Greater Manchester, Lancashire and South Cumbria Clinical Senate

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Follow-up to the Independent Review of Proposed Clinical Models for the North, West & East Cumbria Success Regime: Maternity and Paediatrics

RESPONSE PAPER

27th February 2017

Contents

Chair's Foreword

In March 2016, the Greater Manchester, Lancashire & South Cumbria (GMLSC) Clinical Senate received a commission from Cumbria Clinical Commissioning Group (CCG) on behalf of the West, North and East (WNE) Cumbria Success Regime to review the proposed models of care for Integrated Care (including Community services), Mental Health, Elective Care, Proactive and Emergency Care, Children and Maternity.

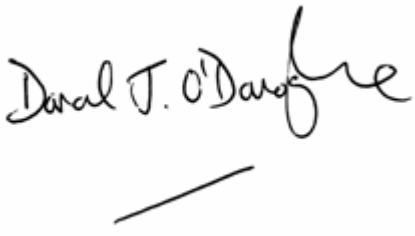
The Senate produced its report in May 2016, which contained a number of recommendations. Since the publication of the Senate report in May 2016, the WNE Cumbria Success Regime have undertaken a public consultation and approached GMLSC Clinical Senate to undertake the additional work described in this paper.

The Senate would like to acknowledge the considerable amount of work undertaken by the Cumbria Success Regime towards progressing transformational service change in WNE Cumbria, particularly towards meeting many of the Senate's original recommendations.

This paper is solely based on the work, supplementary reports and data submitted by the Success Regime at the time of the review, and the clinical workshops held on 7th and 14th February 2017. The Senate would like to stress that the process that has been undertaken does not amount to a full clinical review for the purposes of assurance.

I would like to thank the clinicians and managers who have contributed to this review. The contributors to this process provide their commitment, time and advice freely. I am grateful to the review team and members of the Clinical Senate for their ongoing support and commitment to the provision of robust clinical advice. I would like to thank Stephen Singleton and the Success Regime Team for providing the additional information requested in a timely fashion.

The clinical advice within this report is given in good faith and with the intention of supporting commissioners in further development of the models for maternity and paediatrics services in WNE Cumbria. This report sets out the methodology and findings of the review, and is presented with the offer of continued assistance should it be needed.



Professor Donal O'Donoghue
Senate Chair
Greater Manchester, Lancashire & South Cumbria Senate

1.0 Introduction

1.1 This response paper is written in response to the WNE Cumbria Success Regime's approach to the GMLSC Clinical Senate to undertake the work described in this response paper, regarding maternity and paediatrics services.

1.2 This follows the Senate's original report in May 2016 regarding the proposed models of care for Integrated Care (including Community services), Mental Health, Elective Care, Proactive and Emergency Care, Children and Maternity. This report contained a number of recommendations (the recommendations for maternity and paediatrics can be seen in Appendices 1 and 2 respectively).

1.3 The Senate have been made aware that mental health service transformation is taking place in a separate programme to this piece of work. From the evidence seen so far, the Senate recommends that the CCG should not underestimate the work required to meet these needs, particularly with regards to severe and enduring mental health.

1.4 Similarly the challenges facing the population of WNE Cumbria, as with many other areas, of a super-ageing population and rising dementia prevalence, cannot be under-estimated.

1.5 This response paper is solely based on the work, supplementary reports and data submitted by the Success Regime at the time of the review, and the clinical workshops held on 7th and 14th February 2017.

1.6 The Senate would like to acknowledge the considerable amount of work undertaken by the Cumbria Success Regime towards progressing transformational service change in WNE Cumbria, and particularly towards meeting many of the Senate's recommendations. This includes an audit of expected patient transfers under each of the options as well as consideration of the interdependencies between each of the models for maternity and paediatrics, and the wider system, including emergency departments, anaesthetics and surgery. Indeed, aspects of this additional work have been valuable in allowing the Senate's panels to produce this response paper.

1.7 For this response, the Senate has focussed on the identification of the most clinically robust and sustainable solutions, as well as highlighting any clinical concerns or issues that need further examination or that should be considered by the CCG in making their decision regarding the future service delivery models for maternity and paediatrics in WNE Cumbria.

1.8 For further information please contact Caroline Baines, Clinical Senate Manager (NW) on carolinebaines@nhs.net

2.0 Background

2.1 Following the GMLSC Clinical Senate's commission in March 2016 from Cumbria CCG (on behalf of the Cumbria Success Regime) to review the proposed models of care for Integrated Care (including Community services), Mental Health, Elective Care, Proactive and Emergency Care, Children and Maternity, the Clinical Senate:

- Agreed the Terms of Reference,
- Convened two independent review panels made up of clinical experts and citizen representatives (membership of which can be seen in Appendix 3),
- Reviewed the information provided,
- Provided a report in May 2016[1].

2.2 Due to the stage of development of the proposed clinical models at the time of the review, the process undertaken did not amount to a full clinical review for the purposes of assurance. Based on the work submitted by the Success Regime at the start of the review, the Senate focussed on the identification of the most clinically robust and sustainable solutions, as well as highlighting any clinical concerns or issues that need further examination or that should be considered by the CCG and other partners to inform the next steps in the development of the Success Regime programme.

2.3 Since the publication of this report, the WNE Cumbria Success Regime has undertaken a public consultation which, at the time of writing has drawn to a close and moved into a period of reflection and analysis. The Success Regime will report to the CCG Governing Body on 8th March 2017 regarding the consultation exercise, subsequent workshops and their recommendations.

2.4 It is clear from the consultation process that neither the public nor some clinicians supported any of the presented options for paediatrics and maternity. Therefore the WNE Cumbria Success Regime approached GMLSC Clinical Senate to undertake some additional work. The commission was that for both maternity and paediatrics, the senate:

1) Revisits the options and advises what they believe to be the best options and identifies any additional issues for consideration in the light of the consultation.
2) Revisit the preparatory work, including risk assessments, and provides a view regarding the quality of that work (i.e. a judgment about the relative safety and appropriateness of any of the options compared to doing nothing).

2.5 Supplementary information was provided to the original review teams to support part 1 of the commission:

[1] GMLSC. (9th May 2016). *Independent Review of the Proposed Clinical Models for the North, West & East Cumbria Success Regime.*

"Revisits the options and advises what they believe to be the best options and identifies any additional issues for consideration in the light of the consultation."

2.6 Panel responses to this supplementary information were fed into two clinically-led workshops on Tuesday 7th February and Tuesday 14th February 2017, which were attended by Clinical Leads nominated by Chief Executives, together with Strategic/Director Leads from each provider organisation. The workshops were also supported by Independent Clinical Experts from the North of England Clinical Senate and the Greater Manchester, South Cumbria and Lancashire Clinical Senate. Other attendees included NHS Cumbria CCG Governing Body Lay Members and GP Locality Leads. There was no patient representation at the workshops.

2.7 At the latter workshop, the outcome was to recommend that Cumbria CCG chooses between the following:

2.7.1 *Option 1 Paediatrics and Option 1 Maternity*

This was with a caveat that an agreed review period is put in place (between 1-2 years) and if this option is deemed unachievable and/or unsustainable then the system moves to Option 2 paediatrics and Option 3 maternity.

This approach was deemed preferable because it demonstrates that the decision makers have listened to the consultation feedback. It involves the least change from the current situation and allows a period for co-production of the future model with the community. It also allows current initiatives regarding recruitment and wider system change to play forward to identify whether they reap rewards.

However, there was some feeling that this is too similar to the status quo, the recruitment challenges are insurmountable and that there needs to be a bold decision to go straight to:

2.7.2 *Option 2 Paediatrics and Option 3 Maternity*

The general (though not unanimous) consensus was that this is the right clinical choice of options and is more achievable and sustainable.

However there is likely to be significant opposition to this choice from the clinicians in West Cumbria including most of the GPs, most of the consultants in all specialities and most of the midwives. In addition opposition is likely to come from the public and politicians.

2.8 The recommended choices for Cumbria CCG, described in section 2.8, were fed back to the review panel leads to seek their responses to the second part of the commission:

"Revisit the preparatory work, including risk assessments, and provides a view regarding the quality of that work (i.e. a judgment about the relative safety and appropriateness of any of the options compared to doing nothing)."

2.9 This response paper summarises the GMLSC Clinical Senate response to this commission, for which a final view from GMLSC was required by Tuesday 28th February 2017.

3.0 Maternity

3.1 The first aspect of this follow-up commission was for the senate review panel to revisit the options and advise what they believe to be the best options, identifying any additional issues for consideration in the light of the consultation.

3.2 The three maternity options are described in detail in Appendix 4. The preferred option going into consultation was Option 2: A consultant-led unit (CLU) and alongside midwife-led unit (MLU) for births in Carlisle and a 24-hour standalone MLU unit for low risk births at Whitehaven.

3.3 The review panel noted that all options had strengths and weaknesses, but that the most clinically robust and sustainable model was Option 2. This agreed with the preferred option highlighted in the consultation. The panel considered it a transformational model that needs testing, assuming the risks are robustly identified and properly mitigated against.

3.4 One of the key risks identified was that women would opt not to use MLU. Public expectation in the area is not in line with current best practice guidance and could lead to an unintended consequence of women requesting caesarean sections to avoid travelling to Carlisle. There is a need to consider how expectations can be managed and attitudes changed.

3.5 The panel felt that the team had clearly thought about the model and that it contained some good ideas, such as assessing women in the latent phase of labour at Whitehaven to prevent unnecessary travel to the obstetric unit in Carlisle.

3.6 They were also reassured and pleased to hear that the North West Ambulance Service (NWAS) had been fully involved in the discussions and planning regarding the use of the dedicated ambulance vehicle.

3.7 However, they identified a number of issues regarding the robustness of the plans, which would need addressing before this model was implemented. These are:

3.7.1 Would the elective consultant service at Whitehaven be an outpatient service or include elective caesarean section? If elective caesarean sections were to be delivered during consultant-hours this would need to be timed to ensure there is post-surgical doctor cover within the hospital.

3.7.2 Would the day unit be for planned activity only or could it accommodate non planned maternity assessment for common complications of pregnancy?

3.7.3 What would be the protocol at weekends when there was no medical cover? There would need to be robust management algorithms for during and outside consultant presence at Whitehaven.

3.7.4 Would the VBAC provision be a clinic alone or include deliveries?

3.7.5 How does the day assessment unit from 8.00am-6.00pm described in Section 3.1 of the Maternity Options Addendum paper differ to the antenatal assessment day unit from 8.00am-8.00pm described in the same section?

3.7.6 Why are anomaly scans not down to be performed at Whitehaven?

3.7.7 Would the Emergency Gynaecological Unit be provided during weekend days?

3.7.8 Is paediatric medical cover 7 days a week from 8.00am-11.00pm?

3.7.9 It is not usual for a retrieval team to attend MLU. Red 1 Paramedic ambulance is the norm. Would the maternity ambulance be equipped to transfer neonates with a midwife (and paediatrician during their hours)?

3.7.10 Who would provide cover for post-surgical complications overnight?

3.7.11 Could telemedicine provide some useful support?

3.8 Further issues identified concerned workforce issues in particular:

3.8.1 The ability to provide the required upskilling of midwives in a timely way and whether any work was underway with the local educational establishments regarding the provision of this.

3.8.2 Whether there had been a consideration using midwives in specialist roles such as diabetes management

3.9 The panel agreed with the case for change as the current service was felt to be unsustainable and fragile due to workforce issues, particularly regarding recruitment of consultants, the lack of advanced nurses and an ageing midwifery workforce.

3.10 Option 1 was felt to be too close to the status quo and therefore subject to the same issues previously identified in the case for change. It was not seen as transformational and reliant upon an expanded workforce, particularly consultant, which is unlikely to be deliverable.

3.11 Option 3 was not supported as this removes all provision for births at Whitehaven and there is good evidence to support standalone MLUs and the provision of high quality care for low-risk multiparous and nulliparous women[2].

3.12 In light of the recommendations being made to the CCG (described in Section 2.8), the review panel does not support a decision that would lead to there being no MLU in Whitehaven.

[2] Nice. December 2014. *Intrapartum care for healthy women and babies.* www.nice.org.uk/guidance/cg190

4.0 Paediatrics

4.1 The first aspect of this follow-up commission was for the senate review panel to revisit the options and advise what they believe to be the best options, identifying any additional issues for consideration in the light of the consultation.

4.2 The three paediatric options are described in detail in Appendix 5. The preferred option going into consultation was Option 1: Full service at Carlisle and short stay paediatric assessment unit (SSPAU) and low acuity beds at Whitehaven plus Dedicated Ambulance Vehicle and consultant on-call overnight.

4.3 The review panel felt the best option was Option 2: Full service at Carlisle and 14 hour SSPAU at West Cumberland Hospital plus Dedicated Ambulance Vehicle.

4.4 The primary reason for this preference is that it is a transformational model that has a good clinical case. This is demonstrated through provision of SSPAU on both sites, having consultants working across both sites in a network model to provide resilience and maintenance of skills, as well as integration of community and secondary care.

4.5 Option 2 was also considered to offer higher deliverability and sustainability by being more attractive to prospective consultants (offering an improved on call rota ratio) and by requiring fewer overall WTE consultants than in Option 1 – the preferred option.

4.6 Option 2 presents a minimal number of additional transfers required between Whitehaven and Carlisle than Option 1 (estimated as 58 additional journeys/year with 279 in Option 1 and 337 in Option 2[3]).

4.7 The panel felt that the following issues required consideration before the implementation of Option 2 to strengthen the case:

4.7.1 A strong narrative to support the vision (e.g. better access to consultants who will be present until 22:00).

4.7.2 The development of APNP role including:

4.7.2.1 More work needs to be undertaken to enable recruitment and retention of these highly skilled practitioners.

4.7.2.2 Consideration of the reasons for the previous loss of advanced nurse practitioners to primary care.

4.7.2.3 Consider as to where this workforce will come from (e.g. experienced paediatric nurses).

4.7.2.4 Time needed to train this cohort and resilience of rotas during that period.

[3] Data based on *"Acute Hospitals Travel Impact Assessment version 0.8"*. 17th October 2016.)

4.7.3 Reliance on GPs within development of the whole system approach and the need to develop required skills through education, training and recruitment.

4.7.4 The lack of overnight paediatric cover at WCH requires:

4.7.4.1 By-pass policies and procedures for Whitehaven.

4.7.4.2 Public education around facilities at Whitehaven to minimise seriously ill children presenting there.

4.7.4.3 Consideration of ED/Anaesthetic staff and their management of critically ill children. These clinicians are likely to feel deskilled with fewer critically ill children passing through the ED and would feel vulnerable without presence of Paediatricians. This could be mitigated through provision of targeted training (e.g. by Nectar / Paediatric Critical Care ODN).

4.8 If the decision is made to move to Option 2, this could be phased in over 1 year by initially keeping overnight beds at Whitehaven. This has been done elsewhere but carries risks to the service (e.g. resilience).

4.9 Reflection on the current service is that it is fragile, and as such the case for change is supported. In particular, at Whitehaven, where there is a high reliance on locum consultants. Indeed, CQC West Cumberland Hospital Quality report (08/09/2015) states *"Review the consultant paediatric cover provided out of hours. This was a concern as the service still offered a 24 hour emergency service for children and young people"*. To date, Whitehaven has not been able to recruit substantive consultants. The panel noted that the outcome of the consultation was that either the current service, or the least possible service reconfiguration (Option 1), was the preferred choices. However staffing and service resilience makes these options difficult to support.

4.10 Option 1 also includes overnight beds at WCH. This would support overnight deliveries in maternity and again it was noted that the outcome of the consultation was that the current service or the least possible service reconfiguration (Option 1) were the preferred choices. However the panel felt that due to this option delivering minimal change from the current service, then there is significant uncertainty as to whether this is either deliverable or sustainable. Some of the key issues highlighted include:

4.10.1 The requirement for two rotas or a dual rota across Whitehaven and Carlisle.

4.10.2 The number of consultants required to support these rotas and associated daytime work.[4]

[4] RCPCH "*Facing the Future"* document suggests 7.8 wte consultants for a small unit such as Whitehaven (<2,500 admissions/year) and 8.6 wte for a medium sized unit such as Carlisle (2,500-5,000) based upon 2SPAs/consultant and 10PA job plans.

4.10.3 No indication that it is possible to recruit the number of substantive consultants required to cover these rotas thereby placing an undue reliance on locums (often long term).

4.10.4 Any maternity option based upon this paediatric option would also be at risk if Option 1 becomes unsustainable.

4.11 Option 3 had no convincing clinical case and there would be a significant number of transfers required (1,713/year). It also had minimal support at consultation and is therefore not supported by the panel.

4.12 In light of the recommendations being made to the CCG (described in Section 2.8), the review panel:

4.12.1 Reiterates to the CCG that clinically Option 2 is the panel's preferred option but that if Option 1 is chosen then the panel would suggest that the CCG seeks reassurance that there are clear timetables for recruitment to substantial posts, training of APNPs and an audit of inpatient stays at WCH. The CCG would also need to develop criteria by which 'current initiatives regarding recruitment and wider system change' are measured and decide upon the response to any failure to meet these criteria to ensure robust and sustainable service delivery.

4.12.2 Suggests that the quality impact assessments for the Paediatric Options 1 and 2 are revisited before a final decision is made to take into account additional information and discussions that have been held since they were written (e.g. from the travel impact assessment) and include mitigations for potential negative impacts.

5.0 Summary and Conclusions

5.1 Regarding maternity services, the Senate agrees with the Success Regime's originally preferred option, i.e. Option 2. It is considered to be a transformational model that warrants testing, assuming the risks are robustly identified and mitigated against. The Senate does not support a decision that would lead to there being no MLU in Whitehaven.

5.2 Should Option 1 maternity be implemented then the Senate would suggest that the CCG seeks reassurance that there are clear timetables for recruitment to required posts (no more than two years). The CCG would also need to develop criteria by which current initiatives regarding recruitment and wider system change are measured and decide upon the response to any failure to meet these criteria to ensure robust and sustainable service delivery.

5.3 Regarding paediatric services, the Senate reiterates that clinically the preferred option is Option 2. This is consistent with the Clinical Senate's original response in May 2016 but differs to the Success Regime's originally preferred option, i.e. Option 1. If Option 1 is chosen then the Senate would suggest:

5.3.1 That the CCG seeks reassurance that there are clear timetables for recruitment to substantial posts, training of APNPs and an audit of inpatient stays at WCH (no more than two years). The CCG would also need to develop criteria by which current initiatives regarding recruitment and wider system change are measured, and decide upon the response to any failure to meet these criteria to ensure robust and sustainable service delivery.

5.3.2 That the quality impact assessments for the Paediatric Options 1 and 2 are revisited before a final decision is made to take into account additional information and discussions that have been held since they were written (e.g. from the travel impact assessment) and include mitigations for potential negative impacts.

5.4 The Senate notes that, with regards to interdependencies between maternity and paediatrics, its preferred options are deliverable but would require some detailed work to develop robust pathways for very sick children and babies who present at Whitehaven out of hours.

5.5 The Senate notes the diverse range of opinions regarding the range of both maternity and paediatric services. It should be noted that the Senate's advice is based on the clinical challenges and the most robust clinical solutions.

5.6 The advice within this report is given in good faith and is correct at the time of writing. Moving forward the Clinical Senate extends the offer of further assistance should it be required.

Appendix 1: Clinical Senate Recommendations Regarding Maternity Services (May 2016)

Recommendations: Maternity services The Success Regime Leadership Team for Maternity Services is encouraged to:	
	Ensure that the proposed clinical models build on NICE guidelines and quality standards.
	Consider the clinical co-dependencies involved during the development of the proposals for maternity services. Sources of useful information about the process for identifying clinical co-dependencies are: o The South East Senate report on clinical co-dependencies o The Making It Better and Healthier Together Programmes o The GM Devolution Specialised Services co-dependency assessment framework o The Healthy Liverpool Programme
	Consider and take account of the critical interface between maternity services and paediatrics in the further development of the proposals
	Clarify how Cumbria responded to the concerns of the CQC. It would be helpful to see evidence of how the concerns raised from previous reports have or are being addressed.
	Undertake further work to develop a robust and realistic workforce plan which addresses the following: o models the proposed workforce roles and numbers and testing the assumptions re potential financial savings o Clarifies the age profile and turnover of the staff o Clarifies the assumptions which have been made about the recruitment of new staff into the area and whether the anticipated numbers are realistic. o Clarifies the assumptions which have been made re the flexibility of the workforce and whether these are realistic o Builds on the results of a risk assessment of staffing numbers and clarifies the proposed governance arrangements to manage the identified risks o Outlines plans for the ongoing training and development of staff o Describes how professional isolation will be addressed o Embeds Quality Improvement into work force training and CPD o Describes the extent that local commissioners have been engaged in the development of the workforce plan.
	Clarify further the Enhanced Neonatal Nurse/Midwife roles in terms of: o Training numbers o Plans for supervision and ongoing training o Proposed level of ongoing support from the wider staffing infrastructure to reduce professional isolation o Proposed level of professional responsibility and accountability etc.
	Develop robust quality metrics and standards which can be used as a marker of progress and or success

Appendix 2: Clinical Senate Recommendations Regarding Paediatrics Services (May 2016)

Recommendations: Children's Services The Success Regime Leadership Team for Children's Services is encouraged to:	
	Make timely decisions and decide concurrently on models of care for both maternity and children & families in order to maintain the viability of any future services. o The requirements of a consultant led obstetric unit are such that the paediatric model of care needs to be robust to support it. This was considered by Dr Shortland in his review. o The Senate Review Team recommend that his opinion is considered further i.e. a 14 hour SSPAU at the WCH site may be a more achievable and sustainable option.
	Consider the following issues when modelling the effects of each option, reviewing achievability and making a decision: o cross-border activity (e.g. the number of patients that would move to Barrow) o Interim arrangements in terms of both staff resources and financial costs and likelihood of meeting target configuration.
	Further develop a robust and realistic workforce plan which addresses the following: o models the proposed workforce roles and numbers and tests the assumptions re potential financial savings o Clarifies the age profile and turnover of the staff o Clarifies the assumptions which have been made about the recruitment of new staff into the area and whether the anticipated numbers are realistic. o Clarifies the assumptions which have been made re the flexibility of the workforce and whether these are realistic o Builds on the results of a risk assessment of staffing numbers and clarifies the proposed governance arrangements to manage the identified risks o Outlines plans for the ongoing training and development of staff o Describes how professional isolation will be addressed o Embeds Quality Improvement into work force training and CPD o Describes the extent that local commissioners have been engaged in the development of the workforce plan. Also See General Recommendations in Section 4.3
	Employ novel recruitment models once a clear vision for the future of the service has been established. Suggestions include: o Movement of clinical leaders between sites o Secondments of senior well established clinicians who may also provide additional clinical leadership o Working alongside universities to provide academic units
	Consider CAMHS and other service interdependencies throughout the decision making process and when putting in place transitional arrangements.
	Ensure that a whole systems approach is maintained by considering community services and general practice at the heart of the decision making process.
	Support the Trust to continue to build upon its existing successes such as telemedicine.
	Ensure that a robust engagement plan which builds on Sam's House is developed and implemented. It also needs to address and explain the reasons why changes are required.
	Further develop the standards and quality measures for the service.

	Undertake an audit of likely number of patient transfers if the SSPAU model was implemented.

Appendix 3: Contributors to the Review

Maternity Clinical Senate Review Team

Dr Helen Scholefield (Review Team Lead)	Consultant Obstetrician Liverpool Women's Hospital,
Dr Ngozi Edi-Osagie	Consultant Neonatologist, Central Manchester FT
Dr David Rowlands	FROG, Associate Medical Director, Arrowe Park Hospital,
Kathy Murphy	Deputy Director of Nursing & Head of Midwifery , Central Manchester FT
Judith Shaw	Volunteer Patient Cabinet member

Paediatrics Clinical Senate Review Team

Dr Jeff Perring (Review Team Lead)	Director of Intensive Care and Vice Senate Chair, Sheffield Children's Hospital
Dr James Bunn	Consultant Paediatrician, Alder Hey Children's Hospital
Angela Douglas	Scientist and Genomic Lead, Liverpool Women's Hospital
Kate McNulty	Patient Representative GMLSC Clinical Senate, Oversight & Planning Group & Patient, Carer Public Advisory Group GMLSC

GMLSC Clinical Senate Council

Forename	Surname	Job Title	Organisation
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Caroline	Baines	Clinical Senate Manager	NW Clinical Senates
Ivan	Benett	General Practitioner	Central Manchester CCG
Maureen	Chadwick	Managing Director	Diabetes Complete Care Ltd
Irfan	Chaudry	Consultant Critical Care Medicine & Anaesthesia, Divisional Medical Director/Honorary Senior Clinical Lecturer Manchester Medical School	Lancashire Teaching Hospitals NHS FT
Julie	Cheetham	Associate Director	Greater Manchester & Eastern Cheshire SCN
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Philip	Jennings	Head of Clinical Innovation, Liaison & Deployment	The Innovation Agency, AHSN
Sakthi	Karunanithi	Director of Public Health	Lancashire County Council
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Patrick	MacDowall	Consultant Nephrologist	Lancashire Teaching Hospitals NHS FT
Claire	Maguire	Consultant Clinical Psychologist	Pennine Care NHS FT
Angela	Manning	General Practitioner & Deputy Medical Director	NHS England Lancs & Gtr Mcr
Phil	McEvoy	Managing Director	Six Degrees Social Enterprise
Kate	McNulty	Patient Representative	
Javeed	Mehran	Consultant in Old Age Psychiatry & Clinical Lead Primary Care	Salford Royal NHS FT
Jane	Ooi	Consultant Breast Surgeon	Bolton Foundation Trust
Vats	Patel	Pharmacist	Manchester
John	Patterson	Medical Director & GP	Hope Citadel
Jaydeep	Sarma	Consultant Interventional Cardiologist	South Manchester Hospital NHS Trust
Mohammed	Sarwar	CEO Multicultural Arts & Medica Centre & Patient Representative	Rochdale
Graham	Spratt	Consultant Clinical Psychologist	5 Boroughs Partnership
Ian	Trodden	Director of Nursing	Pennine Care NHS FT
Jan	Vaughan	Associate Director	NWC SCN
Stephen	Watkins	Director of Public Health	Stockport Council
Irfan	Zafar	GP	Blackburn

Appendix 4: Descriptions of Maternity Services Options 1 to 3

Option 1

- Maintaining consultant-led units on both sites, with 'alongside' midwife-led units and special care baby units.
- This option is not the status quo – some high-risk mothers will birth at Carlisle.
- This option will use new ways of working to maintain safe staffing – one team across two sites with an innovative staffing structure.
- There will be a full range of antenatal and postnatal services as well as gynaecological services both in Whitehaven and Carlisle.
- The option for home birth and Penrith Birthing Unit will be available.

Option 2

- At Cumberland Infirmary in Carlisle: a consultant-led unit and 'alongside' midwife-led unit for births. There will be a full range of antenatal and postnatal care and a special care baby unit serving all of west, north and east Cumbria.
- At West Cumberland Hospital in Whitehaven: a 24-hour standalone midwife-led unit for low risk births and a daytime consultant service offering antenatal and postnatal care and some gynaecological services (non-emergency cases) (8am-8pm).There will not be a consultant-led service for births. There may be the ability to offer elective caesareans in this new staffing model in the future. It is anticipated women will not be transferred back to WCH for postnatal care as NICE guidance supports discharge to home as soon as possible. Women requiring medical treatment will remain in Carlisle. There will be an antenatal day assessment unit (8am-8pm) provided five days a week (Monday-Friday) and could be staffed by midwives with telemedicine support.
- Consultant obstetric and gynaecology input would be solely during the day but would include day case services across gynaecology (including day case surgery), outpatient investigations, emergency gynaecology unit, fertility, colposcopy and uro-gynaecology. All inpatient emergency gynaecology and complex elective gynaecology as well as the consultant-led obstetric unit would be at CIC.
- The option for home birth and Penrith Birthing Unit will be available.
- There will be a Dedicated Ambulance Vehicle (DAV) for maternity and paediatric transfers.

Option 3

- Cumberland Infirmary in Carlisle: a full obstetric service and a special care baby unit serving all of west, north and east Cumbria. Consultant-led service and 'alongside' midwife-led unit for births. There will be a full range of antenatal and postnatal care.

- West Cumberland Hospital in Whitehaven: no births at West Cumberland Hospital. Consultant and midwife out-patient antenatal and postnatal care available.
- There will be an antenatal day assessment unit (8am-8pm) provided five days a week (Monday-Friday) and could be staffed by midwives with telemedicine support.
- Consultant obstetric and gynaecology input would be solely during the day but would include day case services across gynaecology (including day case surgery), outpatient investigations, emergency gynaecology unit, fertility, colposcopy and uro-gynaecology. All inpatient emergency gynaecology and complex elective gynaecology as well as the consultant-led obstetric Unit would be at CIC.
- The option for home birth and Penrith Birthing Unit will be available.

Appendix 5: Descriptions of Paediatrics Services Options 1 to 3

Option 1

- Full service at Cumberland Infirmary Carlisle and short stay paediatric unit and low acuity beds at West Cumberland Hospital plus Dedicated Ambulance Vehicle and consultant on-call over night

Option 2

- Full service at Cumberland Infirmary Carlisle and 14 hour short stay paediatric unit at West Cumberland Hospital plus Dedicated Ambulance Vehicle

Option 3

- Full service at Cumberland Infirmary Carlisle for West, North and East Cumbria. No beds or short stay paediatric unit at West Cumberland Hospital