel appear to be severely underestimating these changes. We are presented with a model based upon past data with a declining working age population which is then reflected in a downgrading of proposals, rather than a model preparing for significant local expansion.

The consultation document presents proposals clearly at odds with national and other key government plans thus failing badly to underpin the future of West Cumbria.

If the success regime preferred options come to fruition, acknowledgement exists that they will only meet the needs of the area with significant support from CIC, which is already under severe pressure. Nowhere does the Success Regime look to the **unique** future circumstances that this area will experience whilst servicing future national needs. We question to what extent these proposals represent clear joined up government planning regarding West Cumbria or indeed the whole of the Counties health integration.

These proposals if implemented may be viewed by future generations as significantly negligent.

The Future of Healthcare

in West, North & East Cumbria

Public Consultation Document

Response from Copeland Borough Council

14 December 2016

PART TWO

Copeland Borough Council has 52 Elected Members and an Elected Mayor, all of whom have been duly elected to represent the views and promote the best interests of the residents in each individual ward in Copeland and the borough.

Copeland Borough Council OSC Committee have gathered qualitative and quantitative data to formulate and present a formal response to the success regime public consultation document.

The response to part one of this consultation document and the preferred options for service changes are presented by Copeland Borough Council, as the Council in its capacity as elected representative of the residents of Copeland Borough. It is therefore fitting to complete part two of the consultation document about personal circumstances in a way that includes/counts all residents in the borough which our 52 Councillors and Elected Mayor represent.

What is your age?

Copeland total population is 69,600, those aged 15+ years amounts to 58,700.

(Office of National Statistics ONS 2015 population estimates - [from Nomis on 23 November 2016])

Copeland 2015	
Age	**Total**
Aged 15 - 19 years	3,700
Aged 20 - 24 years	3,700
Aged 25 - 29 years	4,000
Aged 30 - 34 years	3,800
Aged 35 - 39 years	3,600
Aged 40 - 44 years	4,300
Aged 45 - 49 years	5,200
Aged 50 - 54 years	5,600
Aged 55 - 59 years	5,200
Aged 60 - 64 years	4,600
Aged 65 - 69 years	4,800
Aged 70 - 74 years	3,600
Aged 75 - 79 years	2,900
Aged 80 - 84 years	2,000
Aged 85 and over	1,700
Total	**58,700**

What is your gender?

Male35,000 Female34,600 Total 69,600

(ONS 2015 population estimates - [from Nomis on 23 November 2016])

Is your gender different to that assigned to you at birth?

We do not have this data across our borough

Are you married or in a civil partnership?

Married 31,153 Not married 27,460

(ONS – 2011 census data updated 2013)

What is your sexual orientation?

We do not have this information across our borough

What is your religion or belief?

Census data from 2011 sets out most recent borough statistics.

What is your ethnicity?

Ethnic origin is not about nationality, place of birth or citizenship. It is about the group to which you perceive you belong.

Ethnic Groups Copeland	
All Usual Residents	70603
White; English/Welsh/Scottish/Northern Irish/British	68679
White; Irish	190
White; Gypsy or Irish Traveller	15
White; Other White	607
Mixed/Multiple Ethnic Groups; White and Black Caribbean	117
Mixed/Multiple Ethnic Groups; White and Black African	37
Mixed/Multiple Ethnic Groups; White and Asian	109
Mixed/Multiple Ethnic Groups; Other Mixed	76
Asian/Asian British; Indian	137
Asian/Asian British; Pakistani	79
Asian/Asian British; Bangladeshi	70
Asian/Asian British; Chinese	164
Asian/Asian British; Other Asian	179
Black/African/Caribbean/Black British; African	52
Black/African/Caribbean/Black British; Caribbean	21
Black/African/Caribbean/Black British; Other Black	11
Other Ethnic Group; Arab	12
Other Ethnic Group; Any Other Ethnic Group	48

(ONS – 2011 census data updated 2013)

Do you consider yourself to have a disability or health condition?

21.3% of Copeland population are living with a limiting long term illness or disability.

(Local Health.org Public Health England metadata July 2014 – compiled by Cumbria Intelligence Observatory)

Current population estimate is 69,600, 21.3% equates to 14,825 residents

If you wish to give further information, please do so here:

Please see our comments in Part One.

Do you have caring responsibilities?

Data unavailable

Are you currently pregnant?

Data unavailable

Do you have a child under 24 months?

Data unavailable

How do you think the options contained in this consultation document will particularly affect you?

The OSC Task and Finish group would prioritise four key areas of how the options will affect residents in Copeland:

1. The proposed loss of existing good enough service delivery which is locally more accessible than travelling a minimum of 30+ miles to the next hospital. This lack of local services which other people in England expect and take for granted within a certain travelling distance causes individual and family stress and is compounded by the poor transport and road infrastructure.
2. The proposed loss of 17% bed capacity when it appears that there is not enough beds now leaving residents worried that they will not be able to be looked after properly and once beds and services from these beds are gone they will not be put back – particularly concerning in the light of the nuclear growth plans for the area.
3. Cannot get to see doctor easily now so do not view the proposals on the integrated care communities as being able to work unless more resources are put in to help make it work.
4. Feel that Copeland is being treated unfairly and will not receive best level of care without travelling long distances in comparison to other Cumbrians nearer to the CIC.

How would you normally travel to your local NHS hospital?

Data unavailable