The Future of Healthcare in West, North and East Cumbria

Consultation response from

Cumbria Third Sector Network
and
Cumbria Action for Health Network

Introduction

1.1. This response to "The Future of Healthcare in West, North and East Cumbria" comes from Cumbria Third Sector Network (http://cumbriacvs.org.uk/giving-you-a-voice/cumbria-third-sector-network/) and its specialist health and wellbeing network, Cumbria Action for Health.

1.2. Cumbria Third Sector Network currently comprises 17 specialist networks. Cumbria Action for Health, one of these specialist networks, has over 500 members, and membership is open to any third sector organisation with an interest in health and wellbeing.

1.3. This response has been prepared by support officers for these networks – Carolyn Otley (Cumbria CVS Engagement Team Manager, and Cumbria Third Sector Network Coordinator) and Jozi Brown (Cumbria CVS Senior Engagement Officer, who provides support to Cumbria Action for Health Network).

1.4. It is based on information gathered during network events, and other engagement with the Success Regime process by officers and network members.

1.5. The members of Cumbria Third Sector Network's Executive, which includes the Chair of Cumbria Action for Health, have had the opportunity to comment on a draft, and approve this final response.

1.6. Any questions relating to this consultation response should be addressed to Carolyn Otley: CarolynO@cumbriacvs.org.uk / 01768 800350

Summary

2.1. Cumbria Third Sector Network has a number of general concerns with the Success Regime process, and "The Future of Healthcare in West, North and East Cumbria" consultation that has followed it.

2.2. It has become increasingly clear that both the Success Regime staff and our local health system leaders, although committed to finding solutions that work for the people of Cumbria, are too constrained by national regulations and structures to have the freedom to do this effectively.

2.3. We believe these constraints are partly financial, but, significantly, also ideological and regulatory, and that these are primarily national issues that cannot be solved locally. These are explored in further detail in sections below.

2.4. The consequence of these restraints is that many of the options proposed in the consultation document would clearly have the greatest impact on those already disadvantaged – for example, by low income, rural isolation, disability, or caring responsibilities. Again, these concerns are explained in later sections.

2.5. Proposals to provide care "closer to home" are reliant on a social care system under significant strain. Whilst we understand that this is outside the scope of the consultation, it is a significant concern.

2.6. These general concerns are discussed first, followed by responses to the specific consultation options.

National Financial Allocation

3.1. It was stated in a Success Regime update, and reiterated at public consultation meetings, that the NHS in Cumbria had for many years been "spending NHS money from other parts of the country". Whilst we accept the Cumbrian NHS has overspent its allocated budget for many years, we do not accept the emotive suggestion that this is money that rightly belongs to other parts of the NHS. If a similar suggestion had been made by the community, it would have been robustly refuted, and therefore we feel it necessary to challenge the Success Regime's assertion.

3.2. This is money that "belongs elsewhere" only if we accept the current NHS funding formula. We do not. We believe there are good reasons why it costs more to deliver acceptable health services in an area with both very rural communities and isolated, deprived urban areas. Surely one of the benefits of a "national" health service is that more sophisticated spending decisions can be made, allocating more money to areas with higher need, or where delivery costs are higher. If the best method of resource allocation that national government can come up with is simple per capita formula, this is, quite frankly, disappointing.

3.3. The principle that it costs more to deliver services in rural areas is enshrined in DEFRA's rural proofing guidance, which suggest a potential solution is to "allow for higher rural unit delivery costs in funding formulae or allocations." (https://www.gov.uk/government/publications/guide-to-rural-proofing-national-guidelines)

3.4. Many of these additional costs of health service delivery in Cumbria are linked to other national government spending decisions; a lack of investment in road and rail infrastructure and public transport, and less support for economic development activity outside of London and the big cities. We therefore feel national government has to bear some of the responsibility for meeting these additional costs, rather than those costs simply being passed to local residents.

3.5. In addition, it seems likely that West Cumbria may soon be the location of 3 nuclear power stations as part of the Moorside development – another national government decision. In time, these would produce a significant proportion of the UK's electricity, but mean the local population will carry the significant risks of proximity to a nuclear facility as a result. This development will provide very welcome employment opportunities on the West Coast; however, it will however, mean an increase in the population (both temporary and permanent) that will place additional demands on local primary care and hospital services. These impacts are currently being examined in NuGen's Health Impact Assessment, and we consider no final decisions on the configuration of local health services should be made before this is available.

3.6. Finally, the current funding allocation does not take account of the significant numbers of tourists who visit Cumbria each year, and make some use of local health services.

Centralisation of health services

4.1. There appears to be an increasing emphasis on the centralisation and specialisation of secondary health services; this is often justified on the basis that it reduces cost, but there is increasing evidence that this is rarely the case. This argument is outlined in existing publications, including the King's Fund report "The Reconfiguration of Clinical Services." (https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_summary/Reconfiguration-of-clinical-services-kings-fund-nov-2014.pdf)

4.2. There is also an assumption that centralisation will improve clinical outcomes. We accept there is good evidence for the benefits of consolidation of specialised services, particularly for the most complex cases and services. However, it appears that many of the arguments for centralisation in Cumbria are based on an extrapolation of the existing data – for example, assuming that the evidence of benefit to travelling up to 50km to access specialist trauma services still holds true for longer travel distances. There must be a "tipping point" at which the increase in travel time outweighs the benefits of more specialised care on arrival at hospital; we have seen no clear evidence that this "tipping point" has been robustly identified.

4.3. Further, we believe policies and guidelines are being developed by those who work in large urban areas, and that their lack of experience of remote areas is inadvertently disadvantaging rural populations. Royal College staffing guidelines developed for rural areas are contributing to recruitment difficulties in Cumbria, and do not necessarily ensure that decent, everyday secondary health services are easily accessible to the population of Cumbria.

4.4. As a (simplified) example, it has been stated that Royal College of Paediatrics and Child Health guidelines suggest that it is not acceptable for the on call Consultant Paediatrician to be on call from home; they must be based on the hospital site. Whilst superficially this is a simple choice, with "on site" senior paediatric support clearly a safer solution, this causes significant staffing difficulties for a small, remote unit. All the options in the consultation document involve West Cumberland Hospital not accepting paediatric inpatient admissions overnight.

4.5. This means that patients in rural areas are actually facing a very different choice – sitting in a warm hospital (with A&E staff and other support) for perhaps half an hour whilst a consultant paediatrician travels in from home, or over an hour's journey for the child to the Cumberland Infirmary in Carlisle. This journey is unlikely to be straightforward – a typical scenario is an ill and scared child in the back of an ambulance, with a stressed parent following behind in a car - attempting to follow a vehicle driving on blue lights, in the dark on poor roads, and perhaps with other children in their car. It should not be hard to see why patients find it difficult to understand the benefits of centralisation; whilst high clinical standards are clearly important, we must not forget that there is much more to good medical care.

4.6. Similar difficulties exist in other Royal College guidelines – for example recommendations that anaesthetists should not be put in positions where they are on call for multiple departments (for example, both A&E and maternity). Whilst it would clearly be very stressful to working in a situation where simultaneous requests for support were a frequent occurrence, this may still be the best solution in small units where it will be an infrequent occurrence. Medicine is never without risk; even in a large hospital demand for anaesthetists will occasionally exceed the number available

4.7. This dilemma was clearly noted when the Royal College of Obstetrics and Gynaecology undertook a review of maternity services across Cumbria at the request of Cumbria CCG. The review team arrived expecting to recommend centralisation to a single Consultant Led Unit (for Cumbria and North Lancashire), but left favouring the retention of the existing four units (whilst noting the many difficulties of safely staffing these). "*Providing quality health services within Cumbria is challenging because of a number of issues including mountainous geography, poor highway and road infrastructure, social isolation, significant deprivation and strong, lifelong loyalties to local hospitals. It is difficult to appreciate quite how difficult the road structure is without personal experience.*" "*The assessors felt prior to their visit that a unitary provider was likely to be the preferred option, due to the benefits that a 5,000 delivery unit would confer on women and their babies. However, the geographically complex configuration in this county renders such an option undeliverable*." (http://www.cumbriaccg.nhs.uk/about-us/2015-03-23--rcog-options-appraisal-final-report-(nopword).pdf)

4.8. We understand that Cumbria CCG has met with the Federation of Royal Colleges, and explained the difficulties that such guidelines pose in delivering safe care in a rural area, and that as a result, it was agreed that guidelines would be reworded to make it clear which were non-negotiable, essential standards, and which were amenable to flexibility where they were unsuitable to a local situation. However, any revisions are still to be published, and so these guidelines remain a barrier recruitment and meeting the requirements of the regulators.

Regulatory issues

5.1. NHS organisations are subject to a complex system of regulation, but for brevity, we will only consider Care Quality Commission (CQC) inspections.

5.2. CQC inspects against national standards, many of which we believe are set with an urban model in mind, and are so particularly challenging to meet in a rural area. The issues here are very similar to the issues discussed above in relation to the Royal College guidelines, and so we will not elaborate further.

5.3. There is an additional problem. CQC inspects the services within a single NHS organisation; this means that, from the regulator's perspective, it is clearly safer to centralise services, such as consultant led maternity services, onto a single site with more senior staff available, as it is considering only the risk once the patient arrives at the hospital.

5.4. However, this often simply moves the risk to the patient (who has reach the more distant site before they can access services), or moves risk and work onto another NHS organisation (for example, the Ambulance Service).

5.5. We believe that regulation needs to be across the whole health system – and not just within the NHS organisations, but starting from the point at which patient needs a service (for example, becomes ill, has an accident, or goes into labour).

5.6. At the start of the Success Regime process, the Chief Executive of NHS England, Simon Stevens, suggested that it should be possible to allow some freedom from regulatory restraints during the transition to new, rural models of care – these freedoms do not appear to have materialised to the extent we had hoped, and the timetable for the Success Regime and the subsequent consultation appears to have been driven by CQC requirements. We find this extremely disappointing.

Increasing existing disadvantages, vulnerabilities and inequalities

6.1. Our fundamental concern with the consultation proposals is that many options, including many of the "preferred options", will have the greatest negative impact on those who are already vulnerable or disadvantaged, and so they are likely to increase existing health inequalities.

6.2. It is well established that parts of Cumbria, particularly parts of the relatively small urban communities on the West Coast, suffer high levels of **deprivation**. This is described in detail in the Inequalities chapter of Cumbria's Joint Strategic Needs Assessment. (http://www.cumbriaobservatory.org.uk/health/JSNA/2015/inequalities.asp)

6.3. Given many of the options for acute hospital services propose the removal of services from West Cumberland Hospital in Whitehaven, and consolidation at Cumberland Infirmary, Carlisle, the people of West Cumbria will increasingly need to travel to Carlisle to access secondary health services. This may have a relatively minor impact on those with a good income and easy access to a car; however, it will place significant strain on those on a low income (particularly those on means tested benefits), those reliant on Cumbria's poor (and reducing) public transport, those with existing health conditions or disabilities that mean they need to make more frequent use of health services, and those, such as single parents, who have additional caring responsibilities.

6.4. It is perhaps worth emphasising the depth of the financial strain. A person on Job Seekers Allowance, Employment Support Allowance or Universal Credit receives £73.10 per week, which has to cover all expenses apart from rent and Council Tax. A return trip from Whitehaven to Carlisle costs £11.50 by train, or £10.80 by bus – a full day's benefits. It is clear that this is trip that simply cannot be made frequently by those on such a low income. Undertaking this journey can take all day by public transport.

6.5. Similar concerns are applicable to the removal of Community Hospital beds in communities such as Maryport, which also have high levels of deprivation.

6.6. There is already anecdotal evidence that people are choosing not to attend hospital appointments because of the cost of travel, or because other worries, including that they will miss DWP appointments and suffer benefit sanctions.

6.7. Whilst the following example, given by a local third sector organisation in 2015 during work to follow up that of the earlier Cumbria Welfare Reform Commission (http://cumbriacvs.org.uk/wp-content/uploads/2013/05/20467_WelfareReform_v3-2.pdf) refers to the difficulties of travel between Carlisle and Newcastle, it gives a good indication of the extreme difficulties faced by those on a low income: *"Gary (38) and his partner Liz have lived on the estate for 10 years, they have a daughter Sophie (10). Liz is bi-polar and has gone through some difficult episodes, Gary has become her carer. Liz doesn't receive any psychiatric support. In November 14, Liz developed heart problems and had to be admitted to hospital in Newcastle. She was really ill and didn't get home until February 15. Then she developed an aneurism, was taken back to Newcastle where she passed away in*

March. Gary still hasn't had his benefits sorted (mid-May). We are supplying food from our community Foodbank regularly. He is in fuel poverty and debt. We helped them with the funeral, he has a massive fine for buying a child ticket for the train when Liz was dying in intensive care. Sophie said "It's like we are being punished for Mam dying". This is poverty"

6.8. A further example from the same project gives an illustration of the choices working people on low incomes are forced to make: *"It's a choice between food, heating, or my medication, so I leave my medication as I can't afford my prescriptions."*

6.9. Much of the support provided to these people and communities comes from third sector organisations, and these organisation are likely to face an increase in workload at a time of decreasing resources.

6.10. **Rural isolation** is another well-established issue in Cumbria. Eden has a number of communities are a very long way from key public services, but there are also small communities in other parts of West, North and East Cumbria that face similar difficulties.

6.11. Long travel distances to services can be a particular problem for those reliant on public transport, who face a "double whammy" as some services are centralised and public transport options reduce (for example, as bus services lose subsidies and are withdrawn).

6.12. The removal of Community Hospital beds from Alston is a particular concern. Alston is one of England's most isolated communities, with poor public transport, and in addition, is frequently inaccessible following snow (and the December 2015 floods).

6.13. Alston's unique situation has already been recognised by the NHS, in the development of the Alston Community Ambulance model with North West Ambulance Service.

6.14. Providing services in patients' homes, instead of in community hospitals may provide some solutions to these difficulties, but poses some challenges of its own. It places additional demands on family carers (more detail below), but also requires health and care staff to travel more, and face additional challenges from lone working. It is already proving difficult to recruit health and care staff to work in homes in the most rural parts of Cumbria.

6.15. Neighbours, volunteers (including volunteer drivers) and third sector organisations also play an important role in rural communities, and proposals are likely to increase demands on them. This is of concern as the availability of volunteers is decreasing as people work longer, and lead busier lives.

6.16. Unpaid (usually family) **carers** play a crucial part in the care of many patients, and it can be an extremely demanding role. Many of the consultation proposals are likely to place additional demands on carers, and not all carers will be able to cope with these.

6.17. An increase in the amount of care provided at home is the most obvious concern. Whilst there are clear disadvantages to prolonged acute hospital stays, community hospital beds often provide carers with essential respite when a loved one's medical needs increase. Even the best care at home is unlikely to provide the same, albeit it temporary relief, from their responsibilities.

6.18. This has been raised as a particular concern around end of life care. Again, whilst many people would prefer to die at home, this can place great demands on family carers, and local Community Hospital beds are frequently seen as the best compromise.

6.19. Consolidation of acute hospital services also places increased demands on carers, who will frequently need to accompany family members to hospital appointments (both to provide transport and support).

6.20. Many unpaid family carers are older people, and/or have long term health conditions themselves, which reduces their ability to cope with an increase in their already demanding role.

6.21. People with **disabilities** frequently need to make more use of Acute Hospital services. They often face additional difficulties with travel, compounding the impact of any consolidation of services.

6.22. Concerns have also been raised that, whilst local disability organisations have had considerable input to the design of the new West Cumberland Hospital building, the Cumberland Infirmary, Carlisle, is very poorly designed for wheelchair access, both as a patient and a visitor (for example, having insufficient space on some wards to have a wheelchair alongside a patient bed).

6.23. People with learning disabilities often find hospitals a hostile environment, and this is much worse when the hospital is further away and unfamiliar. A longer travel distance places additional demands on family carers, taking up significant amounts of time and causing distress. Individuals who are supported by paid care staff face additional costs and logistical difficulties where these staff have to travel to a distant hospital. These difficulties can have serious consequences; there are needless deaths every year because of communication difficulties between hospital staff and people with learning difficulties – described in Mencap's "Death by Indifference" report. (https://www.mencap.org.uk/sites/default/files/2016-06/DBIreport.pdf)

6.24. **Women** seem almost certain to be more affected by the proposals than men; directly (as a result of changes to maternity services) and indirectly as they are more likely to be the primary carer of children and other family members.

Integrated Care Communities

7.1. Whilst Integrated Care Communities (ICCs) are included in the introduction to the consultation document, there are no options presented, presumably as their development not seen as a significant service change that requires public consultation.

7.2. Cumbria Third Sector Network is broadly supportive of the concept of Integrated Care Communities, and believes they could bring many benefits for patients; however, a number of the general concerns noted above around an increased burden on carers are particularly relevant to the development of ICCs.

7.3. It is clear that an **integrated** care community will be critically dependent on the commitment of partner organisations from outside the NHS. We understand that this is outside the scope of this consultation, but the increasing pressure on adult social care services as the result of the combination of an aging population and cuts to local authority budgets, is a significant concern. Other partners, including housing providers, voluntary organisations and community groups will also have important roles to play, and must be fully involved in the development of ICCs.

7.4. Third Sector organisations are still unclear about the role they may play, or be expected to play, in ICCs. Some early discussions have taken place, and ICCs in some areas are further developed than in others. Progress so far is promising, but there are many details that still need to be worked through.

7.5. Engaging at a more local level, for example with multiple ICCs, can pose challenges for smaller, specialist voluntary sector providers. This is particularly pronounced when ICC boundaries are different from other boundaries (such as District Council boundaries).

7.6. Whilst we endorse the principle of integrated care, it is difficult to give unequivocal support to ICCs without further reassurance that they will be adequately resourced.

Maternity Services

8.1. All the options presented present some change to existing delivery, and the removal of the choice of at least Consultant Led care during birth at West Cumberland Hospital for some women. The concerns are fundamentally the same for all options, differing only in the number of women affected.

8.2. Given it affects the lowest number of women, Option 1 is clearly our favoured option of those presented.

8.3. Whilst we are aware of the difficulties in the "safe" staffing of a Consultant Led Unit (CLU) at West Cumberland Hospital, women remain concerned about the safety of travel to Cumberland Infirmary, Carlisle during labour.

8.4. Given the unpredictable nature of labour, this is an entirely understandable concern. It seems inevitable that an increased number of babies will be born before arrival at Cumberland Infirmary, and, as a group, babies "born before arrival" are known to have poorer outcomes.

8.5. In addition, there are concerns that an increased travel time and distance will increase stress at an already emotional time. This may have a number of adverse effects, reducing the chances of a straightforward labour and birth, and increasing the need for interventions. A poor birth experience can have long term consequences, including negative impacts on breastfeeding and maternal mental health.

8.6. It may also prove harder to arrange care for older siblings, causing an additional stress. There is a real danger that families will become preoccupied with the logistics of travel and childcare when they should be celebrating the birth.

8.7. A standalone Midwife Led Unit (MLU) at West Cumberland Hospital would be, in reality, over an hour's ward to ward transfer time from a CLU at Carlisle Infirmary. Whilst there are remote MLUs in other parts of the UK and beyond, they deal with a much smaller number of births than a MLU at West Cumberland Hospital would, and so there is limited data on which to assess the safety of this option.

8.8. This is a particular concern to women from the more deprived communities in West Cumbria, who are more likely to have risk factors that lead to them being recommended to give birth in a CLU, but are also likely to find it more difficult to travel a long distance in labour.

8.9. Finally, it is unclear to us how a "safe" staffing solution has been found for a CLU Furness General Hospital, Barrow, but cannot be found for West Cumberland Hospital. They would appear to be broadly similar in number of births and geography.

Children's Services

9.1. Again, all the options represent some degree of change from the status quo, with an increased number of children having to travel to Carlisle for some or all inpatient paediatric services. The concerns are broadly the same for all options, with more children and families being affected under options 2 and 3.

9.2. Our preferred option is option 1, as this affects the smallest number of children and families, but we still have some concerns with this option.

9.3. Again, the families most affected by these changes will be those in West Cumbria, particularly Copeland. There are many families in this area who already suffer high levels of disadvantage, and these families are more likely to need to use paediatric inpatient services. Any increase in travel in travel distance will be almost certain to further disadvantage these families.

9.4. These changes will affect the whole family, including other children who may end up being separated from their main carers for prolonged periods of time.

9.5. These impacts would be most pronounced if the Special Care Baby Unit (SCBU) was lost from West Cumberland Hospital. Not only is having a baby in special care a particularly emotional experience, but mothers have often undergone a caesarean section - they are unable to drive, creating further travel difficulties. Amongst the many other consequences, being further from SCBU makes it likely that a mother will be forced to make less frequent visits, making it much harder to establish breastfeeding.

Community Hospital Inpatient Beds

10.1. All the proposed options involve the removal of beds from a number of community hospitals.

10.2. The Community Hospitals that will lose their beds under Option 1 appear to have been identified because they have outdated facilities, and not on the basis of community need. For example, Alston is an incredibly geographically isolated community, and would appear to have more need for local community hospital beds than other many other areas. Services in these communities are frequently interdependent, and there is a considerable risk that, for example, loss of community hospital beds will make it harder to recruit and retain general practitioners in the area.

10.3. Therefore, none of the current consultation options are acceptable to us. We understand that there is considerable work going on to identify alternative proposals, and would fully support further investigation of these.

Emergency and Acute Care

11.1. We consider that it is essential to maintain 24/7 Accident and Emergency Services at West Cumberland Hospital, and recognise that a huge amount of work has gone in to finding a solution that allows this.

11.2. We therefore support the preferred Option 1.

11.3. Other options would cause us considerable concern, as they would place an additional burden on both the people of West Cumbria and North West Ambulance Service (NWAS). There are already many concerns that ambulance response times are increasing, and that volunteer Community First Responders (CFRs) are facing increased demands. The increase in the time it takes for an ambulance to arrive to take a patient to hospital may not be fully reflected in the "response time" data recorded by NWAS. Our understanding is that the "clock stops" when the first trained responder (such as a CFR or paramedic in a response car) arrives on scene, rather than when an ambulance able to transport the patient arrives. There are reports that on some occasions there can be as much as an hour's delay between the arrival of a CFR and the arrival of an ambulance, and this will not show in the data.

Hyper-acute Stroke Services

12.1. We accept that there are clinical advantages to a specialised hyper-acute stroke model.

12.2. There is some concern that the preferred Option 2 will disadvantage patients who live south of West Cumberland Hospital, and so the possibility of a "drip and ship" model should be investigated further.

12.3. Again, we have concern around the impact on NWAS and their ability to respond promptly to emergency calls across WNE Cumbria, as ambulances spend an increasing amount of time on transfers to distant hospitals (and potentially then responding to calls in Carlisle or beyond before returning to their "home" station).

Emergency surgery, trauma and orthopaedic services

13.1. We support the proposal to allow additional surgery and trauma care to take place at West Cumberland Hospital, with only the more complex surgery being consolidated in Carlisle. It is, however, important that there is no drift in the definition of "complex surgery" without further consultation.

Conclusions

14.1. Cumbria Third Sector Network, and its specialist Action for Health Network, recognise that significant effort has gone into attempting to find acceptable solutions to the longstanding challenge of providing health services that are both safe and accessible to the people of West, North and East Cumbria.

14.2. Whilst this has been largely successful for some services such as Accident and Emergency, we are disappointed that it has not yet been achieved for other services such as Consultant Led Maternity services or Community Hospital beds.

14.3. As a result, for some services, there is no option we consider acceptable. In others, we do not consider the preferred option to be acceptable; they do not make sense to the people of Cumbria.

14.4. We recognise that this is, to some extent, the result of national government policies, and that whilst local system leaders have made significant efforts to influence and change these, this has not always been achieved.

14.5. We accept that in some cases, treatment at a more specialist centre results in better clinical outcomes. Indeed, we have examples of third sector organisations working in partnership with the NHS to ensure patients have rapid access to specialist services – for example, mountain rescue volunteers and the Great North Air Ambulance staff working together to ensure patients are transported straight from remote locations to specialist NHS services such as PCI following a myocardial infarction, or neurological services in Newcastle.

14.6. However, for most medical conditions, we believe that acute hospital services are better provided in a local District General Hospital. This is particularly true when the need to use services cannot be planned, such as Accident and Emergency and Maternity Services.

14.7. In many situations, people will consider a wide range of factors when considering where they would like to access medical services; they are not simply considering where will achieve the best clinical outcome. Although this may mean they have a different perception of "risk" to the regulators and professional bodies, this does not make their preferences "wrong"; it is perfectly reasonable to balance travel time, familiarity, proximity to family, and the ability to meet other responsibilities against the quality of care achieved within a hospital. This is particularly true when the improvement in clinical outcomes achieved by a significantly longer travel distance may be slight.

14.8. A key concern is that any centralisation of services will cause the greatest difficulty for those who are already disadvantaged or vulnerable. Centralisation may have unintended consequences: for example, patients may simply choose not to access care, or carers may find themselves unable to cope with additional demands. Both these examples are likely to lead to increased demand on both statutory and voluntary sector health and care services in the long term.

14.9. In conclusion, we are concerned that some of the proposals will not work well given the geography of Cumbria, and that they will further entrench the disadvantages and health inequalities suffered by some parts of Cumbria's population.