Durham County Council's Joint Health Overview and Scrutiny Committee

Response to the public consultation on *Seizing the Future* - proposals for NHS service reconfiguration in County Durham and Darlington

December 2008

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1. Foreword

By Cllr Richard Burnip
Chair of the Overview and Scrutiny review looking at *Seizing the Future*

Proposals to reconfigure or change service provision are often perceived as a loss of a service or a downgrading of service provision. From a community perspective I know this is a highly emotive issue. Organisations leading change need to articulate clearly why change is necessary, what is being proposed, what will be improved, what will it cost and most importantly what the benefits will be for communities.

The health overview and scrutiny process looking into NHS proposals to reconfigure hospital services across County Durham and Darlington - *Seizing the Future* - has led the charge to challenge and better understand these proposals for change. The scrutiny process in my opinion has been rigorous, robust, with a clear focus on outcomes for communities informed by an evidence base.

This report presents the evidence and makes recommendations. The recommendations will be shared with NHS County Durham that I hope will assist them to make the best decision for all our communities in both County Durham and Darlington for a safe and high quality health service.

I would like to thank all the witnesses who gave evidence, my Councillor colleagues from the District Councils and the County Council who worked with me on this scrutiny review, and finally the officers who supported and advised the working group.

Cllr Richard Burnip,

Chair, County Durham *Seizing the Future* Health Scrutiny Working Group, and
Vice Chair, Durham County Council Joint Health Overview and Scrutiny Committee

2.0 Executive Summary

In October 2008 NHS County Durham (formerly County Durham Primary Care Trust) initiated a consultation on the *Seizing the Future* proposals of County Durham and Darlington NHS Foundation Trust (CDDFT) for the reconfiguration of its hospital services. Consultation on the proposals began in October 2008 and concludes on 12th January 2009. Because NHS County Durham is the body responsible for planning and purchasing health services for residents in the County Durham it is leading the public consultation.

Under Section 244 of the NHS Act 2006, local NHS bodies have a duty to consult local Overview and Scrutiny Committees on proposals for any substantial development or substantial variation in health provision in their areas. Decisions that are made in relation to these proposals will take into account views expressed during the public consultation and the contents of this report.

CDDFT has spent many months developing and refining its options for the future provision of its services across the three sites contained within *Seizing the Future* proposals. The review was initiated by clinicians at the Trust and supported by engagement with the Trusts governors, managers, stakeholders and staff. The *Seizing the Future* proposals are aimed at delivering high quality and safe healthcare services and ensuring the future of all of the Trust's hospitals.

The County Durham Joint Health Overview and Scrutiny Committee (JHOSC) established a Working Group – the County Durham *Seizing the Future* Health Scrutiny Working Group - to develop a response to the proposals on its behalf. A project plan was developed and the scrutiny review planned in discussion with NHS County Durham and County Durham Local Involvement Network (LINk).

There are a number of challenges facing CDDFT:

- The need for specialist service provision;
- Accident and Emergency (A&E) departments need the back-up of a full range of medical and surgical services;
- Need to improve children's services;
- European Working Time Directive;
- 24/7 Diagnostic cover.

These issues are explained in more detail in Section 6 of this report.

The Trust is proposing two options (see pages 21-22) to address the challenges it faces and to deliver the following benefits:

- Better access to specialist treatment
- Reduced risk of cancelled operations
- Reduced risk of hospital acquired infections
- Better rehabilitation after being ill
- Quicker tests and diagnosis
- Being on the right ward

Some communities perceive the proposals to reconfigure hospital services as a loss of some services and a downgrading of others. Therefore the Joint Health Overview and Scrutiny review has taken evidence from the CDDFT and its clinicians, and listened to the views of the trade union and a local campaign group, County Durham Local Involvement Network, and well as other public sector agencies including Durham County Council, the Fire and Rescue Service and others. The full project plan is Appendix 2.

The main findings and associated recommendations in the report conclude:

- The case for change is grounded in a strong clinical base that will provide for safe, high quality services that aim to improve patient/health outcomes;

- The case for change must be delivered through a 'whole systems' approach that takes into account:

    - the need for investment at Darlington Memorial Hospital (DMH) and University Hospital North Durham (UHND) to provide for adequate capacity to cope with the increased demand for emergency admissions;
    - transport implications for people who have to travel to both specialist and generalist services;
    - the need to ensure that services are developed as close to people's homes and in their communities – investing in community hospitals and other community based health and social care provision planned in partnership with social care providers and voluntary and community agencies;
    - the need to invest in services at Bishop Auckland General Hospital (BAGH) to ensure future sustainability including:
        - establishing a centre of excellence for rehabilitation, investment in stroke services that are delivered alongside rehabilitation services, and central hematology and pathology services (diagnostic services);
        - consideration of basing the Trust's headquarters at the hospital.
    - a systematic approach to address health inequalities and the burden of ill health in a partnership context;
    - community concerns about exactly what will be provided in district general hospitals, community hospitals, and community based facilities;

- the need to engage and involve key stakeholders and communities through ongoing dialogue in the development of service improvement proposals, informed by the outcome of the consultation exercise and the decision on hospital reconfiguration by NHS County Durham.

- The recommendations of the National Clinical Advisory Team (Professor Sir George Alberti, August 2008) should be implemented in full including:

  - Inclusion within the plans for a GP ward;
  - New facilities need to be in place before services are withdrawn;
  - Concerns about parking at Darlington Memorial Hospital must be addressed.

- The NHS Constitution, World Class Commissioning, the NHS Next Stage Review all signal the importance of involvement. Significant energy has been expended and resources committed to consulting on the proposals. The consultation has ultimately been satisfactory in that it has enabled NHS Country Durham and CDDFT to hear community views and concerns in relation to the proposals, and for this process to help share an understanding of the proposals and what they will mean for communities in future. However, there are lessons that should be learned about how this can be done more effectively in future:

  - There should be early engagement with key stakeholders, including with County Durham Local Involvement Network, to plan how to consult most effectively and to meet the duty to involve;
  - Barriers to the clear communication of messages and proposals should be better understood.

  For a summary of all the recommendations contained within this report – see Section 9, pages 55-57.

3. Introduction

> *"Major service change is about modernising treatment and improving facilities to improve patient outcomes, developing accessible services closer to home and saving lives. Sir Ian Carruthers' report on major service change, published in February 2007, was clear that patients' clinical needs must come first in any proposals. This is reiterated in the interim report of the NHS Next Stage Review, which also recognised that the best examples of strong service planning and change had been led by clinicians – with appropriate managerial support – and that no major service change should occur except on the basis of need and sound clinical evidence." (David Nicholson CBE, NHS Chief Executive May 2008 in "Changing for the better")*

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Under Section 244 of the NHS Act 2006, local NHS bodies have a duty to consult local Overview and Scrutiny Committees on proposals for any substantial development of the health services, or substantial variation in health provision, in their areas. Decisions that are made in relation to these proposals will take into account views expressed during the public consultation and the contents of this report.

This report sets out the findings of an extensive review of the proposals undertaken by Durham County Council's *Seizing the Future* Health Scrutiny Working Group before and during the full period of the public consultation.

4. Background to the proposals

Strategic drivers for the CDDFT proposals include Lord Darzi's (Parliamentary Under Secretary of State at the Department of Health) report on the future of the NHS *Our NHS, Our Future* (July 2008) and the NHS North East's strategic vision for transforming health and health care services within North East England *Our Vision, our Future, Our North East NHS* (May 2008). In 2006, two white papers established important principals which are driving modern health service provision: *Our Health, Our Care, Our Say* proposing more care in the community and care as close to home as possible were established; and *High Quality Care for All* which placed emphasis on safe, high quality 24/7 emergency care with patients travelling further if this was required, at the same time as improving local care wherever possible.

The interim report of the **NHS Next Stage Review**, prepared by Professor Lord Ara Darzi and issued in October 2007, emphasised the need to:

- Ensure that any major change in the pattern of local NHS hospital services is clinically led and locally accountable, by publishing new guidelines to make clear that;
- Change should only be initiated when there is a clear and strong clinical basis for doing so;
- Consultation should proceed only where there is effective and early engagement with the public;
- Resources are made available to open new facilities alongside old ones closing.

The Next Stage Review recommended that a set of guidelines on how local areas should undertake major changes to NHS services should be published, based on the principles and recommendations set out by Sir Ian Carruthers (acting chief executive of the NHS in England at the time) in February 2007 namely:

- Change will always be to the benefit of patients and, where appropriate, their carers. This means that they will improve the quality of care that patients receive – whether in terms of clinical outcomes, experiences, or safety;
- Change will be clinically driven. We will ensure that change is to the benefit of patients by making sure that it is always led by clinicians and based on the best available clinical evidence;
- All change will be locally led. Meeting the challenge of being a universal service means the NHS must meet the different needs of everyone. Universal is not the same as uniform. Different places have different and changing needs – and local needs are best met by local solutions;
- The local NHS will involve patients, carers the public and partners. Those affected by proposed changes will have the chance to have their say and offer their contribution;
- NHS organisations will work openly and collaboratively;

- Existing services will not be withdrawn until new and better services are available to patients so they can see the difference.

The Interim Report of the NHS *Next Stage Review* recognised the benefit of clinical involvement when considering major service change proposals. It also set out a recommendation that any proposals to change services should, prior to consultation, be subject to independent clinical and management assessment.

These assessments have been provided for all schemes from April 2008 through the Office of Government Commerce's (OGC) **Gateway Review Process**. The Gateway Review Process is a series of short, focused, independent peer reviews carried out at key stages of a programme or project. The reviews are designed to highlight key risks and issues, which if not addressed would threaten the successful delivery of the business outcomes. The review process usually takes approximately 3–4 days and involves interviewing a wide range of key stakeholders, including clinicians, patients, users, boards, staff and responsible managers for the programme. At the end of the review the Gateway Review Team provides a short, focused report outlining key findings and recommendations. The Gateway Review Team will take account of the findings of the independent clinical review process conducted by the National Clinical Advisory Team (NCAT) or – and in agreement with the Department of Health – be based on any other such clinical advice that may be appropriate that will precede the Gateway Review.

The Gateway Review of the *Seizing the Future* proposals took place from 29th July to 1st August 2008. The review concluded that CDDFT has a good strategic grasp of the issues and workload ahead, and has confidence that the next stage of activity can be completed successfully. It commended the involvement of clinicians, governors, staff, the OSCs and others and the effectiveness of communications. The review indicated a status of Amber i.e. the programme should go forward with the following recommendations addressed:

- Ensure that the evidence supporting the options is made transparent in the consultation document;
- The Trust should produce an integrated business case which takes into account the wider capital expenditure initiatives;
- Ensure that the consultation strategy and plans being developed set the proposals in a whole systems context and is comprehensive in covering all segments of the community affected;
- Review the current risk and issues process in terms of rigour and scope and consider the adoption of a joint risk register with the PCT;
- Develop a change management plan for handling the implementation. This will become more detailed during the consultation process.

CDDFT has spent many months developing and refining its options for the future provision of its services across its 3 sites contained within *Seizing the Future*. The review was initiated by clinicians at the Trust and supported by engagement with the Trusts governors, managers, stakeholders and staff. The Northeast SHA requested clinical review by

National Clinical Advisory Team (NCAT) to provide clinical quality assurance of the suggested reconfiguration of hospital services, particularly those provided at Bishop Auckland. Professor KGMM Alberti, supported by Mr Patrick Garner, visited the Trust at the Darlington and Bishop Auckland sites on the 31st July and 1st August and this report is attached as Appendix 3. It proposed significant modifications to the Trust's proposals but its central conclusions are noted below:

- No change is not an option.
- There should be two full acute sites and a "plus" site. It seems inevitable and sensible that BAGH should be the "plus" site.

It should be noted that in 2002 Lord Darzi reported on acute services in County Durham and at that time suggested a series of changes which allowed most services to continue in all three of the Trust's services (although acute surgery was withdrawn from Bishop Auckland and other services curtailed). Since then the challenges facing the Trust remain but there have been major changes in policy as well as in medial care – these policy drivers are noted above.

IMPORTANT CONSIDERATIONS:

- Change should only be initiated when there is a clear and strong clinical basis for doing so.
- Consultation should proceed only where there is effective and early engagement with the public.
- Resources are made available to open new facilities alongside old ones closing.

The consultation process

The consultation process was a formal statutory process of 13 weeks which in this instance has been extended to 14 weeks to take account of the Christmas holiday period, ending on 12 January 2009. There are four key partner organisations involved in the process. These are:

- NHS County Durham as commissioners will lead the process and one of their roles is to ensure that the process is robust, completely above board and that it gives people the opportunity to have their say;
- County Durham and Darlington Foundation Trust;
- Consultancies: Proportion has been appointed to manage the consultation process and the handling of responses;

- M & M are developing the consultation document and will be responsible for communications and awareness raising. They will also help to manage the issues that arise during the process.

As part of the process a suite of documents need to be developed which will help people to understand the process at their level. Mail shots went out to all households and web links were also be provided. A series of sixteen public meetings were arranged. It was stressed that careful consideration needed to be given on how they were arranged and to ensure that the right locations and participants were engaged to achieve a constructive dialogue and a two way communication process.

A series of drop in sessions were arranged at local shopping centres which allowed people to have a one to one discussion with key players and to register their comments. It was important that different media and different formats were used to try and reach all levels of the community.

Proportion was responsible for managing all information received during the consultation. It was important to understand that if the issues and information had arisen in the community, they could be addressed. The consultation process was launched on 6th October with a media awareness raising event.

5. The Scrutiny Review: Methodology, Terms of Reference and Membership

5.1 Methodology

The County Durham Joint Health Overview and Scrutiny Committee (JHOSC) established a Working Group - the *Seizing the Future* Health Scrutiny Working Group - to develop a response to the proposals on its behalf. A project plan was developed and the scrutiny review planned in discussion with NHS County Durham and County Durham Local Involvement Network (LINk).

During the scrutiny review eight formal evidence gathering meetings were held at which an extensive range of stakeholder organisations (13) were invited to give their views and opinions to the Working Group. Full details of the meetings and stakeholders who gave evidence are included in the project plan as Appendix 2. In addition, written evidence was received from stakeholders and other interested organisations unable to attend the formal meetings. In addition, Durham County Council invited Professor Sir George Alberti, the national expert on acute services, from the National Clinical Advisory Team, to give his views on the proposals to all councillors, and this information too is included with the deliberations of the health scrutiny committee on these proposals.

Members of the Working Group visited both Darlington Memorial Hospital and Bishop Auckland General Hospital to find out more about the sites affected in the proposals and to inform their deliberations.

County Durham Local Involvement Network (LINk) has been involved throughout the process and a board member of County Durham LINk has been co-opted as a Member of the Working Group. The LINk, together with Durham County Council's Community Development Team, has played a valuable role in assessing the consultation process for *Seizing the Future* and identifying gaps in the process.

5.2 Terms of Reference

The full Terms of Reference of the Working Group is attached as Appendix 1. The main purpose of the Working Group is to examine the proposals and consider evidence to asses whether they:

- Meet the needs of our patients, communities and adhere to best practice in terms of clinical outcomes, patient safety and achieve national standards.
- Meet the emerging recommendations of the national review led by Lord Darzi.
- Are in line with PCT commissioning intentions and local health improvement strategies; reflect planning for community infrastructure, respond to the *Big Conversation.*
- Identify regional planning implications.

- Demonstrate an effective and clinically driven case for change that meet the need of communities and deliver improved health outcomes.
- Take into account the socio economic implications for change; accessibility, transport.
- Include adequate and effective consultation arrangements.
- Provide value for money.

5.3 Membership

The *Seizing the Future* Health Scrutiny Working Group comprises the Chair and Vice Chairs of the County Durham Joint Health Overview and Scrutiny Committee and a representative from each District Council in the County, as well as co-opted members of the County Durham Local Involvement Network. The full Membership of the Working Group is detailed in Appendix 1.

6. The Case For Change - County Durham and Darlington Foundation Trust

6.1 Introduction

The Trust's *Seizing the Future* proposals are aimed at delivering high quality and safe healthcare services ensuring the future of all of the Trust's hospitals. The proposals are driven by changes in the way modern health services are to be delivered. Because over the coming years more services are to be provided closer to home reducing the need for hospital visits, and because standards are being driven up by new technology, treatments and guidance on best practice, the Trust needs to respond to these changes to continue to meet patients' needs for high quality care and make the best use of all its sites.

The Trust provides hospital services from three main sites: Bishop Auckland General Hospital, Darlington Memorial Hospital and University Hospital of North Durham. In addition it runs two community hospitals at Chester-le-Street and Shotley Bridge.

The case for change lies in improving outcomes for patients and it is why the project is being lead by clinicians. The issues facing the Trust are around patient safety and quality of services. Therefore they need to ensure they have the right numbers of staff with the right skills and that there are sufficient patients. This has arisen over the last 10 years with the move to specialisation and the achievement of better outcomes for patients. Staff cannot become specialists if they do not see enough patients. As an example this has occurred in the treatment of cancer where patients may be diagnosed at their local hospital but will go to a specialist centre for treatment. This has resulted in an increase in survival rates. Patients who suffer heart attacks are now taken to specialist centres for immediate stenting, which improves survival rates.

There is also an issue with recruitment and retention of staff. If the Trust wants to recruit the best staff it needs to provide the right environment. Staff will not come to work for the Trust if it is unable to offer the structure of services which will enable them to specialise and to meet their professional standards. By creating these structures the Trust receives accreditation for the training of junior doctors. There are areas where the Trust is struggling to recruit staff. Training accreditation for anaesthetics was lost several years ago at Bishop Auckland because the Hospital was unable to offer the support and experience and as a result the Trust has struggled to recruit consultant anaesthetists.

The other area where the Trust has been challenged to recruit staff is in paediatrics. Fewer children now come into hospital as best practice recognises that children should be with their parents and care is provided closer to home. In February 2007, the Healthcare Commission rated the Trust as "weak" in a review of children's services. Although an action plan has addressed some of the concerns raised, other problems remain as a result of services being spread over three sites.

If the Trust were to take no action there will be a need to continually put in place emergency contingency plans to sustain services. It is estimated that to keep services at the present standards will cost a minimum £2M without any improvements to services.

6.2 Challenges facing the Trust

The Trust believes that there is significant evidence that hospitals in County Durham and Darlington need to change if they are to provide services which meet the expectations of a modern health service and offer patients high quality services to nationally recognised standards. Whilst some services are to be provided closer to patients' homes via community based provision and 'hospital at home', there are other services which need to be provided more centrally in order to be safe, sustainable and of high quality – these are specialised services.

Challenges facing the Trust are summarized below:

6.2.1 The need for specialised service provision

The Trust believes that specialisation provides benefits to patients by improving outcomes of care. Doctors specialise and a surgeon who performs the same operation many times becomes more skilled at it than the surgeon who does so less frequently. However, to provide specialist care, doctors and surgeons need to work together in bigger teams covering larger populations. The Royal College of Surgeons recommends that acute hospitals should each serve at least 500,000 people if staff are to develop and retain specialist skills – this the total population served across all three of the Trust's hospitals. Bishop Auckland, Darlington Memorial and University Hospital are small hospitals serving small populations. The Trust believes that it will be unable to sustain safe services in acute medicine, accident and emergency, critical care and children's services, in particular at Bishop Auckland and Darlington Memorial.

6.2.2 A&E departments need the back-up of a full range of medical and surgical services

Back-up of a full range of medical and surgical services is required to make sure that all of the expertise a patient might need in an emergency is available. This support does not exist at Bishop Auckland, where on site emergency surgery has not been available for several years following the local Darzi review of services. National guidance now suggests this puts patients at risk.

A&E also needs the support of an intensive care service. The intensive care service at Bishop Auckland struggles to recruit the doctors to provide out of hours cover for ill patients and this problem is expected to worsen.

Accreditation by the Royal College of Anaesthetists for training of junior doctors was removed because of the inability to provide the appropriate range of experience for trainees as a result of the medical only workload.

The Trust believes that the best outcomes for patients are achieved in bigger A&E departments where more specialist services are available, and if patients need to travel further for treatment, with the appropriate paramedic support on the way to hospital, there will be no adverse effect on health outcomes.

6.2.3 Need to improve children's services

The Healthcare Commission rated the Trust as 'weak' in a review of children's service*s* in February 2007. National recommendations suggest that where small units are located in close proximity to larger units, consideration should be given to amalgamating services in order to provide the level of specialist care that is now expected. This allows paediatricians to maintain and develop their skills to improve standards of care. Currently the Trust is unable to recruit the necessary calibre of staff to maintain smaller teams across three sites, and in future larger more specialised teams will be required.

6.2.4 European Working Time Directive

From 2009, junior doctors' working hours will reduce from 56 to a maximum of 48 hours a week, representing a loss to the Trust equivalent to 31 full-time doctors. In responding to this challenge the Trust cannot simply recruit more doctors, as this would dilute their training experience. There needs to be a combination of new roles for other staff, such as nurses, and the need to reduce the number of on call rotas that are operated.

6.2.5 24/7 Diagnostic cover

Currently the Trust is only able to provide limited diagnostic cover 24 hours a day, seven days a week at all three sites. In order to expand the range of diagnostic services and to provide treatment, support is required around the clock from other clinical support staff and this cannot be achieved across all three sites.

7. Evidence in relation to the options for future service provision by County Durham and Darlington Foundation Trust

The Trust believes that doing nothing is not an option and that this view is supported by a range of clinical evidence including the report of the National Clinical Advisory Team (Professor Sir George Alberti, August 2008) and is set within the context of Lord Darzi`s next stage review.

The Trust is therefore proposing two options (A and B – see pages 21-22) to address the above challenges and to deliver the following benefits:

- Better access to specialist treatment – bringing specialists together on two sites to cut the number of "single-handed" specialists and improve care.
- Reduced risk of cancelled operations – having planned care and emergency care in different hospitals would mean operations were less likely to be cancelled because of emergencies.
- Reduced risk of hospital acquired infections – separating planned and emergency care reduces cross infections.
- Better rehabilitation after being ill – the new unit at Bishop Auckland would be a new development for the area giving access to more intensive physiotherapy and other therapy support.
- Quicker tests and diagnosis – more diagnostics available 24/7.
- Being on the right ward – for example reducing medical patients staying on surgical wards, making sure patients are cared for by nursing staff experienced in their condition.

7.1 Acute Services

The Working Group received evidence that CDDFT proposals are to concentrate their main acute services on Darlington Memorial Hospital (DMH) and the University Hospital North Durham (UHND). Bishop Auckland General Hospital (BAGH) will be developed as a planned care centre supporting and complementing the acute sites. The services at Shotley Bridge and Chester-le-Street will be mainly unchanged apart from additional outpatient appointments and an increase in day care surgery at Shotley Bridge Hospital.

In terms of acute medicine, in the modern path of care it is recommended that the sickest patients need to be managed by specially trained consultants called acute care physicians. They are supported by a team of 'ologists' i.e. cardiologists, gastro-entologists etc. After a period of 12 to 24 hours the patients will be handed onto the 'ologists' to receive specialist care which will result in a better outcome with patients leaving hospital earlier. This model of care is provided in Durham because the hospital has sufficient staff to provide that level of support. It has not been possible to offer this level of care at Darlington and Bishop Auckland because of the number of physicians that are available.

It was explained that critical care is the cornerstone of acute care. Bishop Auckland has struggled to meet recommendations made in 1997 on staffing levels. A recent recommendation on the level of critical mass of activity to maintain a level three unit (i.e. caring for the sickest patients) means that there is insufficient activity across the County to maintain three level three units.

Whilst some services will be moved, many of the existing services will remain with other services being developed. The Trust is planning to develop a centre for rehabilitation excellence at Bishop Auckland which will be suitable for 100% of stroke sufferers.

The Working Group was informed that Bishop Auckland had been chosen as the planned site because it is reasonably geographically central and the quality of the facilities that are available. The independent report by Professor Alberti on behalf of the National Clinical Advisory Team supported the clinical model in the review of '*Seizing the Future*'.

Changes to the role of one of the sites will have an impact on the workforce as a result staff will need to transfer between sites. There are more staff based at Durham and Darlington than at Bishop Auckland. If Durham or Darlington were to be the planned centre approximately 1,000 staff will have to move. If the centre is based at Bishop Auckland around 100 staff will have to move.

Changes to the hospitals will have an impact on patient flows, particularly on those close to the boundaries of other hospitals. It is estimated that making Bishop Auckland the planned site will result in the loss of 3,000 acute activity episodes. Basing the planned centre at Darlington will mean the loss of 9,000 acute activity episodes, while basing it at Durham could lead to the loss of 22,000 acute activity episodes. This is an important consideration because loss of patients would mean loss of income and all of the Trust's services would become less viable.

The Working Group were informed that there is a range of cases that do not come to the A&E department at Bishop Auckland. A proportion of heart attack patients already travel to specialist centres at James Cook Hospital and the Freeman Hospital for immediate treatment. Patients with serious injury/trauma have been taken to Darlington for the last 8 years. Major head injuries are already taken to James Cook or to Newcastle. It was stressed that the site will not be closing and two thirds of 'A&E' patients will still be seen and treated at the site. A proportion of patients will benefit from seeing specialist staff and will have to travel further for treatment. As an example it was explained that two of the sites have single handed specialities. If the appropriate specialist is away a patient will see a general physician and, whilst they will get good care, they will not receive specialist care. By centralising services on one site this will enable patients to see specialist staff.

The Working Group was advised that there is no evidence that a patient's condition worsens when they are transferred by ambulance to a specialist centre. There is usually a better outcome for the patient when they are treated at specialist centres. Paramedics will often spend time stabilising a patient before transporting them to the hospital which has the

right services for their condition. It has been noted that there are concerns about response times in Teesdale and Weardale. The PCT has invested additional resources in the area and this is expected to improve response times. The Trust has been working with North East Ambulance Service (NEAS) and they have confirmed that they will take account of the changes if the proposals in '*Seizing the Future*' are approved.

7.2 Accident and Emergency (A&E)

In determining these options the Trust advised the working group that Bishop Auckland Hospital does not meet the recommendations of what a full A&E should be. There is insufficient A&E activity in the County to have three full A&E Departments. The A&E department has not taken major trauma cases for the past 8 years. It has dealt mainly with minor injuries and medical emergencies.

Referring to A&E attendances by time of day, it was explained that there are approximately 50,000 patients attending each A&E Department at Durham and Darlington and around 30,000 patients attending A&E at Bishop Auckland during 2006/07 and 2007/08. Most of these patients attend during the day time and this allows the hospitals to plan for this. Most of the patients attending during the evening period have minor problems. Patients with medical problems will usually attend during the daytime and hence the development of the medical rapid assessment clinic. This will allow patients to be assessed by a consultant, undergo tests, and, if well enough, be allowed to go home rather than be admitted to hospital.

In relation to the additional A&E patients to be treated at Durham and Darlington, these would be the most acutely ill patients who would need admission and treatment from a specialist. Two thirds of "A&E" patients will continue to be treated at Bishop Auckland. It was explained that no two hospitals offer the same A&E service. There have been occasions when patients have presented themselves at Bishop Auckland and have had to be transferred in an emergency to Durham or Darlington.

7.3 Planned care considerations

It was explained that if Darlington were to become the planned care centre it would cost £120M to make the changes to support this move – mainly to extend the Bishop Auckland site, which is the smallest of the three hospitals, to absorb the additional acute workload. Analysis of patient flows indicates that this option would have serious effect on the Trust's income. The largest conurbations are at the north and south of the County and to be sustainable as a business they need to retain Darlington and Durham as acute sites. It was further explained that a scheme is underway to renew the infrastructure of Darlington and has been ongoing for the last 18 months. This work would still need to be undertaken even if Darlington became the planned care centre. The Trust does not expect there to be a movement of patients from Darlington when the new hospital at Wynyard Park (between Stockton and Hartlepool) opens. To the south of Darlington, North Yorkshire PCT is carrying out a review of services in Hambleton and Richmondshire, which includes services at the Friarage, and Darlington may benefit from any changes.

It is expected that work currently undertaken in hospitals will be provided more locally in the future such as diagnostics and assessments. The primary consultation should be made as close to where the patient lives. However it was explained that patients may then need to travel a little further in order to receive specialist treatment. It is expected that routine care will be accessed closer to home. In order to make best use of existing facilities the Trust will be offering more day surgery at Shotley Bridge. Consultants from UHND also hold clinics at Shotley Bridge and Chester-le-Street and other settings and perform surgery at Shotley Bridge as well as in Durham. The Trust has evidence that patients are willing to travel if they receive a high quality service. There will be the option to receive rehabilitation services at Shotley Bridge but there may be some patients who need intensive rehabilitation to go to Bishop Auckland. It was further explained that if acute care is concentrated on two sites then other services will have to move and this will result in more services being provided locally.

The Working Group was informed that the Trust had to bid against North Tees and Gateshead for the colorectal screening unit. If they had not been successful all County Durham patients would have had to travel further for screening. The colorectal screening unit will be at Bishop Auckland and all patients will have to travel there for screening.

In relation to services at Shotley Bridge it was confirmed that there are no plans to downgrade services at the site. Patients treated at Shotley Bridge will not be expected to travel to Bishop Auckland. Some patients from the Durham and Chester le Street areas will need to travel to Bishop Auckland or Shotley Bridge for day surgery.

7.4 Paediatrics

In terms of the paediatric services, the Working Group were informed that at present there are two acute services at Durham and Darlington. At Bishop Auckland acutely ill children are seen by clinicians and they might stay overnight if they are stable and won't require medical attention during the night. No new admissions are taken in overnight at Bishop Auckland. One of the problems of caring for acutely ill children is that many children will come to hospital because there are concerns that they may develop a serious illness though only a small number will do so. If a service is offered, even for a small number of seriously ill children, then the service must be staffed accordingly. It was explained that from March to July this year that on ten nights there were no patients, on 30 occasions there was one patient and on another 30 nights there were two patients. It was pointed out that even if there is only one child on the ward there needs to be two trained nurses on duty. There were 1400 emergency attendances at Bishop Auckland in the last year, which is an average of 3 or 4 cases per day. It is felt that acutely ill children will benefit from travelling to a fully equipped unit as most will be admitted for only a short time under observation and assessment.

7.5 Outpatients

A full range of out patient services will be maintained at Bishop Auckland and there is no intention to reduce this. It is expected that children who have been dealt with at the main units will be able to have their follow up appointment locally at Bishop Auckland. The Rapid Assessment clinic will deal with children where GP's have concerns and need a second opinion without the need to wait for an out patient appointment.

7.6 Obstetrics and Gynaecology

It was explained that there will be no changes to the maternity services. Across the County the gynaecology services have been successful and outreach services are provided to patients which enables them to be nursed at home.

7.7 Option A

This option proposes to redevelop Bishop Auckland as a planned centre for supporting and complementing Darlington Memorial and University Hospital – side by side with local health services and 24-hour urgent care; and concentrating main acute services at Darlington Memorial and University Hospital.

At **Bishop Auckland** services will include:

- Day case and inpatient surgery
- Cataract centre
- Hip and knee surgery
- Midwifery-led unit
- Colorectal screening centre.

Hospital services for the local community including:

- A full range of outpatient clinics in medicine, surgery and women and children's services
- Diagnostic tests, including X-ray, CT scanning and MRI
- An urgent care centre operating 24 hours a day
- Intermediate care inpatient beds for the local population.

At **Darlington Memorial Hospital and University Hospital of North Durham** services will include:

- Accident and emergency
- Acute medicine
- Emergency surgery
- Planned surgery
- Obstetrics

- Gynecology
- Pediatrics
- Outpatients
- Diagnostics (e.g. X-ray, CT scanning and MRI).

7.8 Option B

This option proposes the service changes outlined in Option A, plus additional services at Bishop Auckland, to enhance its urgent care provision and further increase its role as a planned care centre:

- A Trust-wide rehabilitation centre of excellence – a completely new service for the area
- Intermediate care inpatient beds serving the whole of the Trust
- Rapid medical assessment centre for GPs to refer patients for an urgent consultant opinion
- Pediatric rapid access clinic – where GPs may refer children for an urgent consultant opinion.

Outpatient clinics and diagnostic tests (e.g. X-ray and other scans) would still be provided at all three sites. Under both options, community hospital services would continue at Chester-le-Street and Shotley Bridge, and the Trust is proposing the future development of these services. To maintain local access, both options also propose an increase in day surgery at Shotley Bridge, securing the future of the day case unit.

7.9 The Trust's preferred option

The Trust's preferred option is Option B – to enhance access at Bishop Auckland for medical patients and strengthening its role as a planned care centre, and providing a new service to improve the care of patients needing rehabilitation following acute illness.

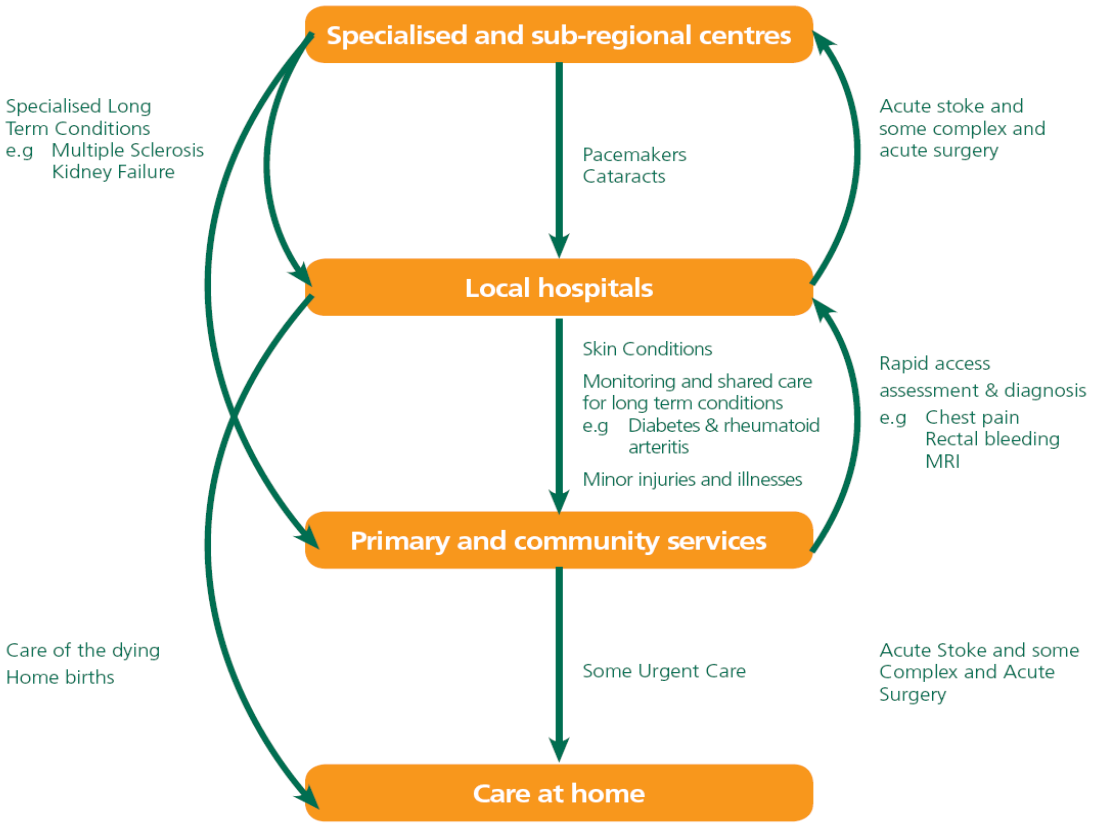
8. Response to the consultation proposals

Responses provided here are based on the deliberations of the Health Scrutiny Working Group, considering the case for change expressed by the Foundation Trust and the evidence presented to the Working Group by stakeholders.

8.1 North East Strategic Health Authority (SHA)

Evidence from the SHA is that the North East of England has the highest dependency on acute hospitals in the Country. The SHA approach is to ensure the whole system of health service provision is able to meet the key health challenges in the region. In terms of health outcomes for the population of the region and county as a whole, more emphasis needs to be placed on prevention rather than cure and to tackle the big issues of smoking, binge drinking, healthy eating and physical activity. In terms of healthcare provision this will need to be more personalised, local where possible, balancing clinical quality, safety and local access. To achieve this will require a fundamental rebalancing of overall healthcare provision - set out diagramatically below - where some services will move to more specialist provision and others to more local provision.

Rebalancing the system:



It is in this context that the scrutiny review has been determined to assess the overall sustainability of the reconfiguration, in particular in relation to the proposal for two acute hospitals serving the Trust's 'catchment' area within County Durham and Darlington.

Evidence from the Royal College of Surgeons (Appendix 4) suggests that acute hospitals should serve populations of at least 500,000 people if staff are to retain the specialist skills expected of them by todays standards. In all the total population served by the Trust is 500,000 across all its sites. The Strategic Health Authority has indicated that the Royal College of Surgeons now believes that populations of 300,000 may be a workable interim position (Appendix 12). The Trust has indicated that a 2 acute site option is practicably workable model for a rural area such as County Durham, and that rotas for specialist staff and quality of care/critical mass issues can be adequately addressed over two acute sites, and that three sites is unworkable for the reasons set out in the case for change.

Members have been keen to determine whether, in the longer term, the approach the Trust is proposing is sustainable. In particular, as this consultation covers plans for periods of only five years, in the medium term, with the future provision of a new hospital at Wynyard, and when patient choice and demands for more modern facilities become more important to patients, then Darlington Memorial Hospital may be at risk of not having a long term sustainable future.

IMPORTANT CONSIDERATIONS:

- Evidence for rebalancing of healthcare systems and the Trust's proposals are understood and supported.
- Visits have been undertaken by Members of the Working Group to all the hospitals affected by the proposals and have proved very useful in developing understanding of the assets the Trust has. The proposals are for better use of the Trusts assets and for a more sustainable configuration of its assets.
- A systematic approach to addressing the burden of ill health /health inequalities through partnership based approaches between the NHS and Local government in the main is required. Investing in Prevention and not just cure.
- Long term viability of 2 hospitals serving a population of under 700,000 across County Durham and Darlington must be seen within the context of hospital developments and provision with in the region and sub-region namely Teesside and surrounding areas.

Recommendation:

The *Seizing the Future* Health Scrutiny Working Group note key evidence in relation to the rebalancing of health care systems as described, and recommend that this rebalancing of health care systems model be used to prioritise investment in prevention rather than cure.

8.2 Professor Sir George Alberti - National Clinical Advisory Team (NCAT)

Professor Sir George Alberti explained his background and the background to the establishment of NCAT. All consultations now must have a clinical review. The key questions asked when undertaking a review includes is it good for patients, what does it do for access and is it sustainable. Professor Alberti said that what impressed him about the proposals were that clinicians were involved in formulating the proposals and that CDDFT and NHS County Durham were working together.

He explained that the problem with the current configuration is that there is not enough staff for three acute hospitals and an insufficient volume of patients for three acute hospitals. It is important sick patients are able to see an experienced doctor straight away whenever they are admitted on all three sites. In addition all three sites need to be able offer a fully operational intensive care unit, x ray/diagnostic services on a 24 hour basis. Emergency surgery has already moved from Bishop Auckland. Providing critical care is not cost effective because of the limited numbers. The team examining the proposals has considered options but were of the view that two acute hospitals are sustainable. It is expected that 10-15 patients per day will be affected with 8 patients a day having to travel further. In relation to concerns about whether patients would die because they have to travel further, he explained that evidence from Scotland and Cumbria indicated that an extra 20-30 minutes travel would not lead to further deaths. There is evidence that patients with serious breathing problems would benefit from attending the nearest hospital. This can be dealt with by better training for paramedics. It was emphasised that treatment starts from the time the paramedic arrives and not when they arrive at hospital.

Patients with heart attacks do not attend the local hospital but will be transported to James Cook (Middlesbrough) or Freeman (Newcastle) Hospitals. Similarly major trauma patients are transported to James Cook or Newcastle. Discussions are ongoing on where stroke patients for the North East will be treated in future.

There is a need to provide a good quality urgent care unit to replace the current A&E and walk in centre at Bishop Auckland, which will deal with about 22,000 patients per year.

Referring to the White Paper *Our Health Our Care Our Say* Professor Alberti expressed the view that there is a need to provide more outpatient appointment services and treat patients close to home. Step down care needs to be provided and patients should be moved from specialist centres to their local hospital when it is safe to do so. There needs to be an assessment service to deal with elderly patients with complex problems to enable them to be seen by an expert. This will prevent hospital admissions.

It was stressed that Bishop Auckland will not be closing as the facilities are needed. In addition the community hospitals need to be used to provide local services, outpatient appointments and step down care. He expressed the view that if the proposals are not accepted it will set back health services in County Durham.

8.2.1 Regarding capacity - If the changes go ahead, the Trust will have to make sure that the other two hospitals have the capacity and staff to ensure that services are safe and better than they are now. He stated that he did not think that Bishop Auckland could be upgraded to make it a safe hospital for 12 acute emergencies a day. What can be done is to provide better care in other areas which can be provided locally. There are inadequate numbers of staff in intensive care and A&E is not properly staffed. The proposals will ensure that there is safe care for the 10/12 people every day who will need to travel further. Staffing numbers will need to be tripled to ensure that there is safe round the clock emergency care. When a new urgent care unit is provided the proposals will only affect a small number of people.

However it is unclear how future demand for services particularly A&E has been assessed and is to be met. At present 30,000 people access A&E services at BAGH and Trusts assessment is that about two thirds would be able to receive treatment at the proposed Urgent Care Center at BAGH. From modeling that the Trust has done it is estimated that 9,000 people (although this may be reduced by those who receive critical care in the urgent care assessment centers) will be transferred to other A&E departments by ambulance:

- 5,000 to Darlington
- 4,000 to Durham

The National Clinical Advisory Team (NCAT) Report (Appendix 3) also recommended:

- that the numbers of local people to be seen at BAGH in the future compared with now should be estimated as well as the numbers who will have to travel to one of the other sites allowing for the fact that some major emergencies will be assessed at BAGH and returned to the community without needing admission;
- There should be a clear account of how the extra emergency workload will be coped with at UHND and DMH should be included, together with the extra investment required, particularly at DMH;
- Parking at DMH is a concern and with expansion in A&E is expected to be exacerbated – although this may be offset by moving numbers of rehabilitation and other planned case to BAGH. The Trust is looking seriously at other options for expanding car parking capacity by 100 spaces.

8.2.2 Regarding access for Dales residents - It was explained that there is a need to talk to the people to fully explain the proposals and to get away from the idea that the hospital is being downgraded or closed. 15% more people from the area will be treated locally and this will benefit the people from the Dale's area. Once the acute episode is over people should be moved to a hospital near to where they live.

8.2.3 Regarding changes to services - New facilities need to be in place before services are withdrawn, as well the Trust need to having a vision on where they want to be in 5 years time. The Trust need to have an implementation plan and this should be made available to the public.

It could be inconvenient for people in the Dales to travel to Darlington and particularly if an ambulance is not based 24 hours per day at St Johns Chapel to deal with emergencies.

The Trust understands the mistrust of the public but there are very clear plans for Bishop Auckland. The majority of day surgery in the County will be happening at Bishop Auckland and there is a clear commitment to Bishop Auckland. Bishop Auckland hospital is under utilised and this is not a good use of public money.

Recommendations by NCAT (Appendix 3):

- The Urgent Care Centre at BAGH should be a fully integrated primary/secondary care service incorporating the GP Out of Hours service. It should be open 7 days a week.
- The proposed Medical Assessment Centre should focus on the needs of older people; be available for GP referrals; be open 7 days a week for 10 hours per day on weekdays and at least 6 hours/day at week-ends; and be staffed by experienced clinicians i.e. consultants or final year Specialist registrars.
- There should be an appointment based urgent paediatric service.
- Outpatient services should be expanded to meet the needs of the local population and follow-up appointments for local people after admission to the acute sites be organised at BAGH wherever possible.
- Plans should include a GP ward.
- An urgent care advisory board should be established to ensure smooth pathways of care and to plan optimal services. This should include social services, the ambulance service, pharmacies, other providers of services as well as the PCTs and the Hospital Trust. Similarly an older people's board could usefully be established to plan for older people's care and needs across the whole system.

8.2.4 Regarding standards of care - they have changed considerably. In 2002 the recommended level for critical care was at level 2 which is now level 3. The difference between the levels means that medical staff have to be available overnight so that they are immediately available. The Trust is no longer able to use trainees. The Trust has tried to recruit six doctors for the past eighteen months but has not been able to recruit. There is insufficient activity to allow surgeons to remain skilled and to be recognised as specialists. There is not enough activity for three acute services which includes A&E and critical care. 2008 standards cannot be met on three separate sites and it is because of the standards and quality of care that the Trust is changing services. The future of Bishop Auckland as the elective centre is important to the Trust and its role will grow in future.

The experience following the merger between Shotley Bridge and Durham is that it is easier to recruit staff now that there is a bigger team and they are able to undertake more specialist work than it was when they were two separate hospitals. There is no

problem in recruiting to Durham but there are problems in recruiting to Darlington and Bishop Auckland. There is difficulty in recruiting to anaesthetics at Bishop Auckland because there is no training recognition and no trainees. There is no emergency surgery carried out at Bishop Auckland.

Service commissioners are very interested in using the community hospitals and it is their intention to provide more activity at those hospitals. Views raised through the consultation process will be listened. The transport issue is a case in point. - the PCT did listen to views on ambulances services in the Dales and provided an extra £600,000 of investment.

8.2.5 Regarding services at the nearest hospital - People who are very sick want to be able to access services at the nearest hospital and not have to travel further - mother with a sick child will want to go to the nearest hospital. It is not down to cost but is down to clinical care which can be sustained. There are a small number of emergencies at Bishop Auckland and there is insufficient activity to keep a consultant surgeon busy. People will not want to come to work at Bishop Auckland because there is not enough volume of work.

IMPORTANT CONSIDERATIONS:

- Proposals have been clinically led and this is a strength of the proposals.
- There are not enough specialist staff for three acute hospitals and an insufficient volume of patients for three acute hospitals to achieve acceptable levels of quality and patient safety.
- New facilities need to be in place before services are withdrawn.
- If the changes go ahead the Trust will have to make sure that the other two hospitals have the capacity and staff to ensure that services are safe and better than they are now.
- Evidence from Scotland and Cumbria indicates that an extra 20-30 minutes travel would not lead to further deaths, due to skills of paramedics.
- Patients with heart attacks do not attend the local hospital but will be transported to James Cook (Middlesbrough) or Freeman (Newcastle) Hospitals.
- It was stressed that Bishop Auckland will not be closing as the facilities are needed.
- If the proposals are not accepted it will set back health services in County Durham.
- There is difficulty in recruiting to anaesthetics at Bishop Auckland because there is no training recognition and no trainees - there is no emergency surgery carried out at Bishop Auckland.
- The issues being faced at Bishop Auckland will be faced at Darlington and at Durham and this will affect all of the service if changes are not made.
- The problems being faced in Durham are mirrored nationally - any decision on future service provision is a balance between access, quality of care and safety of care.
- Invest in community hospitals and community based services to treat and support people as close to home as possible. Where specialist intervention is required staff must be well trained the unit must have accreditation and transport implications of travel to and from hospital are planned for.
- This must be a whole system approach to improve health outcomes for patients.
- Clarification of exactly which services are to be provided at BAGH in future is required in particular what services are to be included in the 24 hour urgent care center that is not currently provided within current A&E provision.

IMPORTANT CONSIDERATIONS:

Contd…

- A Medical Rapid Assessment Clinic that is not currently included in the current acute medical and critical care services.

- Will these services include resuscitation capabilities - concerns have been noted (by Helen Goodman) that, as a center for rehabilitation, and where patients are to be transferred once an acute episode has passed, it is not clear how this would be provided in future.

- Maternity services may be compromised by the lack of anaesthetic provision for the midwife led unit if mothers experience unforeseen problems during childbirth. The Midwife-led unit service at Bishop Auckland will not change, and robust arrangements are in place, and have been in place to deal with the problems arising during childbirth, since the unit opened in 2004.

- That plans to redesign services that involve moving services from one site must be evidence based and not be fully implemented until replacement services are established and their safety audited. This will involve running services in tandem for some time and these extra costs must be factored into plans for reconfiguration. (Academy of Royal Medical Colleges {2007}).

RECOMMENDATIONS:

- The *Seizing the Future* Health Scrutiny Working Group recommend that a whole systems approach **must** take into account the following issues in order to deliver effective health care and health and well being outcomes:

  - the need for investment at Darlington Memorial Hospital (DMH) and University Hospital North Durham (UHND) to provide for adequate capacity to cope with the increased demand for emergency admissions;

  - transport implications for people who have to travel to both specialist and generalist services, via an integrated "transport for health strategy" that is adequately resourced, must be in place and be a key component of service improvement proposals;

  - the need to ensure that services are developed as close to people's homes and in their communities – investing in community hospitals and other community based health and social care provision planned in partnership with social care providers and voluntary and community agencies;

  - a systematic approach to address health inequalities and the burden of ill health in a partnership context. Undertaking a health impact assessment of service improvement proposals to ensure that the wider determinants of health and health care provision are planned for.

  - community concerns about exactly what will be provided in district general hospitals, community hospitals, and community based facilities;

  Furthermore the working group recommend that the recommendations of the National Clinical Advisory Team (Professor Sir George Alberti, August 2008) should be implemented in full including:

  - Concerns about parking at Darlington Memorial Hospital must be addressed.

  - Inclusion within the plans for a GP ward at Bishop Auckland General Hospital.

  - New facilities need to be in place before services are withdrawn.

8.3 The Royal Colleges

A desk-top exercise was conducted - see Appendix 4.

IMPORTANT CONSIDERATIONS:

- Some conditions requiring highly specialised care are best treated in specialist centres.
- There may not be enough doctors to provide safe levels of care in all hospitals.
- A doctor with skills in acute medicine should be present at all times.
- Acutely ill medical patients should not be admitted to hospitals which do not have critical care and appropriate diagnostic services. No further such services should be created.
- Hospitals which do not have critical care and diagnostic services should be reconfigured to provide intermediate or step down care.
- It is not appropriate for a consultant physician to have responsibility for emergency admissions or acutely ill patients on two separate sites.
- It is important to balance access to specialist services; which may need to be centralized with local access for patients with less intensive/ specialist needs.
- Local hospitals with an A&E department, accepting medical cases must be supported by a continuous intensive care service.
- For smaller hospitals medical emergency assessment, with unselected patients receiving rapid assessment in a local hospital, with doctors from the nearest larger acute hospital site advising - patients requiring more intensive acute care would be transferred to the larger hospital.
- Paediatric care should be delivered as part of a managed clinical network including primary care, paediatric assessment units, emergency departments, inpatient paediatric units and specialist units.
- Plans to redesign services which involve moving services from one site must be evidenced based and not be fully implemented until replacement services are established and their safety audited. This will involve running services in tandem for some time and these extra costs must be factored into plans for reconfiguration.
- Recommends that acute general hospitals providing elective and emergency, medical and surgical care should support a population of 450,000 – 500,000 people.

RECOMMENDATIONS:

- The *Seizing the Future* Health Scrutiny Working Group recommends that the NHS County Durham use the evidence from the Royal Colleges in their deliberations in particular the evidence in relation to *"….Plans to redesign services which involve moving services from one site must be evidenced based and not be fully implemented until replacement services are established and their safety audited ".*

8.4 The North East Ambulance Service

NEAS supports the need for patients to receive treatment in specialist centres, and described how for patients with certain 'high end' needs e.g. with head injury, major trauma, burns, chest pains, strokes etc it has for many years been taking patients to hospitals across the region that provide the best specialist care, and not taking patients to the nearest A&E department. It was explained that NEAS provide services across a wide geographical area though it is one of the smallest ambulance service in the country.

The *Seizing the Future* consultation document has been examined by NEAS and it is recognised that it is about maintaining and improve standards for patients and is clinically led. The proposals are about the move towards specialisation and an overall improvement in the level of care which is part of a process which has been ongoing for a number of years.

It was explained that in the past guidance required the ambulance service to take a patient to the nearest A&E Department. A feature of this model of operation is that the job cycle is short typically around 40 minutes and lead to more availability of ambulances which tended to stay local. This model was liked by crews, the local population and politicians. However the outcome was poorer for patients. In terms of high end needs, it was stressed that for serious head injury, major trauma, burns, chest pains, strokes and children there is no point in ambulances taking patients to the local A&E Department because the survival outcomes are very poor when a generalist tries to deal with issues that should be treated by a specialist. In terms of low end needs, the ambulance service will take patients to Urgent Care Centres, Urgent Care Teams, Minor Injury Units and Walk in Centres. This is part of the strategy of treating patients locally. It was explained that with the exception of James Cook Hospital, because of the range of specialities there NEAS has 'bypass' and 'deflection' policies for every other hospital in the region.

The model that is now used by NEAS is the definitive care model which involves taking the patient to the nearest hospital offering definitive care for that patient. The impact of this on the ambulance service is that it extends the job cycle and tends to reduce the level of cover. Under this model ambulances move towards urban areas and if this is not addressed it will lead to poorer response times in rural areas. The ambulance service

believes however, that this model produces much better outcomes for patients. It was pointed out that an increase in day surgery at Bishop Auckland will increase the demand for Patient Transport Services.

The changes will have an impact on the ambulance service as they will have longer job cycles and the patient will be with ambulance service for a longer period. Ambulance crews are therefore highly trained to deal with the following issues:

- Cardiac arrest and arrhythmias
- Medical emergencies in adults
- Specific treatment options
- Trauma emergencies
- Obstetric and gynaecological emergencies
- Treatment and management of assault and abuse
- Emergencies in children.

Ambulance crews are also approved to use a large range of drugs.

The Working Group was informed that NEAS will respond to the consultation by saying that they agree with the clinical rationale (i.e. definitive care). They point out that this will extend the job-cycle times in the Bishop Auckland locality and will probably impact negatively upon emergency performance. This will depend on patient flows, patient numbers, the time of day, the number of deflections and bypasses and the number of transfers together with the effect of PTS activity. NEAS will need to work jointly with the Trust and NHS County Durham in order to re-provide capacity in that area and this will be done by modelling and agreeing costs.

It was pointed out that 8/9 years ago, under the original model of care NEAS employed around 700 staff. Today they employ about 2,000 staff. As services change it is recognised that this has an impact on the ambulance service.

IMPORTANT CONSIDERATIONS:

- A whole system approach in providing safe and quality care services;
- The model that is now used by NEAS is the definitive care model which involves taking the patient to the nearest hospital offering definitive care for that patient.
- Ambulance crews are highly trained and contribute to better health and clinical outcomes;
- Patient transport arrangements should be planned as part of a wider integrated patient transport strategy

8.4.1 Does a greater distance to travel increase the risk of death

NEAS supports the need for patients to receive treatment in specialist centres, and described (Appendix 8) how for patients with certain 'high end' needs e.g. with head injury, major trauma, burns, chest pains, strokes etc it has for many years been taking patients to hospitals across the region that provide the best specialist care, and not taking patients to the nearest A&E department. 'Bypass' and 'deflection' policies exist for every hospital in the region (other than James Cook) to take patients to the nearest hospital offering definitive care for the patient.

NEAS view: Modern practice of paramedics is that if a patient is ill enough to die on the way to their nearest hospital, then the decision to bypass and take them to a specialist centre further away is based on clinical judgement that they will receive the specialist care they require for the best outcome possible, in other words – right place, right time, first time.

SHA view: Overall the evidence suggests strongly that the *real* time that makes a difference in terms of treatment outcome is the overall time it takes a patient to get to the right specialist/service. The point is that this time is usually lower when a patient requiring specialist treatment is taken directly to a specialist centre even if the transport distance is a little longer as opposed to a short initial journey to a non-specialist centre and then – in all likelihood – the need for a secondary journey to the specialist centre anyway once the patient has been assessed.

Other views:

- Professor Sir George Alberti – ''virtually no-one dies in an ambulance and 20/30 extra minutes makes virtually no difference.'' Respiratory problems provide real risks – by care provided by ambulance crews has improved significantly over past 10 years.
- A study by the Emergence Medical Care Research Unit at Sheffield University suggests claims that patients risk of death increases the further they have to travel – by 1% for every six miles they have to travel. This data has been criticized as being based on data which is 7-11 years old and paramedic practices have advanced hugely since then.
- Emergency Medical Journal May 2007 (Appendix 15). This indicates there is potential for increased mortality for a small number of patients with life threatening medical emergencies, unless care is improved as a result of service re-organisation.
- European Heart Journal 2003. Evidence suggests transfers of patients can result in fewer deaths in treatment of acute myocardial infarcation with angioplasty versus thrombolysis (Appendix 14).

IMPORTANT CONSIDERATIONS:

- The question of length of ambulance journeys is complex. There appears to be a lack of definitive evidence in relation to patient outcomes from increased Ambulance travel times vs better specialist care at specialised centres, but there is clear and overwhelming clinical and professional consensus that overall for patients it is the *real* time that makes a difference in terms of treatment outcome is the overall time it takes a patient to get to the right specialist/service.
- Role of the paramedic with highly skilled early intervention is key.
- Response times to emergencies is key and recent investment in the service in the Dales is noted.

RECOMMENDATIONS:

- The *Seizing the Future* Health Scrutiny Working Group notes the investment that has gone into the Ambulance service over recent years. It also notes that evidence on the subject of risks from increased ambulance journey times is inconclusive and recommends that there is ongoing monitoring of potential risks to patients from increased traveling for emergency treatment, with regular performance reporting to the health scrutiny committee as part of its monitoring function.

8.5 Adult and Community Services (Durham County Council)

It was explained that Adult and Community Services (ACS) accept the clinical need for change. In terms of sustainability there are concerns that the proposed changes have arisen soon after the last changes which suggests that the previous reconfiguration may not have been substantial enough. ACS would like to see a firm statement that these changes are sustainable for a certain period into the future.

ACS have identified additional vulnerable groups and the Trust have been asked to give presentations to the Older Peoples Partnership Board and the Learning Disability Partnership Board.

It was pointed out that the consultation refers to some of the County's Community Hospitals while others are not mentioned. It was felt that there should be greater clarity about Community Hospitals.

In relation to transport it was explained that there may be difficulties for residents of the Dales to access treatment and to visit families and friends. It is also felt that there is no explanation whether residents from Easington will be required to attend the colorectal screening clinic and the cataract centre at Bishop Auckland when it is easier for people from this area to attend Sunderland and Teesside.

In terms of specific issues there is concern about the definition of intermediate care and clarification is needed on what is being proposed (step-up or step-down) though it is thought that this will be 'step-down' care. If it is 'step-down' it is suggested that the terminology used in the proposals should be changed.

There is a resource issue in terms of social work assessments if the intermediate care beds are Trust wide. Social Workers undertake assessments in hospitals and may have increased travelling time to visit patients.

There is also potential duplication with the use of some of the community hospitals at Shotley Bridge, Chester le Street, and Sedgefield. It is not clear whether these will be local intermediate care beds or trust wide intermediate care beds as these will be in addition to social care intermediate care beds. ACS are preparing a joint Intermediate Care Strategy for the County, in conjunction with the PCT and the Trust's plans need to be discussed further and reflected in the strategy. Any intermediate care beds proposed by the Trust need to complement, not replicate, other resources (in the community). It was noted that Professor Alberti had commented that this proposal (i.e. County-wide beds) would be inconvenient for patients and families.

In relation to the countywide rehabilitation centre of excellence, there is concern that the proposal will have resource implications with social workers having to travel from all areas of the County to make assessments. In addition this will lead to additional travel for patients and families. ACS supported the rapid medical assessment centre at Bishop Auckland if it was for local residents only.

In response to questions about community hospitals it was explained that the consultation is about the services provided at the acute hospitals. NHS County Durham wants to see more services provided at community hospitals. A strategy for community hospitals is being developed but is not ready for consultation at the present time.

IMPORTANT CONSIDERATIONS:

- Guarantee of future sustainability
- Use of Community Hospitals
- Relationship with Social Care
- Definition of Intermediate care referred to in proposals

RECOMMENDATIONS:

- The *Seizing the Future* Health Scrutiny Working Group notes the important relationship with Durham County Councils Adult and Community Service in meeting the healthy and social care needs of our communities.

- The *Seizing the Future* Health Scrutiny Working Group recommends that as part of the "whole systems" approach to planning health - social care delivery must be an integral function of that planning.

8.6 Public Health

The key public health domains are health protection – emergency planning, major incident involvement, flu pandemic planning, infection control, safeguarding children, community safety immunisation and vaccination programme; health improvement – smoking cessation, obesity services, physical activity programme, healthy eating initiatives, alcohol and substance misuse, mental health improvement, sexual health; high quality services - supporting the PCT and other organisations in developing high quality and effective services.

The key issue is access to healthcare services which will be addressed through care and treatment provided closer to home where possible. Transport is recognised as a major issue and a separate work stream has been established with the County Council.

Health Impact Assessment would indicate that transport will be an issue but that detailed work would only be undertaken once the consultation process is completed.

IMPORTANT CONSIDERATIONS:

- Health Impact Assessment on service improvement proposals will be required;

- Systematically addressing health inequalities (responding to the social determinants of ill health) must be a priority.

RECOMMENDATIONS:

- The *Seizing the Future* Health Scrutiny Working Group notes the health inequalities that exist in County Durham and the strategic commitment to respond to the social determinants of health thereby adding life to years and years to life.

- The *Seizing the Future* Health Scrutiny Working Group recommends that a systematic approach to address health inequalities and the burden of ill health in a partnership context is given priority. Furthermore in support of the next stage of *Seizing the Future* a health impact assessment of service improvement proposals is done to ensure that the wider determinants of health and health care provision are catered for.

8.7 Helen Goodman MP

Helen Goodman MP has shared her substantive comments in writing - see Appendix 5. Members are asked to note her concerns fall in to two categories in the main:

- The nature of the current consultation, and
- Substantive questions as to whether the proposals will improve medical outcomes and are sustainable.

IMPORTANT CONSIDERATIONS:

- Nature of consultation
- Services at BAGH i.e. rehabilitation with stroke services as a centre of excellence
- Haematology and pathology services –centre of excellence
- Transport concerns
- CDDFT should use BAGH as the HQ

RECOMMENDATIONS:

- The *Seizing the Future* Health Scrutiny Working Group notes the plans for Bishop Auckland General Hospital (BAGH) and recommend that its future sustainability must be planned for. The overview and scrutiny review group recommend that:
    - in establishing a centre of excellence for rehabilitation there should be investment in stroke services that are delivered alongside rehabilitation services;
    - that haematology and pathology services at best provide a trust-wide service from BAGH accepting the need to maintain such diagnostic services at a local level;
    - that consideration is given to locating the Trust's headquarters at the hospital;
    - sustaining services so that the existing A+E does not become a "second rate" service but a service that continues to meet the needs of those communities who need treatment for minor injuries and medical emergencies;

8.8 Save Our Hospital Group

The Group want the Trust to think again and listen to what the local people are saying. They want the hospital to provide a good viable health care facility. This hospital covers an area of 195 square miles with a population of 99,824 people.

The Group stated that the only valid solution is that of an equal co-ordinated acute A&E at all three main hospital sites, thereby offering automatic admission to immediate treatment in the local A&E department. This will minimise travel and further trauma to patients. The Group feel that acute services are being eroded and this is totally unacceptable. The hospital must be preserved and provides a comprehensive service.

Since 2002 the following events have taken place for which the Group feels there has been a distinct lack of public consultation:

- Ward 3 Medical and haematology closed 2006
- Ward 9 Surgical closed 2007
- Maternity downgraded to nurse led unit
- Children's Ward downgraded to daytime admissions only
- Special Care baby unit to Darlington
- Orthopaedics downgraded to knee and hip only
- General surgery downgraded
- ITU downgraded

The present proposals include:

- Accident and Emergency to Darlington
- Complete removal of Acute Medicine
- Paediatrics downgraded completely
- Stroke Ward/Unit removed completely

It is known that out of 3,482 local authority wards in the country, a Bishop Auckland ward is the 56th worst for health inequalities.

This hospital is to be made into a care/rehabilitation hospital. The Group stated that the same procedure was implemented in the Redditch and Kidderminster area which is a similar rural area to Bishop Auckland. Services were cut at Redditch and Kidderminster Hospital was closed down which resulted in the inability of other surrounding hospitals to cope. As a consequence Kidderminster Hospital had to be re-opened. It was suggested that this is exactly what is going to happen at Bishop Auckland. Darlington and Durham hospitals will not be able to cope with the influx of new patients. It is strongly felt that standards will plummet and due to extended travelling and poor assistance on arrival, lives will be lost.

The Group felt that as the consultative period carries on, it has become quite apparent that it is flawed in many ways:

- In particular why have meetings been held at Easington, Chester le Street and Sedgefield, where people are not affected as they already have a choice of hospitals? Requests were made to extend the consultative meetings to include locations, such as Spennymoor, Crook, Stanhope and other venues local to Bishop Auckland which were taken up.
- Why are people attending the meetings requested to make a choice from two options, not including the choice of an acute hospital at Bishop Auckland. It is felt that the people are not getting a choice. This came out very loud and clear from the people of Shildon on 19th November 2008.
- Too long is spent explaining the Trust's proposals which are biased. The Group claim that no-one present knows what is being recorded and it can be shown that the answers to the top four prescribed questions do not correctly record the views of the people in attendance.
- At every public consultation event the public are informed that the proposals are not a done deal. If that is the case, why are filing cabinets and boxes being moved out of areas in Darlington Memorial to cater for people from Bishop Auckland. Why allocate £30 million to be spent on Darlington Memorial?
- The Group considered that staff at Bishop Auckland General Hospital were criticised in presentations and when challenged about this, it was denied. Also the group stated that request for a playback of the tape had not been allowed on Monday 3rd November 2008 at Sedgefield. (Transcripts are posted on the consultation website shortly after the events).
- Other criticisms by the group were that the public are informed that ambulance drivers were driver trained to police class 1 standard. There is no police class 1 standard. The public are continually informed that doctors do not want to work at Bishop Auckland General Hospital. This is because of the hospitals proposed future. The inability to recruit Doctors reflects on the capability of the management of the Trust.

The Group felt that the Trust is not interested in the public. It strongly appears as though they are only interested in removing the acute health care services from Bishop Auckland. Wear Valley had been designated as a 'spearhead' area due to deprivation and inequalities. Why are acute health services being removed from this area?

Many thousands of people have signed petitions and on Saturday 6th December 2008 at 11 a.m. many more thousands of people were to congregate in the Bishop Auckland Market Place to ask that services are not removed from Bishop Auckland Hospital. The Group concluded that the consultation is "a sham".

IMPORTANT CONSIDERATIONS:

- Save Acute Services
- Concerns over consultation process
- Perceived down-grading of services
- Regarding petitions - petitions have collected signatures from residents of Bishop Auckland and other areas, which will be taken account of depending on the wording of the petition. The strength of feeling of the local population signing the petition (c11,000 signatories) should be recognised (although there may be genuine concerns over the wording – removal or closure of A&E has been suggested – but does not reflect the reality of the situation, as a full A&E service has not existed at BAGH for many years). The channel of a formal consultation process needs to be used - the necessity of an organisation responsible for commissioning a service to determine a process of consultation should be respected.

RECOMMENDATIONS:

- The *Seizing the Future* Health Scrutiny Working Group notes the concerns expressed by the Save our Hospital Campaign group.
- The *Seizing the Future* Health Scrutiny Working Group recommends that NHS County Durham working in partnership with other NHS organizations takes steps to meet the significant challenges in informing and engaging communities about the range of services that will be provided across the healthcare system in primary, secondary and tertiary settings.
- That NHS County Durham and other NHS organizations in our area adopt a model of engagement that enables and achieves close working with patient groups, communities of interest and other local community groups to ensure their views are taken into account in the next stage of *Seizing the Future* namely business planning and service design.

8.9 County Durham and Darlington Medical Committee

The Working Group received a presentation from Dr David Robertson, a GP from Barnard Castle who is the Secretary of the Local Medical Committee which is the body that repesents General Practitioners.

He informed the Working Group that the Local Medical Committee has a diverse range of opinions on the proposals and are unable to reach a consensus.

IMPORTANT CONSIDERATIONS:

- Evidence noted

8.10 Joint Staff Consultative Committee County Durham and Darlington Foundation Trust

The Working Group received a presentation from the Staff Side Chair, JSCC, County Durham and Darlington Foundation Trust about the staff side view of the proposals.

The Working Group was informed that staff have a diverse range of opinions depending on where they work. There is however a general view that there needs to be change. There are issues of capacity across the Trust. There is little flexibility at Bishop Auckland. There is space but it is not staffed and this results in patients being diverted to Darlington or Durham. Families will usually request that patients be transferred back to Bishop Auckland if there is a bed available. However in the majority of cases, families are usually content to remain at Darlington/Durham if the care is of a high standard.

Members were informed that there is a clinical need to focus on two acute sites. Whilst there is spare capacity at Bishop Auckland it has insufficient capacity to accommodate all acute services at Bishop Auckland. There are clinical risks if the provision stays the same.

IMPORTANT CONSIDERATIONS:

- Evidence noted

8.11 County Durham and Darlington Fire and Rescue Service

The Working Group were that the service and staff would expect patients to be admitted to the most appropriate hospital for treatment. It was further explained that the Fire and Rescue Service try to reduce impacts on the health service by carrying out risk assessments and home fire safety checks in vulnerable communities. The Fire Service also gives life skills training to young people in order to avoid admission to A&E Departments. The Fire Service supports the North East Air Ambulance to ensure a timely response in rural areas and at road traffic collisions.

IMPORTANT CONSIDERATIONS:

- Evidence noted

8.12 Durham Constabulary

Concerns were expressed about the potential for adverse impacts from hospital reconfiguration on current and future joint-working arrangements, particularly in relation to:

- The potential for increased demand on police time from increased travel/waiting times from taking people detained in custody to A&E at UHND or DMH instead of BAGH. Also there are similar concerns in relation to officers conducting follow up enquiries for those requiring emergency hospital treatment for victims or crime or road traffic collisions.
- Potential impacts on joint emergency responses are to be considered via the Joint Emergency Planning Group.

IMPORTANT CONSIDERATIONS:

- Evidence noted

8.13 Durham County Council's Integrated Transport Unit

8.13.1 Access to health services/travel

Members were informed that a Working Group has been established involving County Durham and Darlington Foundation Trust, NHS County Durham, NEAS, the County Council and Darlington Borough Council so that it can address solutions to transport needs and how to make better use of existing transport resources.

Reference was made to a number of maps which showed communities that are within an hour of an acute hospital when travelling by public transport. There are no bus services in the Dales areas within an hour of an acute hospital. The maps also showed the areas where there will be a transport need if the proposals are implemented. Using data from the Foundation Trust on where patients live and received treatment, the map demonstrated where residents will benefit or be worse off if the proposals are implemented. Overall the data indicates that 5,000 patients per annum will need to travel to a different location for treatment.

In terms of possible solutions the following were considered:

- Dedicated Hospital-to-Hospital Buses – with the number of people involved it wouldn't be necessary.
- Extensions and diversions to current bus services – talks have been held with bus companies to extend or divert existing services. Again the number of people is not significant and the diversion of services will seriously affect existing services.
- Hospital Link Service – This is already runs in East Durham and is much more tailored and focused, is demand responsive and is a possible solution.
- Volunteer Driver Schemes – Under a social car scheme a person can ring a control centre and arrange for a volunteer driver to take them to the GP or a community hospital.

The Travel Response Centre (TRC) was established to meet transport needs in East Durham. It provides a central information and booking point for hospital transport. Its initial use was for social care journeys but was expanded to deal with hospital transport. A patient is provided with a contact telephone number of the TRC. When they telephone the TRC they are assessed to provide a solution to their needs. This might be the Patient Transport Service (PTS) provided by NEAS if they meet the eligibility criteria or via one of the other options. Patients are booked directly onto the PTS system. The service is marketed through GP's and hospitals. The service was established in partnership between NEAS and NHS County Durham.

The East Durham Hospital Link (EDHL) is a service commissioned and paid for by NHS County Durham. It arose because of poor public transport access to hospitals in Teesside and Sunderland. This is a demand responsive door to door minibus service and is booked in advance. It is available for patients, visitors and staff. The fare is charged at £2.50 per journey but concessionary travel passes are accepted on the service. A carer plus pass can be issued if the passenger needs a carer to accompany them. NHS County Durham has a hardship scheme where a reimbursement can be claimed. The service runs to a timetable and is available during the day and in the evenings and weekends for visitors. The vehicles used in the service also provide social care journeys.

In the first two months of operation the TRC has received 4500 phone calls and has made 921 bookings for the PTS and 509 bookings for the EDHL.

Patients are still able to access the PTS but it is only available for those who meet the criteria. The PTS service deals with high demand patients i.e. those who have oxygen or who need two people to help them access transport. This is available door to door and is operated by NEAS with a range of minibuses, volunteer drivers and taxis.

It was explained that a similar solution is needed for the rural areas of the County. This will involve the pooling of DCC and NEAS resources together with car schemes and community transport to provide a low demand solution in the Dales area.

In relation to questions about the planned hospital at Wynyard, it was explained that evidence had been given to Momentum Pathways advising that Wynyard must be joined into the public transport network to serve the population in East Durham and Sedgefield. In addition it is important to ensure that consideration is given on how to meet transport need that might arise if patients from East Durham need to access services at Bishop Auckland.

The current NHS approach to healthcare provision is summarized as 'centralised where necessary, localized where possible', and the NHS is seeking to expand services that are provided more locally. This approach, combined with greater patient choice of where they travel to receive hospital treatment, is likely to increase travel distances for some and reduce travel distances for others.

It has been estimated that annually 30,000 people who access A&E at BAGH currently and of these two thirds will continue to receive treatment at the Urgent Care Center. This implies that 10,000 people will be displaced for emergence treatment.

Issues of access to services and transport is always a major concern for people and concerns have been expressed very strongly about the implications of these proposals for people accessing the Trusts hospitals – particularly from the Dales areas.

Evidence received during the Scrutiny process suggests:

- 8-12 people per day will need to travel further than they do already for medical emergencies.
- Modelling by the County Councils Integrated Transport Unit indicates that of elective spells at the Trusts three hospitals – 4665 admissions will be displaced to BAGH i.e. creating additional hospital activity at BAGH, with 196 additional spells to DMH and 307 to UHND.
- There are no bus services in the dales within an hour of an acute hospital and because of this patient transport schemes are being looked at.

IMPORTANT CONSIDERATIONS:

- Evidence noted Dedicated Hospital-to-Hospital Buses – with the number of people involved it wouldn't be necessary.
- Extensions and diversions to current bus services – talks have been held with bus companies to extend or divert existing services. Again the number of people is not significant and the diversion of services will seriously affect existing services.
- Hospital Link Service – This is already runs in East Durham and is much more tailored and focused, is demand responsive and is a possible solution.
- Volunteer Driver Schemes – Under a social car scheme a person can ring a control centre and arrange for a volunteer driver to take them to the GP or a community hospital.
- The need for an integrated "health" transport strategy with a focus on patients. This must be adequately resourced.

RECOMMENDATIONS:

- The *Seizing the Future* Health Scrutiny Working Group notes the importance of transport for health.
- The *Seizing the Future* Health Scrutiny Working Group recommend that as part of the "whole systems" approach an integrated "transport for health strategy" that is adequately resourced must be in place and be a key component of service improvement proposals.

8.14 Darlington Primary Care Trust: provider perspective

8.14.1 Expanding community based healthcare services

The enhanced provision of more locally based healthcare provision is a stated policy position nationally and locally, however there is little concrete information available as part of the consultation.

The National Clinical Advisory Team commented that the use of community hospitals should be reviewed by the Trust and the 2 PCTs with a view to expanding local services. In particular better use for consultant delivered outpatient clinics should be considered as well as forming a network of Urgent Care Centres together with the three main hospitals. A detailed analysis of how they will be used for intermediate care and step down care should also be performed.

Darlington PCT as the provider of County Durham and Darlington Community Health Services (CDDCHS) are supportive of the *Seizing the Future* strategy as this will support the drive to moving services closer to the community and provide an opportunity for it to work collaboratively with CDDFT to move more services closer to the community. The Head of Organisational Development, Darlington PCT on the CDDCHS explained that CDDCHS was established as the provider arm of the PCT's to offer a range of community services.

IMPORTANT CONSIDERATIONS:

- Need to work collaboratively with CDDFT to move more services closer to the community.
- Focused planned care – this speeds up pathway and opens access
- Develop a new integrated model of urgent care with community services supporting in Bishop Auckland
- Improved utilisation of other community hospitals
- Introduction of more intermediate care facilities/rehabilitation facilities
- Opportunity to build a 'whole person' and integrated planned care service with health, social care and other partner input
- Improve standards of care – focused clinical skills and pathways
- Possible increased demand on community services particularly in walk in centres/out of hours clinics.
- Early discharge will need more intensive rehabilitation – there is a need to work together on resources and pathways
- Will rehabilitation take patients from other consultants/hospitals – there are resource implications
- Potential overlap with community rehabilitation and outpatients
- Effective transport systems are essential both for patients and carers particularly around Bishop Auckland.
- Overall CDDCHS are supportive of the *Seizing the Future* strategy as this will support the drive to moving services closer to the community. CDDCHS are working closely with CDDFT to design and manage new urgent care arrangements. Good use of the excellent facilities in Bishop Auckland will provide additional high quality services to people of County Durham and Darlington.

RECOMMENDATIONS

- The *Seizing the Future* Health Scrutiny Working Group notes the need to work collaboratively in order to move more services closer to the community. It is recommended that in line with the "whole systems" approach, investment in community hospitals and community based primary care services are a priority before any hospital configuration is put in place. The important principle is community facilities need to be in place before any services are changed or withdrawn.

8.15 Other issues

8.15.1 Further information

Although it may be unnecessary to provide substantial amounts of statistical information in general public consultation documents – rather summaries and assertions about the most appropriate ways to organise services in future may suffice. However it is important for some stakeholders to be provided with 'hard' statistical information in order for them to form an opinion. Clearly we would expect that NHS County Durham as the body responsible for approving the Trusts plans will be requesting information to assess the viability of the proposals and to help it reach a decision on the proposals.

- **Emergency workload – information required**

  One such area where further information is required is in relation to assessments of future demands on the Trusts services and its capacity to meet this demand, in particular in relation to A&E services. A clear account of how the extra emergency workload will be dealt with at UNHD and DMH is required and the following was requested during the scrutiny process:

  - Information is requested on the frequency with which current capacity at UHND for emergency admissions is reached; and how often it is closed to further emergency admissions?
  - Information is requested on the frequency with which current capacity at DMH for emergency admissions is reached; and how often it is closed to further emergency admissions?
  - When these circumstances arise how often and how many patients are transferred to BAGH?
  - How would this eventuality be addressed in future?

- **Full cost-benefit analysis of the options**

Whilst some information has been provided in relation to the proposals, an overall assessment of the costs of delivering services in different configurations has not been provided.

It has been calculated that the capital costs to the organisation of turning each of the following sites into the planned site - presented as the cost of replacing the acute capacity of each hospital at another site - is as follows :

- University Hospital North Durham - £79.8M
- Darlington Memorial Hospital £117.9M
- Bishop Auckland General Hospital - £6.6M

The revenue costs are calculated in terms of income-loss of different sites leading on planned care:

- University Hospital North Durham – income loss £35.1M
- Darlington Memorial Hospital income loss £9.8M
- Bishop Auckland General Hospital - income loss £2.9M

An estimation has been made (Appendix 6) that keeping the configuration as it currently exists without achieving any improvement in standards would cost £2M per annum. It has also been stated that that BAGH has been ruled out as a possible acute site as it would need significant further construction with lengthy time-scales involved.

The following information gaps exist:

- in relation to the full costs of delivering Option A and Option B (see page 21-22), and
- the costs of meeting additional demands at UHND and DMH from centralising acute services and for full A&E provision at these locations and moving some services to and from BAGH.

IMPORTANT CONSIDERATIONS:

- More statistical information should be in the public domain to help some stakeholders in forming an evidence based opinion on the proposed changes – in relation to the demand for services and in relation to assessments of capacity, and forecasting of future trends.

- Information is outstanding in relation to how the extra emergency workload will be dealt with at UNHD and DMH is required and the frequency with which current capacity for emergency admissions is reached at each of the Trusts hospitals; and how often hospitals are closed to emergency admissions

- There are gaps in relation to the provision of information on costs of the proposals. The full costs of delivering Option A and Option B (see page 21-22) are not stated, and neither are costs of meeting additional demands at UHND and DMH from centralising acute services, and for full A&E provision at these locations and moving some services to and from BAGH.

RECOMMENDATIONS:

- That as part of ongoing engagement with stakeholders around implementation of *Seizing the Future* and further investment in service provision at each of the Trust's hospital sites, there should be a full analysis of costs taking into account future needs for, and demands on, hospital services.

- The **outstanding information** noted in this report is provided to the scrutiny committee.

- That as part of the Overview and Scrutiny systematic review process, implementation of the proposals are closely monitored through the local authority overview and scrutiny function to ensure best outcomes, and the findings and recommendations are addressed.

8.16 Consultation

NHS County Durham has advised that by the time the consultation is concluded in mid January, it will have included:

- 155,000 leaflets / inserts / wraparounds in local papers through doors throughout Co Durham and Darlington. These include freepost opportunities to respond to the consultation and the dates, times and venues of the public meetings.
- 1,000 documents distributed to partner organisations.

- Four awareness / drop in sessions in shopping centres
- 16 public meetings across County Durham and Darlington. These included five additional meetings instigated in response to requests for further meetings.
- Meetings with Local Strategic Partnerships.
- Meetings with various Overview and Scrutiny Committees / councils (including a meeting each with the full councils at Darlington and Durham County).
- Two sessions with children and young people.
- A session with people who are deaf and deafened.
- Audio and Braille versions of the documents have been sent out on request and talking newspapers have been used to assist access for those who need it.
- A session with people with learning difficulties.
- Focus groups with Gypsies, Roma and travellers.
- A meeting with the new Durham County Local Involvement Network (LINk).
- A dedicated website enabling access to a range of literature including much background information on the options and how they were reached. This also provides a facility to respond to the consultation.
- Information in local newspapers, including dates, times and venues for the public meetings.
- Information in GP surgeries, both written and as part of video loops using the Life Channel.
- At the beginning of the week commencing 15th December circa 1,000 responses had been received through the website and the post and approximately 220 people had attended the 15 public meetings held.

There are a number of consultation documents, including a full version, summary version, newspaper inserts and a document aimed at children and young people. In addition, a number of more detailed documents are available through the website (which has links to it from DCC, CDDFT and NHS County Durham websites).

The public consultation document set out the plans for consultation which initially included nine public meetings and four shopping centre promotional days.

The scrutiny committee and County Durham Local Involvement Network provided support and advice to the consultation process by advising on potential shortcomings including:

- Inadequate number of public meetings particularly in the Dales areas of County Durham
- Inadequate 'targeted' consultation with hard to reach or hard to hear groups
- Lack of a comprehensive database of organisations across all localities in the County to inform of the consultation

It is also clear that NHS County Durham and the Trust responded to the concerns made in an effort to communicate the proposals widely.

IMPORTANT CONSIDERATIONS:

- The consultation process ends on the 12th January and as a result NHS County Durham's report on the consultation has not yet been completed.

There is evidence that concerns have been expressed that the consultation initially had significant shortcomings:

- By presenting the two options as they are seems curious to Members, as Option B is "the same as Option A" with additional services provided from Bishop Auckland General Hospital. On this basis Option B is clearly preferable to Option A - it is not clear under what circumstances anyone would choose Option A?

- The options present too narrow a set of choices. By seeking to consult within set parameters the consultation does not appear to be offering those participating the opportunity to fully express preferences and concerns about their future health services.

- Clear messages about exactly what services are to be provided from BAGH have not been communicated effectively.

- The language used is difficult for many to understand – although this reflects the complex nature of the issues being consulted upon – it is nonetheless incumbent on those leading a consultation to present information (from the outset) in a way that is understandable and appropriate for different audiences. However, the Trust has taken steps to do this through more simplified leaflets and documents aimed at young people.

- Provision of too little statistical analysis of services needs and demands.

- That NHS County Durham and the CDDFT have engaged in dialogue with the scrutiny committee and the County Durham Local Involvement Network to identify gaps and weaknesses and have addressed some of them.

- As leaders of the consultation process and ultimately as commissioners of health services in the County NHS County Durham who will make the final decision, were unable to provide a view on the proposals during the formal consultation process:

    - NHS County Durham will ultimately have to consider all the evidence available, including that of Scrutiny, the public consultation and any issues and concerns of its own. As a consequence it has not felt able to provide opinions or assessments of the proposals for the Health Scrutiny Committee to consider during the process as it believed the provision of this information during the consultation may:

        - influence a process that was already ongoing, and
        - influence decisions that it would have to make in the future.

IMPORTANT CONSIDERATIONS:

- Significant energy has been expended and resources committed to consulting on the proposals. The consultation has ultimately been satisfactory in that it has enabled NHS Country Durham and CDDFT to hear community views and concerns in relation to the proposals, and for this process to help share an understanding of the proposals and what they will mean for communities in future. However, there are lessons that should be learned about how this can be done more effectively in future:

  - There should be early engagement with key stakeholders, including with County Durham Local Involvement Network, to plan how to consult most effectively and to meet the duty to involve;
  - Barriers to the clear communication of messages and proposals should be better understood.

RECOMMENDATIONS:

- The *Seizing the Future* Health Scrutiny Working Group notes the importance of involvement in key NHS policy directives namely The NHS Constitution, World Class Commissioning and the NHS Next Stage Review.

- The *Seizing the Future* Health Scrutiny Working Group recommends that NHS County Durham undertake an evaluation of the recent consultation process so that they may plan to address any perceived loss of credibility in failing to get messages across. Lessons from the consultation exercise should be identified so that future "engagement events" can benefit from this experience.

9. Summary of Recommendations

The following recommendations are made by Durham County Council's Joint Health Overview and Scrutiny Committee's *Seizing the Future* Health Scrutiny Working Group:

Recommendation -1

- The *Seizing the Future* Health Scrutiny Working Group notes that the case for change is grounded in a strong clinical base that will provide for safe, high quality services that aim to improve patient/health outcomes.

- The *Seizing the Future* Health Scrutiny Working Group recommends that delivery of *Seizing the Future* to address the case for change **must** be through a *whole systems approach*.

- The *Seizing the Future* Health Scrutiny Working Group recommend that a whole systems approach **must** take into account the following issues in order to deliver effective health care and health and well being outcomes:

    - the need for investment at Darlington Memorial Hospital (DMH) and University Hospital North Durham (UHND) to provide for adequate capacity to cope with the increased demand for emergency admissions;

    - transport implications for people who have to travel to both specialist and generalist services, via an integrated "transport for health strategy" that is adequately resourced, must be in place and be a key component of service improvement proposals;

    - the need to ensure that services are developed as close to people's homes and in their communities – investing in community hospitals and other community based health and social care provision planned in partnership with social care providers and voluntary and community agencies;

    - a systematic approach to address health inequalities and the burden of ill health in a partnership context. Undertaking a health impact assessment of service improvement proposals to ensure that the wider determinants of health and health care provision are planned for.

      - 1community concerns about exactly what will be provided in district general hospitals, community hospitals, and community based facilities;

- Furthermore the working group recommend that the recommendations of the National Clinical Advisory Team (Professor Sir George Alberti, August 2008) should be implemented in full including:

    - Concerns about parking at Darlington Memorial Hospital are addressed.
    - Plans include a GP ward at Bishop Auckland General Hospital.
    - New facilities need to be in place before services are withdrawn.

Recommendation - 2

The *Seizing the Future* Health Scrutiny Working Group notes key evidence in relation to the rebalancing of health care systems as described, and recommend that this rebalancing of health care systems model be used to prioritise investment in prevention rather than cure.

Recommendation - 3

- The *Seizing the Future* Health Scrutiny Working Group recommends that the NHS County Durham use the evidence from the Royal Colleges in their deliberations in particular the evidence in relation to *"….Plans to redesign services which involve moving services from one site must be evidenced based and not be fully implemented until replacement services are established and their safety audited ".*

Recommendation - 4

- The *Seizing the Future* Health Scrutiny Working Group notes the investment that has gone into the Ambulance service over recent years. It also notes that evidence on the subject of risks from increased ambulance journey times is inconclusive and recommends that there is ongoing monitoring of potential risks to patients from increased traveling for emergency treatment, with regular performance reporting to the health scrutiny committee as part of its monitoring function.

Recommendation - 5

- The *Seizing the Future* Health Scrutiny Working Group notes the important relationship with Durham County Councils Adult and Community Service in meeting the healthy and social care needs of our communities.

- The *Seizing the Future* Health Scrutiny Working Group recommends that as part of the "whole systems" approach to planning health, social care delivery must be an integral function of that planning.

Recommendation – 6

- The *Seizing the Future* Health Scrutiny Working Group notes the health inequalities that exist in County Durham and the strategic commitment to respond to the social determinants of health thereby adding life to years and years to life.

- The *Seizing the Future* Health Scrutiny Working Group recommends that a systematic approach to address health inequalities and the burden of ill health in a partnership context is given priority. Furthermore in support of the next stage of *Seizing the Future* a health impact assessment of service improvement proposals is done to ensure that the wider determinants of health and health care provision are catered for.

Recommendation – 7

- The *Seizing the Future* Health Scrutiny Working Group notes the plans for Bishop Auckland General Hospital (BAGH) and recommend that its future sustainability must be planned for. The overview and scrutiny review group recommend that:

    - in establishing a centre of excellence for rehabilitation there should be investment in stroke services that are delivered alongside rehabilitation services;
    - that haematology and pathology services at best provide a trust-wide service from BAGH accepting the need to maintain such diagnostic services at a local level;
    - that consideration is given to locating the Trust's headquarters at the hospital;
    - sustaining services so that the existing A+E does not become a "second rate" service but a service that continues to meet the needs of those communities who need treatment for minor injuries and medical emergencies;

Recommendation - 8

- The *Seizing the Future* Health Scrutiny Working Group notes the concerns expressed by the Save our Hospital Campaign group.

- The *Seizing the Future* Health Scrutiny Working Group recommends that NHS County Durham, working in partnership with other NHS organizations, takes steps to meet the significant challenges in informing and engaging communities about the range of services that will be provided across the healthcare system in primary, secondary and tertiary settings.

- That NHS County Durham and other NHS organizations in our area adopt a model of engagement that enables and achieves close working with patient groups, communities of interest and other local community groups to ensure their views are taken into account in the next stage of *Seizing the Future* namely business planning and service design.

Recommendation – 9

- The *Seizing the Future* Health Scrutiny Working Group notes the importance of transport for health.

- The *Seizing the Future* Health Scrutiny Working Group recommend that as part of the "whole systems" approach an integrated "transport for health strategy" that is adequately resourced must be in place and be a key component of service improvement proposals.

Recommendation -10

- The *Seizing the Future* Health Scrutiny Working Group notes the need to work collaboratively in order to move more services closer to the community. It is recommended that in line with the "whole systems" approach, investment in community hospitals and community based primary care services are a priority before any hospital configuration is put in place. The important principle is community facilities need to be in place before any services are changed or withdrawn.

Recommendation - 11

- The *Seizing the Future* Health Scrutiny Working Group notes the importance of involvement in key NHS policy directives namely The NHS Constitution, World Class Commissioning and the NHS Next Stage Review.

- The *Seizing the Future* Health Scrutiny Working Group recommends that NHS County Durham undertake any evaluation of the recent consultation process so that they may plan to address any perceived loss of credibility in failing to get messages across. Lessons from the consultation exercise should be identified so that future "engagement events" can benefit from this experience.

Recommendation - 12

- That as part of ongoing engagement with stakeholders around implementation of *Seizing the Future* and further investment in service provision at each of the Trust's hospital sites, there should be a full analysis of costs taking into account future needs for, and demands on, hospital services.

- The **outstanding information** noted in this report is provided to the scrutiny committee.

- That as part of the Overview and Scrutiny systematic review process, implementation of the proposals are closely monitored through the local authority overview and scrutiny function to ensure best outcomes, and the findings and recommendations are addressed.

10. Outstanding information required

The following information is requested by Durham County Council's Joint Health Overview and Scrutiny Committee:

- More information should be in the public domain to help some stakeholders in forming an evidence based opinion on the proposed changes – in relation to the demand for services and in relation to assessments of capacity, and forecasting of future trends.

- Information required in relation to how the extra emergency workload will be dealt with at UNHD and DMH is required and the frequency with which current capacity for emergency admissions is reached at each of the Trusts hospitals; and how often hospitals are closed to emergency admissions.

- There are gaps in relation to the provision of information on costs of the proposals. The full costs of delivering Option A and Option B are not stated, and neither are costs of meeting additional demands at UHND and DMH from centralising acute services, and for full A&E provision at these locations and moving some services to and from BAGH.