Appendices

Durham County Council's Joint Health Overview and Scrutiny Committee

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

TABLE OF APPENDICES

APPENDIX 1

County Durham Seizing the Future Health Scrutiny Working Group

Terms of Reference

Purpose

The County Durham Seizing the Future OSC Working Group has been formed to produce a response to the NHS County Durham (County Durham Primary Care Trust) consultation on County Durham and Darlington Foundation Trust (CDDFT) proposals for service reconfiguration: *Seizing the Future.*

Context

Seizing the Future sets out the County Durham and Darlington NHS Foundation Trusts strategic direction for 2008-2013 following a review which it has been conducting over the past nine months.

The approach is supported by major clinical service review focussing on the following areas:

- Examination of current services
- Assessment of adherence to clinical outcomes
- Review of achievement of national standards across all services
- Development of service configuration options
- Public consultation

The approach also builds on and takes into account the national dimension (Darzi Review), PCT Commissioning plans and Adult and Community Service plans.

It is suggested that the case for change is informed by:

- Fall in patient numbers and Trust's income expected due to local and national policies namely:
  - Patient choice
  - Payment by Results
  - Increased competition from other providers
  - Practice Based Commissioning
  - Shift of some of Trust's activity to Primary Care setting
  - 18 week patient journey
  - Reduction in time patients spend in hospital

The case for change also includes a number of clinical issues that need to be taken into account namely:

- Cover and pathways for emergency care
  - Emergency medicine on 3 sites
  - Emergency surgery on 2 sites

- Critical care support
- Children's services
- 24/7 diagnostic cover
- Clinical networks for tertiary care –ENT services
- European Working Time Directive
- Operational efficiency variability across sites
- Development of care outside hospitals
- Finance

Public consultation

On 2nd September 2008 the Board of NHS County Durham (County Durham Primary Care Trust) approved the CDDFT proposals for public consultation subject to further detail being developed. The full options proposed for consultation are to be presented to the PCT Board by the end of September 08. Consultation will be ongoing from 6th October 2008 to 12th January 2009.

The Seizing the Future Health Scrutiny Working Group will encourage members of the public to feed views through the public consultation, and will capture these views as part of taking evidence throughout the scrutiny review process.

Overview and Scrutiny Arrangements

The Seizing the Future Health Scrutiny Working Group is formed specifically for the purpose of considering the evidence from key stakeholders and producing a response. Once it has completed this task the Working Group established for this purpose will be disbanded. Stakeholders from whom evidence will be sought are detailed in the Working Group Project Plan.

The Seizing the Future Health Scrutiny Working Group is proposed in accordance with the Secretary of State for Health's Directions to Local Authorities (Overview and Scrutiny Committees, Health Scrutiny Functions) of 17 July 2003 ("the Directions") for the purposes of formal consultation by the relevant NHS Bodies in relation to the matters referred to at paragraphs 1(a) - (c) of this protocol, and in particular in order to be able to:-

(a) make comments on the proposals consulted on, to the relevant NHS Bodies under the Local Authority (Overview and Scrutiny Committees, Health Scrutiny Functions) Regulations 2002 ("the Regulations");

(b) require the relevant NHS Bodies to provide information about the proposals under the Regulations; or

(c) require an officer of the relevant NHS Bodies to attend before it under the Regulations to answer such questions as appear to it to be necessary for the discharge of its functions in connection with the consultation.

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 representatives from each District Council in the County.

Members: Cllr A Anderson, Cllr R Burnip, Cllr J Chaplow, Cllr P Crathorne, Cllr T Cooke, Cllr R Harrison, Cllr D Lavin, Cllr S Pitts, Cllr R Todd (replaced Cllr V Williams).

In addition the Working Group will seek to co-opt a Member of the County Durham Local Involvement Network to join its Membership.

Reporting

The Working Group will report back to the Joint Health Overview and Scrutiny Committee regularly and on its response to this committee, and prior to submission of the response, at the JHOSC meeting in January 2009.

Press Statements

Press statements in relation to the work of the Seizing the Future Health Scrutiny Working Group should be issued through the Chair of the Working Group.

Meeting arrangements

A project Plan is to be agreed and includes dates of proposed meetings throughout the process.

TERMS OF REFERENCE:

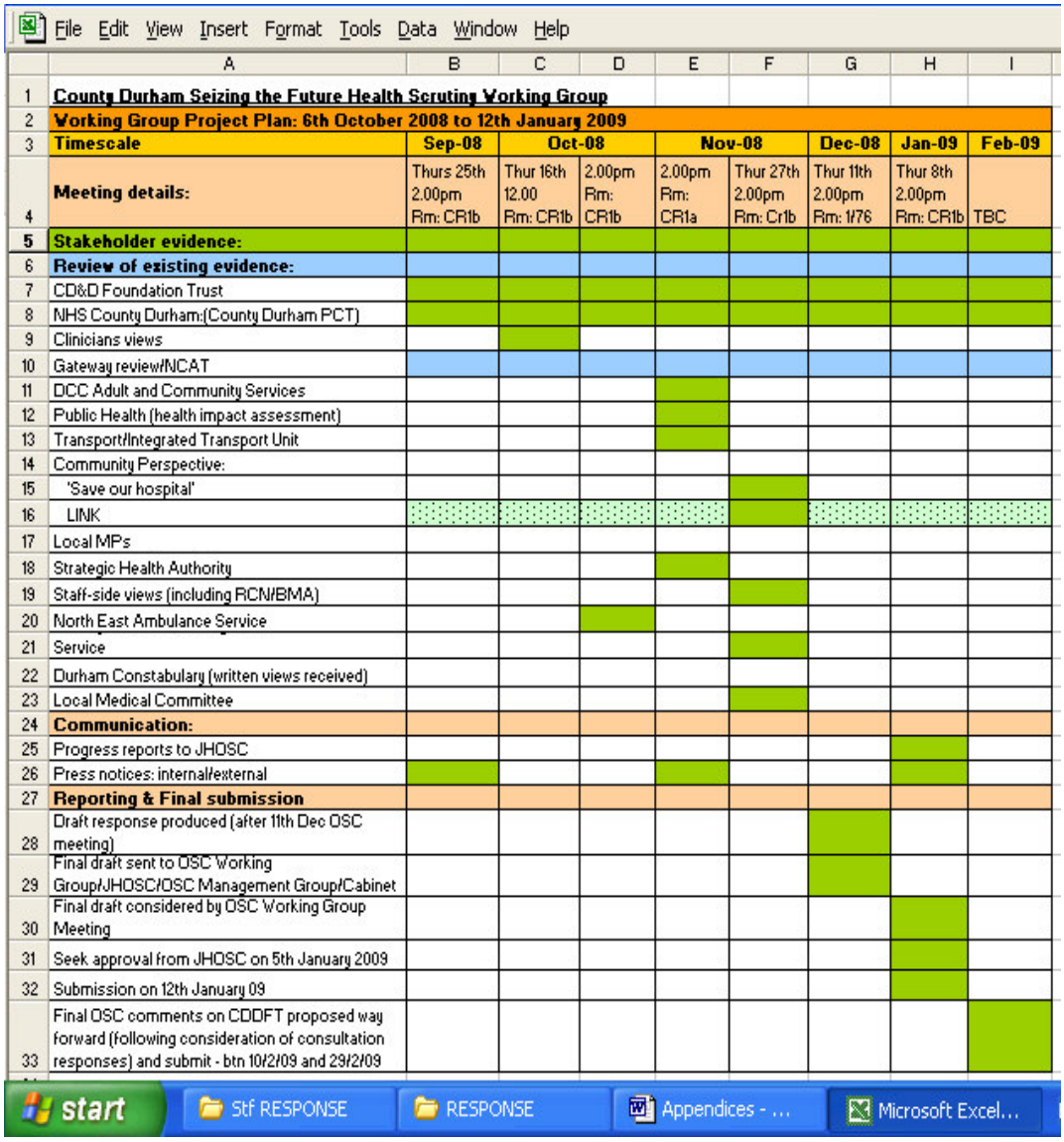
To examine the proposals and consider evidence to asses whether they:

- 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

APPENDIX 2

County Durham Seizing the Future Health Scrutiny Working Group



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	A	B	C	D	E	F	G	H	I
1	**County Durham Seizing the Future Health Scruting Working Group**								
2	**Working Group Project Plan: 6th October 2008 to 12th January 2009**								
3	**Timescale**	**Sep-08**	**Oct-08**		**Nov-08**		**Dec-08**	**Jan-09**	**Feb-09**
4	**Meeting details:**	Thurs 25th 2.00pm Rm: CR1b	Thur 16th 12.00 Rm: CR1b	2.00pm Rm: CR1b	2.00pm Rm: CR1a	Thur 27th 2.00pm Rm: Cr1b	Thur 11th 2.00pm Rm: 1/76	Thur 8th 2.00pm Rm: CR1b	TBC
5	**Stakeholder evidence:**								
6	**Review of existing evidence:**								
7	CD&D Foundation Trust								
8	NHS County Durham:(County Durham PCT)								
9	Clinicians views								
10	Gateway review/NCAT								
11	DCC Adult and Community Services								
12	Public Health (health impact assessment)								
13	Transport/Integrated Transport Unit								
14	Community Perspective:								
15	'Save our hospital'								
16	LINK								
17	Local MPs								
18	Strategic Health Authority								
19	Staff-side views (including RCN/BMA)								
20	North East Ambulance Service								
21	Service								
22	Durham Constabulary (written views received)								
23	Local Medical Committee								
24	**Communication:**								
25	Progress reports to JHOSC								
26	Press notices: internal/external								
27	**Reporting & Final submission**								
28	Draft response produced (after 11th Dec OSC meeting)								
29	Final draft sent to OSC Working Group/JHOSC/OSC Management Group/Cabinet								
30	Final draft considered by OSC Working Group Meeting								
31	Seek approval from JHOSC on 5th January 2009								
32	Submission on 12th January 09								
33	Final OSC comments on CDDFT proposed way forward (following consideration of consultation responses) and submit - btn 10/2/09 and 29/2/09								

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APPENDIX 3

"SEIZING THE FUTURE"

County Durham and Darlington NHS Foundation Trust

Report by Professor KGMM Alberti on behalf of the
National Clinical Advisory Team (NCAT)

Contents:

1.0 Preamble

Seizing the Future is a 5 year strategy being developed by County Durham and Darlington NHS Foundation Trust in response to perceived needs of the population, advances in healthcare and the Next Stage Review. It encompasses the three main hospitals: Bishop Auckland General Hospital, Darlington Memorial Hospital and University Hospital of North Durham as well as Shotley Bridge Community Hospital and Chester-le-Street Community Hospital. The Trust serves a widely dispersed population of approximately 500,000 people over an area of 3000 sq km. Each acute hospital serves a relatively small population. The population includes both urban centres and sparsely populated relatively remote rural areas as well as pockets of intense deprivation.

In 2002 Lord Darzi reported on acute services in County Durham and suggested a series of changes which allowed most services to continue in all three main hospitals, although acute surgery was withdrawn from Bishop Auckland and some other services were curtailed. A single acute trust was formed which helped coordination. He suggested that acute medicine should remain but should link with the other sites. There should also be a new elective centre for surgery, a midwifery-led maternity unit and a 9 am to 9 pm children's assessment unit. He stated that the main challenges were to: maintain access to services for all its communities, improve patient choice, and to make sure that services are sustainable and will thrive in the long term.

These challenges remain but the context has changed. Since the changes were implemented following the 2002 report there have been major changes in policy as well as in medical care. These include the two major white papers: *Our Health, Our Care, Our Say* in 2006 and *High Quality Care for All*. In the former the general principles of more care in the community and care as close to home as *safely* possible were established. In *High Quality Care for All* there was particular 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. There was also major emphasis on both clinical leadership and local ownership. There was in addition commitment that changes would be for the benefit of patients, would be clinically led and would involve patients, carers and the public. There has also been the recognition that for some conditions, such as stroke, myocardial infarction, major trauma and specialist surgery it will no longer be possible to provide up to date optimal care in every hospital and that networks of care with specialist services will be required.

In the light of this the Trust has re-examined services across its 3 major sites. It was obvious that all services could not safely be provided everywhere and that resources and senior staff were spread too thinly. A range of options were developed by the Trust under the banner of *Seizing the Future*. The Northeast SHA then requested clinical review by 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. They met a range of senior staff and clinicians (see Appendix 1) to discuss the clinical aspects of the plans. They also met members of the Gateway

team. Professor Alberti was familiar with all 3 sites having visited them in the past. The following report is based on the discussions and written material provided by the Trust.

2.0 The Current Situation

At present Darlington Memorial Hospital (DMH) and the University Hospital of North Durham (UHND) provide most acute and elective secondary care services. Both have full A & E services, acute medicine, acute surgery, paediatrics, obstetrics and support services. Some tertiary speciality services are provided elsewhere i.e. South Tees and Newcastle. Vascular surgery functions as a clinical network with Gateshead. Bishop Auckland (BAGH) takes acute medicine but not acute surgery and provides limited paediatric services during the day with occasional paediatric cases resident overnight. There is a critical care unit but functioning at best at level 2 primarily because of staffing difficulties. 24/7 diagnostic services are patchy. Consultant cover for A & E is provided from Darlington with day to day cover provided by an experienced Associate Specialist. There are 4 A & E Consultants in DMH. At present there is a primary care led urgent care centre in addition to A & E. BAGH sees about 30000 patients a year of whom about 15% are admitted (10-15 per day). There is a 21 bed medical assessment unit but this regularly overflows. DMH sees 51000 patients in A & E and there are about 25-30 admissions per day. UHND has similar total attendances at A & E but more admissions.

A major problem is that with no specialty in Bishop Auckland can a 24/7 service provided by an experienced clinician be guaranteed? There are 6 physicians on the acute rota and inadequate numbers of SpRs. The latter situation will get worse with the implementation of the EWTD in 2009. Consultant cover for acute specialties is also thin at DMH with 9 physicians taking part in the acute medicine rota, and it is only due to the commitment of staff at both sites that reasonable services are being maintained. Staffing is better at UHND although they are still short of the 8 Emergency Physicians (4 currently in post) to staff A &E which is recommended by the College of Emergency Medicine. There is only one committed acute physician at BAGH and 2 at DMH. Throughout the Trust there are still too many single handed consultants in subspecialties.

The main problems are therefore Acute Medicine, Paediatrics, A & E and Critical Care. The Academy of Medical Royal Colleges has stated that unselected acute medicine admissions should not occur in the absence of acute surgery and a fully functioning level 3 critical care unit. On the other hand selected medical admissions could take place but this still requires a full rota of consultant physicians, a reliable level 2 critical care unit, 24/7 diagnostic services and a senior surgical opinion immediately accessible.

In paediatrics there are currently about 1500 admissions a year at BAGH, 3000 at DMH and 4000 at UHND. There are 4 consultants at BAGH and 5 at each of the other two acute hospitals. One consultant has recently retired at BAGH and another will go in the near future. They have been unable to recruit replacements. There is no middle grade out of hours cover.

Critical care is in an even worse state. The Trust has had difficulty recruiting anaesthetists to provide out of hours cover at BAGH. The most ill patients are now being transferred to the other two sites, which is obviously unsatisfactory.

This should also be put in the context of High Quality Care for All and current trends in specialist care. It is more and more being accepted- and expected by the public- that if they are acutely ill with a serious condition that they will be seen quickly by an experienced clinician. For some conditions such as stroke, heart attacks and major trauma highly skilled teams with appropriate support are needed to provide round the clock immediate care- and it is suggested that these services should be concentrated on a smaller number of sites. Acute myocardial infarctions are already tending to go to South Tees for primary angioplasty. Surgery is also becoming more specialised and properly staffed sub-specialty teams are needed. All of this means that we cannot continue to provide all services everywhere and that thinly staffed hospitals will have to restrict activities to those which can be done safely. This does NOT mean hospital closure but means focusing on more outpatient and planned care. In the meantime more and better care is required in the community.

Obviously the current situation in the Trust cannot continue. Acute services are unsustainable and can no longer continue meet modern needs in terms of safety and quality. No change is not an option.

3.0 Seizing the Future proposals

The Trust has gone through an extensive process of discussion and consultation including close working with the two PCTs. A wide range of stakeholders were involved as well as clinicians and members of the Trust board.
Forty nine options were produced. These were subjected to “hurdle” criteria which included: clinical safety and standards, efficiency/affordability, do-ability. Benefit criteria were also used which included: integrated models of care and patient focus, access, workforce/staffing, and sustainability.

In the end 3 options have been proposed. The first of these is “no change” and for the reasons enumerated above is not a realistic option and would not provide safe high quality care for the population served. The second and third options both envisaged 2 acute sites with the third site being a “plus” site. In option B this would involve a minor injuries unit (8am-8pm), primary care led out of hours and urgent care centre, step-down and intermediate care for local residents, all day-case surgical activity, a midwife-led maternity unit, a cataract centre, primary lower limb arthroplasty, a colorectal screening centre & a full range of outpatient services and diagnostics. Option C would have the same together with additional capacity for assessing and managing urgent medical and paediatric patients, and step-down and rehabilitation facilities. This is the preferred option.

Modelling of costs, capacity and transport have been performed. The least costly is option B which is slightly less expensive than option C. Capital investment will be required whichever option is chosen.

4.0 Critique of the proposals

The options have been examined with particular attention to access and convenience, and clinical criteria: safety, quality, timeliness and sustainability.

Overall option C is favoured. This provides the better service for local residents, good use of existing real estate and least disturbance of services. It seems sensible for BAGH to become the “plus” site. It has the least number of emergency admissions, already does not have emergency surgery, cannot sustain critical care and paediatric services are fragile. However much can be done on the Bishop Auckland site and in the end more local people will receive care closer to home than at present.

4.1 Urgent and emergency care

Currently all 3 sites have moderately busy A & E departments. Obvious surgical cases and major trauma are diverted away from BAGH. BAGH depends on an experienced Associate Specialist with consultant support from DMH where there 4 consultants. Overall consultant numbers in Emergency Medicine are low compared with national recommendations & a long term plan to increase numbers is required so that in the medium term there are at least 6 consultants on each of the two acute sites. The plan to direct all major emergencies likely to require admission to the 2 acute sites is sensible. Two groups of patients will be affected particularly: those with strokes & the elderly patients with multiple co-morbidities. BAGH has run an excellent stroke service since the last reorganisation with a highly committed multidisciplinary team. However with the recent emphasis on stroke with national guidelines and NICE recommendations the service will not be sustainable in isolation for the hyper-acute phase due to lack of support services, critical care and 24/7 access to other specialists. Second phase care, i.e. rehabilitation, will be feasible and indeed desirable for local inhabitants. Not all elderly people will have to travel to the other acute hospitals. This is discussed further below.

As proposed in both option B & option C services for less serious illness and injury should continue to be provided at BAGH. On current numbers this would mean 22000 of the 30000 present attendees at BAGH would continue to be seen there. At present the A & E department and the urgent care centre are separate entities. It is strongly recommended that these should be merged incorporating Out of Hours GP services and employing people with the right skills and competence to deal with all less serious illness and injuries. This would then allow an appropriate service 24/7 on 7 days per week. Some diagnostic facilities such as x-rays would also be required also on a 24/7 basis. Furthermore a strategy should be developed for the whole area to ensure that local services are available to deal with so-called minor emergencies. This should incorporate the front door of the two acute sites as well as Shotley Bridge, Chester-le-Street, and the other community hospitals where appropriate. This should function as a network with a consistent approach to patients and appropriate provision of diagnostics. This together with improved care in the community and extended access to GPs should lessen the numbers of people requiring care at the main sites.

4.2 Acute medicine

At present acute medicine depends on a small number of physicians at both BAGH and DMH with the prospect of progressively less specialist registrar support. As stated above the service at BAGH is not sustainable as it stands. Both options B and C are feasible solutions. It will be important that capacity is increased at both UHND and DMH to account for the extra diverted workload. In particular a doubling of the size of the Medical assessment unit (MAU) at DMH should be anticipated. There are also only 2 acute physicians at DMH, employed as such, a third should be appointed as a matter of urgency. The physicians at BAGH currently participating in the take rota should join the acute rota at DMH which would provide a sustainable critical mass of experienced physicians.

We also support the proposal in option C that there should be a daytime urgent care assessment service for medical patients after major acute services are withdrawn - but with some modifications. This is currently proposed as a 5 day service staffed by SpRs. It would have more impact and be safer and of higher quality if staffed by Consultants or at the very least final year SpRs. It should also focus particularly on older people. These form on average two thirds of major medical emergency cases. Many require assessment and implementation of a treatment plan rather than admission. An experienced consultant is more likely than a less experienced junior doctor not to admit such patients. It would particularly useful if most of this service could be provided by care of the elderly consultants. This service should prevent many older people from travelling longer distances with the attendant difficulties for families.

4.3 Critical care

The current position is unsustainable with one consultant and trust grades running the service at BAGH. We support the proposal in option C to remove critical care services from BAGH, but would add the caveat that workload and staffing should be carefully examined, and expanded if necessary, if the two site acute model is implemented.

4.4 Paediatrics

The preferred option C recommends that inpatient paediatrics be removed from the BAGH site. At the moment BAGH sees acutely ill children during the day and those who are stable remain overnight. However more children now go to the other sites and the BAGH facility is underused. Junior doctor cover is problematic. There are also likely to be consultant retirements in the near future. The proposal to have admitting units only at UHND and DMH is sensible. A facility will be retained at BAGH for GP referred consultant delivered urgent outpatient appointments. We would support these proposals, although we would add that the staff of the Urgent Care Centre should be trained to assess paediatric cases. The change in the service must also be indicated very clearly to the public with appropriate instructions given to the ambulance service.

4.5 Other services at BAGH

The preferred option C envisages a range of other services continuing or being introduced at BAGH. We feel it is vital that these are highlighted in any consultation document, emphasizing the viability and continued provision of a wide range of services for the local population- with the reassurance that these will be safe and of high quality.

1. Outpatients and diagnostics. The range of outpatient services should be spelled out. If possible these should be based on a Trust wide and PCT assessment of the needs of the local population and would represent if anything an expansion of current services. This would be in line with *High Quality Care for All* and the intent to bring services closer to people's homes.
2. Rehabilitation. The Trust proposes to establish BAGH as a trust-wide centre of excellence for rehabilitation. Many skills are already there from the stroke team and other services. We support this but have some concerns about travel times from other parts of the area & thought should be given to peripatetic services being available following an intensive period at BAGH.
3. Step down services. This is also an important proposal for those local inhabitants who have received intensive or specialist treatment elsewhere & is fully supported.
4. Intermediate care. Again this will provide an important resource for local people. It should be allied with GP beds which will prevent particularly older people being admitted to remote sites. We are less certain about using this for intermediate care on a trust-wide basis as this could be highly inconvenient for people from more remote parts of the district. We suggest careful examination of other sites such as Shotley Bridge and Chester-le-Street although cost-effectiveness could be a problem.
5. Day case surgery. The Trust suggests that all day case surgery for the Trust be carried out at BAGH. We support this but careful consideration will have to be given to the increased transport required.
6. Other services. We see no objections to the proposals.
7. Overall the proposed uses of BAGH under option C look acceptable.

5.0 General Comments

5.1 Travel

Information from the Trust suggests that the maximum impact on private travel time would be 30 minutes if the proposed changes go ahead. The Trust acknowledges that further detailed analysis will be required to support the consultation. The impact of the changes on the ambulance service will also need to be explored further with patients travelling further for specialist services. We discussed this with representatives of NEAS who are aware of the changes but detailed modelling and costing will need to be carried out. Discussions with local transport companies will also be necessary.

5.2 Communication

More and better interaction and communication with the public is vital. Members of the publicly elected Governing council participated fully in developing the plans. However, it is not certain how much other members of the general public have been involved so far. A detailed plan should be developed to accompany the consultation.

5.3 Investment at DMH

If DMH is to become one of the two acute sites, which is likely due both to its surrounding catchment area and for the other reasons stated above, then significant investment will be required. This applies both to the physical infrastructure and to staffing. It is assumed that consultants from BAGH will work closely with those of DMH but there will still be a significant shortfall in consultant numbers to provide the sort of consultant delivered services anticipated in *High Quality Care for All.* The same applies to nurses and other health care professionals. Information on both physical changes at DMH and workforce plans should be contained in the consultation documents.

5.4 Consultant workforce

Considerable strides have been made in the Trust having a unified consultant workforce since the Trust was formed 6 years ago. If the proposed plans are accepted then it will be even more important for the medical workforce to have a Trust-wide approach & to be prepared to play a much more peripatetic role. Without this the new plans and the developments expected from *High Quality Care for All* will be much more difficult to implement.

6.0 Conclusion and recommendations

The following section summarises the recommendations of the NCAT review of the *Seizing the Future* proposals:

1. The NCAT review team agrees that NO CHANGE is not an option.
2. The team broadly agrees with the recommendations being proposed under option C, i.e. that there should be two full acute sites and a “plus” site. It seems inevitable and sensible that BAGH should be the “plus” site.
3. Some modifications and refinements of the plans for the BAGH site are suggested. These are:
   a)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.
   b)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.
   c)There should be an appointment based urgent paediatric service.

d)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.
e)Plans should include a GP ward.

Other suggestions and recommendations include:

4)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.
5) 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.
6) 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 and older people's board could usefully be established to plan for older people's care and needs across the whole system.
7) More detailed analysis of transport needs should be carried out & further discussions held with NEAS and local transport companies.
8) A detailed workforce plan should be included in the consultation document including short, intermediate and long-term needs.
9) 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.
10) The communication strategy for consultation should include clear plans on greater public involvement.

APPENDIX 4

Seizing the Future – Evidence from the Royal Colleges

Specialisation

Academy of Royal Medical Colleges (2007) "Acute health care services, Report of a Working Party"[1]

- Specialist Centres: Some conditions requiring highly specialised care, such as serious trauma or acute myocardial infarction, are best treated in specialised centres. Highly specialised treatment will need to be centralised.

- Surgical Specialities: There may not be enough doctors to provide safe levels of care in all hospitals. Emergency medicine with clinical decision unit (CDU) facilities or combined medical/surgical assessment units would be able to provide the initial investigation, diagnosis, stabilisation and treatment of some patients. Triage to a unit with appropriate surgical support which may be on another site, would then be needed. Bypass polices for patients who might need surgical assessment and intervention need to be in place.

Royal College of Physicians (2004) "Acute Medicine: Making it work for patients. A blueprint for organisation and training"[2]

- Staff caring for acutely ill patients should be appropriately trained and that staffing level should be adequate to meet the needs of patients in an expert and timely manner

- A doctor with skills in acute medicine should be present at all times – the report suggests that this should be an SpR or equivalent

Royal College of Physicians (2002) "Isolated acute medical services: current organisation and proposals for the future. Working party"[3]

- 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. Patients should be transferred to these hospitals only when a definite diagnosis has been confirmed, the patient's conditions have been stabilised and a plan for further management has been formulated

[1] Hereafter: "ARMC (2007) 'Acute Health Care Services'"
[2] Hereafter: "RCP (2004) 'Acute Medicine'"
[3] Hereafter: "RCP (2002) 'Isolated Acute Medical Services'"

- It is not appropriate for a consultant physician to have responsibility for emergency admissions or acutely ill patients on two separate sites. Job plans for new or replacement posts should not require post holder to take on this dual responsibility and hospital trusts should work towards phasing out this requirement for existing postholders.

- Further research is needed to establish the potential role of telemedicine in the provision of acute medical services.

Royal College of Surgeons (2006) "Delivering High – Quality Surgical Services for the future – consultation document from the reconfiguration working party"

- Identifies different models of care for delivering acute services across large areas. 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. The document recommends that the clinical network model be considered as a means of achieving the balance between specialist care and local access.

Emergency Care

ARMC (2007) 'Acute Health Care Services'

- Local hospitals with an A & E department, accepting medical cases must be supported by a continuous intensive care service as well as 24-hour imaging and laboratory services. Potentially, separation of medicine from surgery for emergency admissions is sustainable with careful planning and use of networks, but the realignment of all acute services should be a longer term aim. If units need to move to a selected 'medical take', this may result in a significant drop in numbers of emergency patients, affecting the clinical and/or financial viability of such units.

Royal College of Physicians (2007) "Acute Medical Care. The right person, in the right setting – first time. Report of the Acute Medicine Taskforce"[4]

- Emergency care network to co-ordinate acute services

[4] Hereafter: "RCP (2007) 'Acute Medical Care'"

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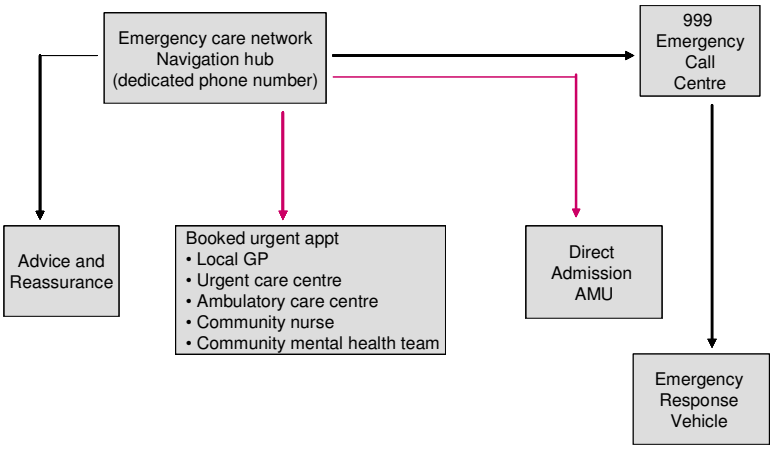
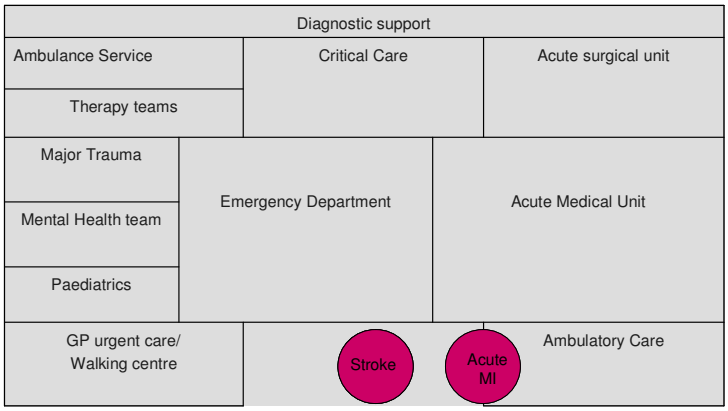


Emergency Floor of Large Acute Hospitals



Medicine, Surgery and Emergency Medicine

- AMU and acute surgical unit co-located in large unit
- AMU/ASU integrated in large medium or small units
- AMU with no acute surgery on site – protocols for surgical assessment
- Watershed conditions e.g. head injury, pancreatitis, GI bleed initial assessment in A&E (clear policies, pathways for ongoing care within a network

<u>RCP (2004) 'Acute Medicine'</u>

- There should be a dedicated area where acutely ill patients can be managed and this should be called an "acute medicine unit" (AMU)

- For smaller hospitals:

  - 24 hour emergency access to medical and surgical care, by using the available trainee and career grade doctors and consultant medical staff more effectively

- 24 hour A&E access and emergency medical care, in the absence of 24 hour resident surgical cover, but with critical care. The model relies upon effective protocols and joint working

Accident and Emergency

ARMC (2007) 'Acute Health Care Services'

- See entry under 'Emergency Care'

RCP (2007) 'Acute Medical Care'

- Improving acute medical care needs access to life saving interventions across a network

RCP (2004) 'Acute Medicine'

- 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 remotely via a telemedicine link. Based on this assessment, patients requiring more intensive acute care would be transferred to the larger hospital

Critical Care

RCP (2007) 'Acute Medical Care'

Medicine and Critical Care:

- Co-located on emergency floor
- Close working relationship with medicine
- Augmented care in AMU – staff competences
- Safe transfer arrangements to be put in place
- Level 3 critical care in large hospitals

RCP (2002) 'Isolated Acute Medical Services'

- See entry under 'Specialisation'

Paediatrics

ARMC (2007) 'Acute Health Care Services'

- 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.

24/7 Diagnostic Cover

RCP (2007) 'Acute Medical Care'

- Improving acute medical care needs access to diagnostics

RCP (2002) 'Isolated Acute Medical Services'

- See entry under 'Specialisation'

Other

ARMC (2007)

- Reconfiguration: 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.

RCP (2002) 'Isolated Acute Medical Services'

1. Interim arrangements should be put in place while existing isolated services are still taking acute admissions. These arrangement should include:

a. Outreach critical care services to identify patients whose condition is deteriorating

b. Agreed protocols for the transfer of sick patients to a hospital with appropriate services. In the case of patients needing critical care this may need to include provision of a flying squad which can resuscitate and stabilise the patient before transfer

c. A 24 hour on site resuscitation team led by a clinician with advanced life (ALS) training.

d. In hospitals which take only selected admission, there should be written protocols which explicitly define those patients who are suitable for admission and those who are not. Staff who are responsible for accepting admissions should have appropriate training on implementation of the protocols as part of their induction course.

e. Hospitals which do not have an on-site surgical service should

i. Not admit patients who might require urgent surgical intervention

ii. Ensure that there are agreed arrangements to provide surgical opinions in a timely and appropriate manner. Patients should not normally have to be transferred to another hospital solely for a surgical opinion, unless this is warranted by their clinical condition or if radiological or other investigations are needed as part of the surgical consultation.

f. These interim arrangements should be audited regularly.

2. Proposed solutions for reconfiguring acute hospital services should be tested in trials before they are introduced.

Royal College of Surgeons (1998). "Provision of Acute General Hospital Services."

- Recommends that acute general hospitals providing elective and emergency, medical and surgical care should support a population of 450,000 – 500,000 people.

APPENDIX 5

Letter from Helen Goodman MP

Cllr Joe Armstrong
Chairman
Overview and Scrutiny Committee
Durham County Council
County Hall
Durham
DH1 5UL

25 November 2008

Re: Bishop Auckland General Hospital

I am writing to you in order to raise a number of concerns about the on-going 'Seizing the Future' consultation that is being conducted by NHS County Durham and the County Durham & Darlington NHS Foundation Trust.

My concerns fall into two categories:

I) The nature of the current consultation and
II) Substantive questions as to whether the proposals will improve medical outcomes and are sustainable

I. The consultation process

I am extremely concerned that the consultation process is inadequate, overly bureaucratic and fundamentally biased toward the PCT and NHS Trust.

The consultation document quotes the 2008 Darzi report, stating 'it is important that the NHS goes through a proper process to determine what will work best, involving patients, carers, the general public and staff, while communicating clearly throughout', but this consultation has done nothing of the sort.[5]

Firstly, it is unclear how much the consultation will cost, how many people the consultation has reached, and how the Trust/PCT have sought to encouragement public engagement in this process

[5] Seizing the Furture, p. 23.

Secondly, the consultation document is utterly inadequate. Not only does it fail to provide anything beyond the most basic statistical analysis (which I will return to in greater depth in part III), but it is written in a mixture of patronising baby-talk and technical jargon that renders the document extremely difficult for the public to read. The numerous hypothetical case studies are particularly pointless as they are contrived and there is no evidence that they would be typical or representative.

The document as a whole reads not so much as a consultation, but rather as a 48-page propaganda tract to support the Trust's proposals.

The on-line consultation response form (see http://www.surveygizmo.com/s/68154/seizing-the-future, but I enclose a hard copy for ease of reference) is also completely unacceptable. Question 9, for example, specifies that 'the status quo is not considered an option', so what, I wonder, is the point of question 1 asking if the respondent 'accepts the case for change'?

It is precisely this kind of loaded questions (i.e. 'do you accept the need for change given that no change is not an option?) that gives public consultations a bad name and serves to reduce public participation in important decisions such as this. It also reveals that the suggestion made by the Chief Executive of the County Durham & Darlington NHS Foundation Trust at a meeting at Westminster on 24 November that 80% of people support the case change is completely empty.

I am also deeply concerned that the online response form is the *only* part of the consultation process which the NHS managers are prepared to take into account. I have been involved in collecting over 11,000 names on a petition about the proposals, but I have now been informed that these representations are 'irrelevant' because they have not been submitted in the approved manner and do not share the assumptions and outlook of the NHS managers promoting the change options. The North East Strategic Health Authority have also banned staff from distributing a second Unison petition opposing these proposals, although they did not ban a petition recently organised by the BMA in GP surgeries.

This approach – where local health authorities will only consult in their own approved manner and will only acknowledge responses that accept the case for change – cannot be described as a 'proper process…involving patients, carers, the general public and staff'. Rather, it is an incredible approach which would have fitted well in the political culture of the Soviet Union.

Coupled with those set out in the next section, these flaws seem to me to be so substantial that I believe the Overview and Scrutiny Committee would be quite within its powers to seek a reference by the Secretary of State to a panel.

The availability of necessary figures and statistics to determine if the Trust's proposals are sustainable and will improve medical outcomes

The numerical information provided in the *Seizing The Future* document is extremely limited and biased. Indeed, on the basis of the information given it is virtually impossible to come to any view at all on the proposals. I attach a note (see Annex A) of the figures that are currently in the public domain.

I have repeatedly asked the local health authorities (all of them, the PCT, the NHS Trust and the Strategic Health Authority) to provide a detailed geographical analysis of vital factors such as demand for health services, travel times to alternative hospitals, number of admissions to hospitals etc., but I have not received any substantive response. I have also received no reply to my enquiries about the estimated capital costs involved in improving the hospitals at Durham and Darlington.

It is absolutely vital that these figures are in the public domain prior to any final decision, and the failure of the health authorities to produce them suggests either that they have not undertaken the necessary analysis or that they are withholding them.

The figures required are:

i) **On the needs/demand side:**

For each postcode served by the Trust: the current population and health needs disaggregated by condition (e.g. births, cancer patients, stroke victims), the current pattern of hospital admissions at each hospital (i.e. the number going to BAGH, Darlington and Durham) – again disaggregated by condition and indicating whether admissions are acute or elective – and how this would alter under the Trusts proposals.
This would show the direct need for particular services within each postcode, and how many people would be affected by the proposed changes.

ii) **On the supply side:**

Analysis of the resources (i.e. beds, staff, money, major items of kit, buildings) involved in providing treatment for each medical condition at each hospital in the Trust, the current level of capacity utilization, and how the proposed changes would affect this.

This would reveal the costs and extra resources that will be needed to be in place to realise these changes, and the spare capacity that currently exists for specific treatments at each hospital.
I attach mock-ups as Annex B since the PCT and Acute Trust seem incapable of understanding what is needed.

iii) **A proper cost/benefit analysis of the following options:**

● Implementing in full the original proposals made by Lord Darzi in his 2004 *Review of Health Services North and South of the Tees.*

● Maintaining the status quo in terms of services available at each hospital, what would be the costs involved in increasing staff numbers to the necessary level (e.g. dealing with the EU Working Time Directive), improving facilities and capital stock (taking account of the differing ages, life expectancy and upkeep of the three hospitals in the Trust).

● The proposals made in *Seizing the Future*, including the inevitable capital costs involved in upgrading Darlington Memorial and Durham Hospitals (as recognised by Professor Alberti).

These analyses need to address medical outcomes and financial costs. Quite frankly it is not credible to claim as the Trust does that despite a three-fold increase in NHS resources over the last ten years that safe care can no longer be delivered without this reorganisation.

iv) **Forecasts for changes in need and demand**

The Trust need to show forecasts for each category of condition (i.e. cancer, stroke, allergy) over the next ten years so that one can see which conditions will require additional resources (i.e. conditions that will experience increased demand) and which will require less. These forecasts must also take into account areas of deprivation.
By producing these forecasts one will be able to see how health services will need to change over the next decade and, therefore, how effective the Trust's proposed changes are likely to be.

Proper use of taxpayers' money must be at the heart of the Trust's proposals, and full disclosure of these figures is essential.

These points also emerge in Prof. Alberti's study for the National Clinical Advisory Team (NCAT). His report says:

a) 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.

b) More detailed analysis of transport needs should be carried out and further discussions held with North East Ambulance Services (NEAS) and local transport companies.

c) A detailed workforce plan should be included in the consultation document including short, intermediate and long-term needs.

d) A clear account of how the extra emergency workload will be coped with at University Hospital of North Durham (UHND) and Darlington Memorial Hospital (DMH) should be included, together with extra investment required, particularly DMH.

e) The communication strategy for consultation should also include clear plans on greater public involvement.

Quite honestly I am appalled that NHS professionals with responsibility for managing a £290 million budget are so financially illiterate and seem to think it is acceptable to take decisions concerning resources and patients with virtually no quantification at all.

II. Substantive Issues

Travel

A large number of my constituents – perhaps 35,000 – will now have an extra 20-30 minutes travel time to hospital in an emergency. Moreover, the road between Bishop Auckland and Darlington is particularly bad, especially at night-time.

I believe this is a real problem, and recent research published in the Emergency Medical Journal by Sheffield University supports this (see enclosed annex C). Dr Bob Aitken has dismissed this research as "old" but has not provided any more recent data. I contacted Sheffield University for their comments, and I attach the relevant papers.

Clearly time taken to get to hospital is an important safety issue: if it were not we would not run a nationwide blue light ambulance service. For the Trust to measure medical outcomes once the patient crosses the threshold and to ignore travel times is wholly irresponsible.

A proper analysis of who will be affected and how it will be tackled is needed. This is a perfectly straightforward piece of work, which Post Office Ltd. undertook recently on their closure programme, and it needs to take account of such facts as that there are wards in my constituency where 40% of the population do not have a car.

The Trust also tells me that much good care can be delivered by paramedics to people at home or on the journey. This will be greeted with horror in West Durham where the

Ambulance Service has been re-organised so badly that their response target has fallen from 45% to 2%. How can anyone rely on such an incompetent service? Moreover, the Acute Trust were unaware of this failure, which demonstrates how narrow is their perspective. This is a point I notice is also in the Royal Colleges document, but one the Trust has conveniently ignored. The Strategic Health Authority is also culpable because they are supposed to look overall at how the services fit together.

Furthermore, on the safety point it is not credible to argue as they do that a paramedic is fine but that BAGH is unsafe.

It has also been suggested to me that greater reliance should be put on the Air Ambulance service. In Scotland, where this is funded by the NHS this might be a credible option. I note, however, that in England the Air Ambulance is a charitable venture which would be asked to bear the extra burden.

A point made to me by a number of doctors at the hospital is that a significant number of seriously ill people, and 50% of seriously ill children, do not arrive by ambulance but are brought by family members to A&E. This means that there will have to be an enormous public education programme to let people know that if they turn up at BAGH A&E there will not be the appropriate staff or facilities to deal with them. Management accept that this will be necessary but have yet to make any plans for such a public campaign.

Triage is difficult for doctors and paramedics, and there is a risk, I believe evident already, that they would err on the side of caution by not sending people to BAGH who could be treated there.

Repeatedly we are told an NHS objective is that people be treated nearer to home – it would appear that this does not apply if you live in Bishop Auckland.

New services proposed for BAGH

In looking at the services proposed for BAGH, I think it is helpful to review the proposals made by Prof. Darzi six years ago in his original *Review of Health Services North and South of the Tees.* I attach a chart from his report as annex D.

Comparing the proposals with current services as described to me by Edmund Lovell, Head of Corporate Affairs at the Trust, a number of planned services have not been provided; viz., cardio-angiography, endoscopy, GUM, Intensive Care, oral surgery and orthodontics, orthopaedics and trauma, radiology, respiratory medicine and urology. In addition, a number of excellent services have been rundown through mismanagement, viz., obstetrics, paediatrics and stroke services. It was also proposed to centralise haematology for the whole Trust in BAGH. One option that has not been considered is to implement the Darzi proposals in full. Another is maintaining the status quo. The failure to implement these changes naturally brings into question the

Trust's capacity to bring about necessary change. Incidentally, the different descriptions of the work in each document make comparison very difficult.

Again, it would be nice to see in quantified terms the work that is proposed to come to BAGH, complete with the patient number and resource implication.

As far as the Trust's proposals for BAGH are concerned there are three issues:

i) Will what is proposed for BAGH work in medical terms?
ii) What are the transport implications: will people choose BAGH so the services are sustainable?

iii) Will DMH and UNHD cope and what will be the cost of investment required to achieve this? Prof. Albert raises this too in his NCAT study.

Medical Issues

Acute General Medicine is by far the busiest department at BAGH. Under *Seizing the Future* all acutely ill people with problems such as asthma attacks, heart attacks, diabetic emergencies, chest infections etc. will be admitted to Darlington or Durham hospitals. Once they have been stabilised and are recovering the plan is to transfer local patients back to BAGH to continue their rehabilitation. There is such demand for medical beds that it is a regular occurrence, especially in the winter months, that all the medical beds at all three hospitals are full, even now with BAGH fully functioning.

There are no plans for any Intensive Care Unit or High Dependency Unit at BAGH. In a hospital here a lot of elective day-case surgery is going on, many of the patients will be elderly and have other medical problems. Even with careful pre-assessment before operations, patients will still from time to time suffer unforeseen complications, and there is currently nowhere in the plans for them to be resuscitated prior to being transferred to another hospital.

Management have not even thought about the need to provide a resuscitation team for unforeseen emergencies. There are no plans at present for any doctors to be resident in the hospitals overnight, despite the fact that a large number of elderly patients will be in the rehabilitation unit. With the pressure for beds at UNHD and DMH, the BAGH physicians are very concerned that patients will be sent back to BAGH too early before their condition is fully stable. If these patients then deteriorate, especially at night, no-one is clear what arrangements will be in place for them to be assessed, resuscitated or treated.

With regard to paediatrics, the Children's Ward will close despite the general agreement that the BAGH children's ward is the best in the Trust, and has the best facilities for patients, families and staff. Al children who need admission to hospital

will have to go to UNHD or DMH. Under option B there may be some provision for a 'Rapid Access Clinic' where GPs or staff in the Minor Injuries Unit could request and urgent out-patient appointment for a child to be seen that day or the next day, which might thereby avoid an admission to hospital. There has, however, been little discussion about how this would be staffed. Under option A there would be no provision for children except the current out-patient clinics. There are no plans for an on-call paediatric rota for BAGH, so if parents did bring in a sick child to the minor injuries unit at night the staff there, who are not trained in paediatrics, would have to cope until a paediatrician could be summoned from Darlington or Durham.

I understand that the Midwifery Led Unit will continue as it currently does. At present there are no obstetric doctors at BAGH so mothers are carefully selected and anyone with any problems cannot have their baby at BAGH. If complications arise during labour, the woman is transferred by ambulance to DMH and this will not change. At present if a mother should collapse during labour there are anaesthetists at BAGH

who can called to resuscitate her. There will be non out-of-hours anaesthetic cover under *Seizing the Future*. If a baby is born with unexpected problems, the midwives are trained in newborn resuscitation but often have to call a consultant paediatrician for help. Under *Seizing the Future* there will be no paediatrician on call and help will be a long way away. In my view this is compounding the risks to mother and babies.

Finally, I agree on these services I agree with Prof Alberti that the use of community hospitals should be reviewed by the Trust and the two PCTs with a view to expanding local services. In particular better use of 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 be performed.

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 Trust. Similarly an older people's board could usefully be established to plan for older people's care and needs across the whole system.

Travel for new services

On the question of daycase surgery and choice the "Case Study"(Albert's story-elective daycase surgery) it is illogical to suggest that a patient from Chester-le-street recommended for day surgery would opt to come to BAGH rather than Shotley Bridge Community Hospital (SBH)

It is quite evident that SBH with 69 beds will be fully utilised by patients from the north of County Durham. (See Page 26 of the document ""there is a proposal to increase the number of operations carried out at Shotley Bridge's day surgery unit) Indeed in line with the white paper; Our Health, Our Care, Our Say in 2006 which stressed the general principles of more care in the community and care as close to home were established.

However, in the Report by Professor Alberti it is stated page 10, Para 2 - Rehabilitation - "We support this but have some concerns about travel times from other parts of the area". Similarly Page 10, Para 4 – Intermediate Care "It should be allied with GP beds which will prevent particularly older people being admitted to remote sites. We are less certain about using this for intermediate care on a trust-wide basis as this could be highly inconvenient for people from more remote parts of the district."

In the same way I would suggest that if it is highly inconvenient for a resident of North Durham to have intermediate care or rehabilitation at Bishop Auckland then it is equally highly inconvenient for residents of the Township of Bishop Auckland, Upper Gaunless Valley, West Auckland, Coundon to be expected to travel to DMH or UHND.

So there must be a question mark as to whether for elective surgery people would chose BAGH and whether this would prove to be sustainable. I am not in a position to

judge the implications for Durham or Darlington, though I know this a concern for people who live there.

I look forward to discussing this with you next week and hope you are able to make use of some of this material in your questioning of Prof Alberti tomorrow.

Yours sincerely,

Helen Goodman
Member of Parliament for Bishop Auckland

APPENDIX 6

DURHAM COUNTY COUNCIL

SEIZING THE FUTURE SCRUTINY WORKING GROUP

25 SEPTEMBER 2008

Present

Councillor R Burnip (in the Chair)

Members of the Working Group
Councillors A Anderson, J Chaplow, T Cooke, P Crathorne, R Harrison and D Lavin

Other Members
Councillors B Myers and M Williams

Also Present
F Jassat, Head of Overview and Scrutiny, Durham County Council,
J Brock, Health Scrutiny Liaison Manager,
J Hartley, Chief Executive, Pioneering Care Partnership
J Rochester, Link Interim Steering Group
E Lovell and D Murphy County Durham and Darlington Foundation Trust
D Gallagher NHS County Durham
B Pike, Durham County Council Community Development Team,

1. Welcome and Introduction

Councillor Burnip thanked everyone for attending.

2. Declarations of Interest

The following interests were declared by Members attending the meeting:
Councillor Anderson declared an interest as the local District Council member for the Cockton Hill ward and also Mayor of Bishop Auckland
Councillor Crathorne declared an interest that she had applied to join the Link
Councillor Lavin declared an interest as the Derwentside District Council portfolio holder for Health
Councillor Myers declared an interest as Chairman of Willington Town Council

3. Draft Terms of Reference

The draft terms of reference (for copy see file) of the working group were explained. The Working Group was advised that the terms of reference were very similar to those previously agreed by the Health Scrutiny Committee with the change of the name of the County Durham PCT to NHS County Durham.

Feisal Jassat explained that the terms of reference needed to reflect media engagement and that any media involvement should be via the Chair of the Working Group. The involvement of the LINK with the Working Group was to be encouraged and the Working Group would seek to co-opt a member of the County Durham Local Involvement Network (LINK).

It was also suggested that 'Talking Together' under the 3rd bullet point should be deleted as this refers to Darlington Borough Council.

The Working Group agreed the suggestions for the amendment of the draft terms of reference.

4. Service Review Process and Responsibilities

The Working group received a presentation from David Gallagher, NHS County Durham about the public consultation process for 'Seizing the Future' (for copy of slides see file).

He explained that the PCT Board had met on 2nd September and received proposals from the Foundation Trust. The Board agreed in principle to support the consultation process. The Board of the PCT and the Foundation Trust met yesterday to discuss outstanding issues. The PCT Board felt that a case had been made and agreed to take the consultation process forward. It was stressed that no decision had been made to close Bishop Auckland A&E Department. He stated that he hoped that the NHS and the scrutiny process could work together and stated that should Overview and Scrutiny require confirmation of any information they should contact him directly. Feisal Jassat said it in terms of the relationship and engagement with the NHS that all contentious information and issues should be shared.

It was explained that the consultation process is a formal statutory process of 13 weeks which will be extended to 14 weeks to take account of the Christmas holiday period. There are four key partner organisations involved in the process. These are:

- NHS County Durham
- County Durham and Darlington Foundation Trust (CDDFT)
- Consultancies:
- Proportion (formerly known as Rocket Science)
- M & M

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. CDDFT have come forward with a number of proposals and Proportion has been appointed to manage the consultation process and the handling of responses. This will provide some objectivity to the process. 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 will go out to all households and web links will also be provided. A series of 10 public meetings will be arranged. It was stressed that careful consideration needs to be given on how they are arranged and to ensure that the right locations and participants are engaged to achieve a constructive dialogue and a two way communication process.

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

It was explained that Proportion will be responsible for managing all information received during the consultation. It is important to understand where the issues and information have arisen in the community so that they can be addressed. It is planned to launch the consultation process on 6th October with a media awareness raising event.

Councillor Cooke requested that advance notification be given of all consultation events and notification also be provided to all, District, Town and Parish Councils. David Gallagher stated that a good level of advance notice will be given for all events.

Councillor Crathorne expressed the view that the consultation document/s should understandable by the general public. In addition she asked how the Trust would provide information to people with sight and hearing disabilities. David Gallagher stated that the Trust will meet the challenge to provide a document that is fit for purpose. In relation to reaching people with disabilities or those where English is the second language he said it would be necessary to have a mechanism that would make them aware of the consultation.

Councillor Lavin stated that it is important that to ensure that all documents issued during the process are consistent and contain the same information. In addition he suggested that it might be helpful if to the Trust if representatives of the County and District Councils attended the launch.
David Gallagher agreed that it might be helpful to have representatives from stakeholder organisations to attend the event and would consider this suggestion.

Councillor Anderson suggested that because of the possible changes to Bishop Auckland Hospital that the public consultation events should be centred on Bishop Auckland and the Dales. David Gallagher explained that 'Seizing the Future' was about changing hospital services across the County and Darlington and therefore needed to have the views of all residents. He accepted that the views in Bishop Auckland would be different to other areas.

Councillor Harrison and Jane Hartley said it was important documents were accessible and user friendly and felt the LINK could help by examining documents and information before it goes out to the public. David Gallagher said there was

tight timescale but welcomed the offer to assist. Assistance on reaching hard to reach groups and communities would be helpful.

Jim Rochester asked whether it was possible that the online information on could be provided in modules rather than having to download the entire document. Edmund Lovell explained that a micro site is being developed and this will enable people to examine the parts of the consultation that interest them.

Jim Rochester asked whether it would be possible to have information to distribute at the LINK launch event. David Gallagher explained that information could change before the consultation launch on 6 October and agreed to discuss the request outside of the meeting.

Councillor Crathorne asked how the consultation and public meetings will be publicised. Diane Murphy and Edmund Lovell explained that during week commencing 20 October space had been booked in the Advertiser series of newspapers and this will include the dates and venues of all public meetings. The meetings will not commence before 3 November so there should be at least 10 days notice before the date of the first meeting. It was acknowledged that there are areas which are not covered by the Advertiser series and it was unlikely that it would reach 100% of households. Members were advised that if they are aware of communities which have not received any information they should let the NHS County Durham know as soon as possible.

Feisal Jassat suggested that it might be helpful to have a meeting involving all County Councillors for them to receive information on Seizing the Future. District Council representatives on the Health Scrutiny Committee should share information with their colleagues.

5. Seizing the Future Proposals and Consultation Plan

The Working Group received a presentation from Edmund Lovell and Diane Murphy of County Durham and Darlington Foundation Trust

Diane Murphy explained that CDDFT proposals are to concentrate their main acute services on Darlington Memorial Hospital and the University Hospital Durham. Bishop Auckland Hospital 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.

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 they are 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 of anaesthetics was lost several years ago 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. Edmund Lovell explained that 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.

Councillor Harrison asked whether it would be possible for the Trust to provide services to the military service with the Gatterick Garrison being close to Darlington Hospital. Diane Murphy explained soldiers and their families from Catterick receive their services from a ward at the Friarage Hospital. The Trust is seeking to provide maternity and orthopaedic services at Bishop Auckland.

Councillor Crathorne sought clarification as to why Bishop Auckland had lost its training accreditation. It was explained that the hospital has insufficient patients. The Royal College of Surgeons have made recommendations that to specialise doctors need a critical mass of 600,000 patients. If this is spread across three sites there are insufficient patients to enable doctors to specialise. Edmund Lovell explained that guidance and technologies have changed over time. There is a need for a hospital in Bishop Auckland and services can be safely provided there. As it is a new facility and is central to the county it creates an opportunity to move countywide services to Bishop Auckland.

Councillor Burnip asked whether it will be possible to say which services will be provided in Bishop Auckland. David Gallagher stated the consultation document will explain what the options are.

Councillor Cooke suggested that better use should be made of excellent community hospitals at Barnard Castle and Stanhope to deal with minor injuries. David Gallagher agreed that community hospitals could meet this level of care.

Councillor Williams said there was a perception that Bishop Auckland hospital would close. David Gallagher stated that the hospital was not closing and would not become a community hospital. It was stressed that the proposals are about making better use of the facilities. At present resources are spread thinly across the County and if the role of one of the hospitals is changed and services moved to the other hospitals, it will be possible to provide a configuration to meet the critical mass to provide services.

Feisal Jassat stated that it would be helpful for Members of the Group to understand the standards that NHS staff work to in terms healthcare delivery. In addition Members might find it helpful if they were aware of the financial implications of legal liabilities and litigation and to understand what accreditation is. Diane Murphy explained that the level of liability premiums depends on the level of accreditation but is not thought to be a major issue in the provision of services. She advised that at the next meeting to take place on 16th October when all the key clinicians will be in attendance, Members of the Working Group will be able to ask detailed questions on services and standards.

Councillor Chaplow pointed out that Bishop Auckland Hospital has good reputation for hip and knee replacement surgery. Diane Murphy advised that this would be one of the benefits of establishing a specialist unit as this would deliver better outcomes for patients.

Jane Hartley suggested that the consultation should provide information explaining the change in the delivery of healthcare services over the last 10 years.

Diane Murphy informed the Working Group that MRSA and hospital acquired infection is a major issue for Trust. The proposed change will help the Trust to make improvements and reduce the level of hospital acquired infections by separating all planned care coming into Bishop Auckland Hospital and acute illness. From next year the Trust will be screening all patients coming into hospital for planned surgery. It is expected that this will reduce MRSA and hospital acquired infections.

6. Scrutiny Project Plan

The Working Group considered the project plan setting out the future dates for meetings and the evidence to be received. Jeremy Brock informed Members that the project plan will be updated as required and any suggestions from Members are welcomed. At the next meeting the Working Group will be taking evidence from medical directors and their colleagues from clinical areas who are affected by the proposals and from the Strategic Health Authority.

Following this meeting a press release will be issued explaining the process. Members of the public will be encouraged to take part in the consultation or to pass on their views via their local Councillor. All local MP's will also be kept informed.

Diane Murphy informed the Working Group that the Trust has been working with the County Council's Integrated Transport Unit and have been developing plans which will be shared with the Working Group in due course.
In response to questions from Bill Pike, David Gallagher explained that the consultation process will not be shortened and will run for 14 weeks. Information will be available at the beginning of the process. He confirmed that Proportion will be managing the process for the PCT but that the PCT will be providing the information.

7. Date of Next Meeting

The next meeting will take place at Noon on Thursday 16th October and will be held in Committee Room 1B at County Hall Durham.

APPENDIX 7

DURHAM COUNTY COUNCIL

SEIZING THE FUTURE SCRUTINY WORKING GROUP

16 OCTOBER 2008

Present

Councillor R Burnip (in the Chair)

Members of the Working Group
Councillors T Cooke, P Crathorne, R Harrison, D Lavin and V Williams

Other Members
Councillors B Myers

Also Present
F Jassat, Head of Overview and Scrutiny, Durham County Council,
J Brock, Health Scrutiny Liaison Manager,
B Aitken, I Bain, G Carton, A Cottrell, S Eames, C Fletcher, E Lovell,
R Mitchell, N Munro, D Murphy, B Potter and C Robinson, County Durham and Darlington NHS Foundation Trust
J Wood NHS County Durham
S Jennings, Pioneering Care Partnership

Apologies for absence were received from Councillors A Anderson and J Chaplow and B Pike and D Gallagher

1. Welcome and Introduction

Councillor Burnip thanked everyone for attending.

2. Declarations of Interest

Councillor Crathorne declared that she was an associate member of the County Durham Local Involvement Network

3. Minutes of the Meeting held on 25 September 2008

The Working Group agreed the minutes of the meeting held on 25th September 2008 as a correct record.

Referring to minute number 4 Service Review Process and Responsibilities, Edmund Lovell informed the Working Group that 'Proportion' and 'Rocket Science' are two separate organisations.

4. Matters Arising

The Working Group noted the revised Terms of Reference (for copy see file). With reference to Minute No 4 the Health Scrutiny Liaison Manager informed the Working Group that a meeting for all Council members to hear the views of Professor Alberti on the proposed changes is to be arranged.
The Head of Overview and Scrutiny informed the Working Group that following the last meeting when it was agreed to co-opt a member from the LINk to the Working Group. It had not been possible to identify a co-opted member from the LINk for todays meeting but Sue Jennings from Pioneering Care Partnership was attending as an observer. Members were reminded that if they identify any gaps in the consultation process then these should be notified to NHS County Durham via the Health Scrutiny Liaison Manager.

5. 'Seizing the Future' – The Case for Change

The Working Group received a presentation explaining the case for change (for copy of slides see file).

Stephen Eames Chief Executive explained that the Trust has to make some of the changes in order to maintain and improve standards. Whilst the Trust is proposing changes they want to see the full utilisation and development of services at all sites.

Bob Aitken, Medical Director informed the Working Group that the clinical model they have developed will have two full acute sites at Durham and Darlington. Some acute services will be moved from Bishop Auckland to Durham and Darlington. Bishop Auckland will be developed as a planned care centre. The community hospitals at Chester le Street and Shotley Bridge will remain broadly the same but with addition of more day care surgery at Shotley Bridge.

It was explained that this process is being clinically lead. The Trust has been judged to be excellent by the Healthcare Commission and this is down to the hard work of the staff, who have maintained services, often in difficult circumstances. The process is being driven by the national drive to specialise at some central sites but to provide services as locally as possible. The Trust is planning to maximise the use of all sites and is not planning to close any of its hospitals. The role of the hospital may change but this will lead to an overall improvement in the level of care. It was stressed that there will be no redundancies.

In terms of current services, the Working Group was informed that there has not been a full A & E Department at Bishop Auckland for a decade. Trauma and orthopaedic patients have not gone to the hospital for a long time and acute major surgery or elective major surgery has not been performed at Bishop Auckland for some time. The hospital has been able to take all patients with acute medical conditions such as stroke but not orthopaedic patients.

Critical care levels are graded 1 to 3, with level 3 being the sickest patients. Bishop Auckland has a level 2 critical care facility which arose from Lord Darzi's review and report of 2002. At that time it was acceptable to have an unrestricted medical intake facility at level 2. In 2004 recommendations changed and hospitals with unrestricted admissions intake should have a level 3 critical care unit. The Trust has tried over the last few years to raise the staffing level of the unit. The Trust has invested resources to recruit additional staff but it has not been possible to obtain the appropriate staff at Bishop Auckland. In October 2007 a decision was taken that all level 3 patients would be transferred to University Hospital Durham or to Darlington Memorial Hospital.

In relation to acute paediatrics it was explained that since Lord Darzi's review, Bishop Auckland's acute paediatrics has only offered a service between 8.00 a.m. and 8.00 p.m. when all sick children can be admitted. Beyond this time sick children will be admitted to Durham. A system is in place where consultant's and junior doctors undertake regular assessments and if it is felt that a child will require additional support, arrangements are made to transfer to the other acute units.

Bishop Auckland has a successful midwife lead maternity unit. Planned surgery is undertaken at Bishop Auckland and it has been successful in undertaking hip and knee surgery. Colorectal cancer screening is provided together with a range of diagnostic services.

The changes are being proposed as a result of rapid developments in medicine and the need to specialise. There is also a need for a critical mass of activity in order to maintain the expertise of highly skilled staff. There is evidence to show that centralisation has beneficial outcomes for patients in cancer care. There is also evidence that demonstrates that specialisation is beneficial in other areas of acute medicine. This may require patients to travel further to be treated by specialised clinical teams but with likelihood that the outcome will be better.

The final phase of the European Working Time Directive will be implemented in August 2009 and all junior staff working hours go down from 56 to 48 hours per week. This is equivalent to losing 32 junior doctors. This puts pressure on the Trust to provide European Working Time compliant on call rotas. If the Trust cannot provide compliant rotas the training committees of the various Royal Medical Colleges will not recognise the Trust's training. Recruiting additional doctors is therefore not a solution as training requirements would not be met.

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.

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 staff of acute care physicians. This is supported by a team of 'ologists' i.e. cardiologists, gastro-entologists etc on the wards. After a period of 12 to 24 hours the patients will be handed onto the 'ologists' to receive their 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 the quality of staffing levels. A recent recommendation on the level of critical mass of activity to maintain a level three unit means that there is insufficient activity across the County to maintain the expertise of three level three units.

In terms of children's care Bishop Auckland was regarded as providing the gold standard of care being mainly lead by consultant paediatricians with support by junior doctors. This model is less favourable now because it is very expensive. It is difficult to recruit consultants in this type of clinical configuration and the Trusts paediatricians feel there is a need to move to two acute sites.

It is proposed to provide the following services at Bishop Auckland (taken from PowerPoint slides):

Now	**The future**
A&E (medical and minor injuries)	24 hour urgent care
Acute medicine including stroke	Medical Rapid Assessment
Midwifery led maternity unit	Midwifery led maternity unit
Acute Paediatrics (limited hours)	Paediatric rapid assessment
Planned surgery Hip and knee surgery unit Colorectal screening Diagnostics Out patients Critical care (level 2)	Planned surgery (Trust wide) Hip and knee surgery unit Colorectal screening Diagnostics Out patients Intermediate care Centre of rehabilitation excellence Cataract centre

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'.

Expansion of any of the three sites to enable them to take on the workload from another site will require the expansion of facilities to accommodate the workload. The Trust has examined the costs for making the each of the sites into a planned care site and the costs are as follows:

University Hospital Durham - £80M
Darlington Memorial Hospital - £120M
Bishop Auckland Hospital - £7M

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 is 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 activity episodes. Basing the planned centre at Darlington will mean the loss of 9,000 activity episodes while basing it at Durham could lead to the loss of 22,000 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.

Dr Neil Munro informed the Working Group that a proportion of heart attack patients already travel to specialist centres at James Cook Hospital and the Freeman Hospital for immediate treatment. A number of cases do not come into the A & E at Bishop Auckland. 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 that member of staff 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.

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 rapid access clinic. This will allow patients to be seen and allowed to go home rather than be admitted to hospital.

The benefits for the patients include:

- Better access to a specialist- will reduce single handed specialists

- Less risk of cancelled operations – the separation of planned and emergency care will lead to less planned operations being cancelled
- Less risk of infections like MRSA – separating planned and emergency care will also reduce the possibility of cross infection and increased screening would reduce infections further.
- Better rehabilitation after being ill – the planned rehabilitation centre will mean patients would have intensive support speeding up their recovery.
- Quicker tests and diagnosis – the changes will help the Trust to provide tests 24 hours per day meaning fewer delays.
- Being on the right ward – the changes will reduce the possibility of patients being placed in a ward which does not specialise in their condition improving the outcome.

The benefits of the changes will provide certainty for the future of services at all hospitals. There will be changes at both Durham and Darlington and Trust wide services will move into Bishop Auckland while some will be moved out. This will allow the Trust to sustain services close to patients. It is not proposed to change outpatient services. The diagnostic services on all of the sites will remain where they are. It was again stressed that there will be no redundancies.

Councillor Cooke advised that there is a community hospital in Barnard Castle. He asked whether it would be possible for minor injuries to be treated in Barnard Castle or for outpatient appointments to be held there rather than residents of Teesdale having to travel further for treatment. Stephen Eames explained that this point will be considered. Barnard Castle community hospital is owned by NHS County Durham. Consultants are happy to consider outreach clinics and they will enter into discussions on this issue. Some services such as the paediatric outreach service are delivered by this model and if there is demand and it is a good use of resources this will be considered. Research has indicated that approximately 14/15% of services currently delivered at the main centres will have to be delivered more remotely.

Councillor Burnip said that people want to know what services will be delivered locally. Stephen Eames said that this issue will be considered and they will be able to advise which specific services are being planned.

Councillor Cooke explained that residents in Teesdale have great difficulty in reaching appointments because of the limited bus services in the area. Diane Murphy informed the Working Group that the Trust is working to overcome some of the challenges that patients face in getting to their sites. The Trust is in discussion with the Integrated Transport Unit and based on a scheme that has been implemented in East Durham they are working to develop a similar scheme for the parts of the County that use the Trusts hospitals. The scheme has the following three elements:

- The Patient Transport Service (PTS) provided by NEAS
- Existing Bus Services
- Additional contracted services

Patients will be able to ring one number to get help. If they need the PTS and are eligible they will be booked onto the service. If there is good public transport available they will be advised of the service. If the patient needs to use the additional contracted service they will be picked up close to their home within a 30 minute timeslot. This service will also be available for visitors and staff. It will not be a free service, but users will be able to use concessionary travel. Stephen Eames advised that the Trust together with NHS County Durham will need to fund this service. He advised that they will describe their proposals at the public consultation meetings although there is a need to listen to the needs of the different communities.

Councillor Burnip asked for clarification on the proposals for the rehabilitation centre at Bishop Auckland. The plan for the rehabilitation centre is to provide a seven day service and it will be an intensive multi disciplinary service to try and get people rehabilitated into their own home or the community as quickly as possible. The service will be available to anyone who meets the criteria. Patients in all areas of the County will benefit from the centre of excellence which will be unique in the North East region.

Councillor Lavin raised the issue of the difficulty that patients from the north west of the County may have in accessing treatment at Bishop Auckland. There is a possibility that those patients may opt for treatment in the Tyneside area which is more accessible from the north-west area particularly if they are required to attend Bishop Auckland for follow up appointments and further treatment. Councillor Lavin said that he found it difficult to accept that Bishop Auckland hospital should be the site that is to be changed, when it is known that Darlington Memorial hospital will require major refurbishment and will be competing with a new hospital at Wynyard Park.

Stephen Eames said that there is competition with other providers and patients in discussion with their GP have a choice where they receive their treatment. It was explained that if Darlington were to become the planned care centre it would cost £120M to make the changes. Analysis of patient flows indicates that this option would have serious effect on the Trusts income. The largest conurbations are at the north and south of the County and to succeed 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 expects that there will be some movement away from Darlington when the new hospital at Wynyard Park opens. To the south of Darlington, the Friarage will be under going a review 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. The consultants who work from Shotley Bridge

consult on a wide geographical basis. 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.

Councillor Crathorne pointed out that the consultation document had omitted Sedgefield Community Hospital. She also raised the issue that patients are being advised by their GP to go to Darlington or Durham because services have been removed from Bishop Auckland. Councillor Crathorne also expressed concern about the impact that the additional A & E patients diverted from Bishop Auckland would have on Durham and Darlington. She was of the view that patients from the Bishop Auckland area and the Dales should have option of attending A & E at Bishop Auckland. She also highlighted that parking at Darlington and Durham is very difficult.

Stephen Eames explained that the Trust is of the view that it can't operate three general hospitals which will be able to provide high quality care. If the Trust is unable to go forward with this proposal it is felt that it will threaten the quality of care at all three sites. Apologies were given for the omission of Sedgefield Community Hospital and it was explained that it is not part of the Trusts remit as it is a PCT operated community hospital.

Councillor Burnip again raised the issue about competition from the new hospital at Wynyard Park. It was explained that this had been taken into account in the analysis of patient flows. It is not felt that the new hospital will be convenient to patients from the Darlington area. The Trust already loses patients to James Cook hospital for specialist services, though James Cook is already near capacity and will be unable to take a substantial number of patients from other areas.

In relation to A & E services it was explained that there will be physical changes to both Durham and Darlington to cope with the additional patients. Changes are needed at Darlington A & E regardless of the outcome of 'Seizing the Future'.

Councillor Harrison pointed out that the main sites are in the south and the east of the area and this will place the focus on the NEAS and that is why residents in the west of the County are concerned about the changes. It was explained that some services will be moving to Bishop Auckland and it will become a sub regional centre for routine planned care.

Councillor Lavin informed the Working Group that he had travelled by bus from his home to Bishop Auckland and that it had taken 2 hour 45 minutes to complete the

journey. Anyone undertaking the journey as a visitor would not be able to get home after 4.00 p.m. without a very difficult journey involving many changes.

In terms of acutely ill patients, Diane Murphy 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 hospital which is right 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 NEAS and they have confirmed that there will take account of the changes if the proposals in 'Seizing the Future' are approved.

In relation to the additional A & E patients to be treated at Durham and Darlington, many of them are likely to be in the major category and will need treatment at a specialist centre as they are at the present time. 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

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 Shotley Bridge for day surgery.

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 don't require intensive care. 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. 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.

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 unit will deal with children where GP's have concerns and need a second opinion without the need to wait for an out patient appointment.

It was explained that there will be not many 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.

Councillor Cooke informed the Working Group that in Milton Keynes non patients are banned from using the hospital car parking facilities. Any patient with an out patient appointment is given preference for parking.

Edmund Lovell informed the meeting that a supplement explaining the consultation will be distributed with Advertiser series week commencing 20 October.

The Chair thanked the Chief Executive and Clinicians for attending the meeting.

6. Project Plan

Jeremy Brock informed the Working Group that invitations have been issued to North East Ambulance Service, the Police and the Fire and Rescue Service to attend the next meeting on 30 October. Once all evidence has been taken there will be a need to discuss the next steps with NHS County Durham

The Head of Overview and Scrutiny informed the meeting that future meetings will take evidence from the Strategic Health Authority about the implications of the strategic health plan, from the PCT about community based services, choose and book and the choice agenda. The Working Group will also be talking to the PCT about the rural health challenge, rurality and access issues.

Members were reminded of the public consultation events and it was suggested that might wish to attend the events and feed back to the scrutiny process.

7. Date of Next Meeting

The next meeting will take place at 10.00 a.m. on Thursday 30th October and will be held in Committee Room 1B at County Hall Durham.

APPENDIX 8

DURHAM COUNTY COUNCIL

SEIZING THE FUTURE SCRUTINY WORKING GROUP

30 OCTOBER 2008

Present

Councillor R Burnip (in the Chair)

Members of the Working Group
Councillors T Cooke, P Crathorne and R Harrison

Other Members
Councillor J Armstrong

Also Present
F Jassat, Head of Overview and Scrutiny, Durham County Council,
J Brock, Health Scrutiny Liaison Manager,
M Usher Adult and Community Services, Durham County Council
Bill Pike, Community Development Team, Durham County Council
S Jennings, Pioneering Care Partnership
J Rochester, LINk Interim Steering Group
E Lovell, County Durham and Darlington NHS Foundation Trust
D Gallagher and J Wood NHS County Durham
C Cessford, North East Ambulance Service NHS Trust

Apologies for absence were received from Councillors A Anderson and D Lavin.

1. Welcome and Introduction

Councillor Burnip thanked everyone for attending.

2. Declarations of Interest

Councillor Crathorne declared that she was an associate member of the County Durham Local Involvement Network

3. Minutes of the Meeting held on 16 October 2008

The Working Group confirmed the minutes of the meeting held on 16 October 2008 as a correct record.

4. Matters Arising

Jeremy Brock referred the Working Group to the following issues outlined in Item 5 of the minutes as points where further information and clarification is required from the

Foundation Trust or NHS County Durham:

Page 3

- 1st paragraph – Further information is required from the Foundation Trust on the decision taken in October 2007 that all level 3 patients would be transferred to Durham or Darlington.
- 4th paragraph – Further evidence is required on the statement that specialisation in other areas of acute medicine is beneficial.
- 5th paragraph – further information is required to clarify Royal Medical Colleges view on the Trust's training.
- 6th paragraph – Members need confirmation that the critical mass of activity is sufficient to sustain 2 A&E Departments in the Trust's area in future.

Page 5

- 2nd paragraph – Further evidence is required on the options appraisal relating to the costing for each site.
- 6th paragraph – Information is required on the definition of the services currently being provided at Bishop Auckland

In relation to Item 6 Members were reminded that they should advise which public consultation events they will be attending to ensure that all events are attended.

Referring to Community Hospitals, David Gallagher informed the Working Group that whilst services are provided separately, there is an integrated route between the services and that NHS County Durham will be commissioning more services at Community Hospitals. Members stressed the need for information to be made available to the public about service provision. David Gallagher advised that they would ensure that the consultation includes the community service providers.

Councillor Cooke informed the Working group that reference to Barnard Castle Community Hospital should have included all Community Hospitals in the Dales. He also pointed out that his question on PFI Hospitals had been omitted from the minutes. The Head of Overview and Scrutiny said this would be taken into consideration when considering evidence.

5. 'Seizing the Future' - Update

David Gallagher informed the Working Group that to date a total of 1000 documents have been distributed to stakeholder organisations and others have received executive summary versions. 155,000 copies of the public summary version are being distributed door to door and to public settings in the community. Many local households will also have received a copy of the public summary as a 'wrap-around' on the local free paper last week. In addition 310 responses to the consultation have been received via post and online. The number of public consultation events has been increased from 10 to 15 meetings. He confirmed that

additional events will be arranged if any are oversubscribed. The first 'drop in' promotion events will take place tomorrow.

Members sought confirmation that two acute hospitals are sustainable bearing in mind that the Royal Collage of Surgeons recommends that an acute hospital should serve a population of 500,000. It is felt that the proposals need to take into account that a new hospital planned to open at Wynyard Park in 2014 providing 660 beds. Edmund Lovell commented that the distribution of the existing sites puts CDDFT in a strong position and the NCAT report gives support to the proposals. He also informed the Working Group that CDDFT are preparing a 5 year plan to ensure that services continue to be fit for purpose. The Working Group was also advised that investment was being made to upgrade the infrastructure at Darlington and that it needs to remain as an acute hospital site or the Trust will lose patients and income to the Teesside area and will not be sustainable. Members were also concerned that future changes to services could lead to the loss of services at local hospitals with the need to use hospitals outside of the County. It was explained that patients have the option to choose which hospital at which they wish to be treated. The Working Group was advised that the planned hospital at Wynyard Park will be most likely to attract patients from the Easington and Sedgefield areas.

Bill Pike explained that the public were not aware of the other issues involved with the proposals other than the proposed downgrading of A&E at Bishop Auckland. He also pointed out that none of the public events were arranged on mornings which might provide for those who need to collect children from school and can't attend the afternoon sessions.

Jim Rochester expressed the view that it might help to have information provided in a graphical format. David Gallagher advised that the full consultation document contains a table showing the before and after proposals for services, though consideration will be given to providing this in the summary document.

Marion Usher said that it would be useful if the public knew what services are provided at Community Hospitals. David Gallagher explained that the consultation was focused on the acute hospitals as the proposals largely relate to them.

Councillor Armstrong asked whether consideration could be given to using intermediate care beds at Bishop Auckland for head injuries and other trauma injuries. It was explained that head injuries are treated at specialist centres and that rehabilitation is also provided at specialist centres. Consideration will be given to the suggestion.

The Head of Overview and Scrutiny informed the Working Group that officers will be meeting with the NHS and the LINk to discuss the consultation and any gaps in the process. The importance of Members attending the public consultation events was stressed.

6. North East Ambulance Service NHS Trust

The Working Group received a presentation from Colin Cessford, Director of Strategy and Clinical Standards North East Ambulance Service about the views of NEAS on Seizing the Future (for copy of slides see file).

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 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 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, 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 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.

Councillor Burnip asked whether NEAS would be able to maintain a good service in the Dales if the job cycles of ambulances are to be extended. Colin Cessford explained that when one ambulance leaves the area it is replaced by another ambulance. Modelling will need to be undertaken with NHS County Durham to ensure that NEAS will be able to cope if the proposals are implemented.

In response to questions about volume of work it was explained that NEAS has more emergency vehicles and that the volume of A&E calls is increasing with the ambulance service having to deal with more complex primary care work. Emergency calls are often initially responded to by a paramedic in a fast vehicle. It was pointed out that the return of spontaneous circulation rates has increased by 500% in the last 7 years.

Councillor Cooke said that if patients from rural areas are taken to a hospital further away from home for treatment it could increase the length of time it takes for a patient to recover if family and friends are unable to visit because of the distance involved. It was explained that once the acute episode has passed it is the intended that patients will move to a hospital closer to home.

The Head of Overview and Scrutiny said that the response to the consultation may need to take into account cost implications and the ambulance response times. In addition there is a need to educate the public on the appropriate use of ambulance and A&E services.

Bill Pike said there was a perception in the Dales that ambulance service performance was falling and that vehicles were getting lost when answering calls. Colin Cessford explained that in general performance was improving, though there may be anomalies in smaller communities because of the low number of calls involved. NHS County Durham take ambulance issues seriously and has already agreed to fund improved ambulance services in the Dales area for additional ambulances and staff. A review of jobs indicates that ambulances do not get lost on a frequent basis.

7 Any Other Business

The Working Group was informed that the Foundation Trust has agreed to accommodate site visits. Edmund Lovell suggested that these should be held in early December.

In addition it may it may be necessary to arrange for a future meeting to focus on discussing the sustainability of two acute sites.

8. Date of Next Meeting

The next meeting which will take place at 2.00 p.m. on Thursday 13th November and will be held in Committee Room 1A at County Hall Durham.

APPENDIX 9

DURHAM COUNTY COUNCIL

SEIZING THE FUTURE SCRUTINY WORKING GROUP

13 NOVEMBER 2008

Present

Councillor R Burnip (in the Chair)

Members of the Working Group
Councillors J Chaplow, T Cooke, P Crathorne, D Lavin, R Harrison and R Todd

Other Members
Councillor J Armstrong, D Taylor-Gooby and M Williams

Also Present
F Jassat, Head of Overview and Scrutiny, Durham County Council,
J Brock, Health Scrutiny Liaison Manager, NHS County Durham/Durham County Council
M Usher Adult and Community Services, Durham County Council
B Pike, Community Development Team, Durham County Council
R Startup, Head of Integrated Transport Unit, Durham County Council
A Aljeffri and D Haw County Durham LINk
D Murphy, County Durham and Darlington NHS Foundation Trust
A Lynch, D Gallagher and J Wood NHS County Durham

Apologies for absence were received from Councillor A Anderson

1. Welcome and Introduction

Councillor Burnip thanked everyone for attending.

2. Declarations of Interest

Councillor Crathorne declared that she was an associate member of the County Durham Local Involvement Network

3. Minutes of the Meeting held on 16 October 2008

The Working Group confirmed the minutes of the meeting held on 30 October 2008 as a correct record.

4. Matters Arising

Jeremy Brock informed the Working Group that the outstanding issues for which further information/clarification was required which were detailed on page 2 of the

minutes, had now been included in an action log which had been circulated for Members information.

Jeremy Brock reported that written information had also been submitted by Durham Constabulary.

David Gallagher advised that work on the Royal Medical Colleges is almost complete and will be forwarded in the near future. The Gateway review document is available on the NHS County Durham website.

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5. 'Seizing the Future' - Update

David Gallagher informed the Working Group that since the last meeting there have been five public meetings which had been reasonably well attended. The format for the meetings has been changed in the light of the experience of the earlier meetings. To date 612 paper responses and 123 online responses have been received to the consultation. A meeting has also been held with Jeremy Brock and the County Durham LINk representatives to discuss possible gaps in the consultation process. Arrangements are being made to organise events to enable hard to reach groups to be involved in the consultation process.

Members of the Working Group made a number of suggestions to improve the format of the meetings:

- Supply copies of powerpoint slides either at or before the meeting
- Provision of paper and pens
- More time for questions
- Information needs to be at a level that can be understood by the participants
- Provide a glossary of 'jargon'

In response to questions about the publicity for the meetings it was confirmed that notices had been placed in relevant newspapers and that all town and parish councils had been notified of the meetings although this will be checked.

Bill Pike advised the Working Group that that he had been made aware that publicity for the additional public meetings had not been notified to some community groups which could have increased participation. He explained that work was on going to close the gaps in the consultation process with hard to reach groups. He also commented that there was a perception amongst the public that they were not fully aware of the differences between the options and also that people were concerned to know what the impacts were on health services in their area. David Gallagher stressed that there were to be no changes to the community hospitals and that the consultation was about the reconfiguration of the three acute hospitals.

Councillor Armstrong suggested that the use of local radio would help publicise the public meetings. It was explained that some work had been done with the local radio stations and that consideration could be given to further use of radio airtime.

Councillor Lavin was of the view that one meeting for the Derwentside area was insufficient to encourage public participation and asked whether there would be an opportunity to add further meetings. David Gallagher explained that six further meetings had been added but that it was not practical to add further meetings across the County although consideration will be given to adding meetings where it is felt there is a need.

6. Stakeholder Perspective – Public Health

The Working Group received a presentation from Anna Lynch, Locality Director of Public Health , County Durham on the public health perspective of Seizing the Future (for copy of slides see file).

It was explained that that there are three public health domains:

- **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 above work is underpinned by the work to reduce health inequalities. There are many factors which impact on health inequalities. Smoking is recognised as the single largest cause of health inequalities.

The main causes of death in County Durham are coronary vascular disease (CVD) and cancers. One in three of the County Durham population will die of CVD and one in three will die of cancers. This is being addressed by a range of the following programmes:

- CVD Screening Programme at each GP Practice
- Increased attendance rates to cancer screening programmes
- Smoking cessation clinics
- Obesity / Weight management service
- Physical activity programmes

In terms of key issues it was stressed that it is essential to have high quality effective clinical services based on the best national and international evidence available to the commissioners and details of this are set out in the different options. It is also important to have 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.

In summary it was explained that reducing health inequalities is a top priority for NHS County Durham. The consultation assessment criteria include health

inequalities and Health Impact Assessments are undertaken throughout changes to service provision. NHS County Durham supports the view that the CDDFT proposals will help achieve the reduction of health inequalities.

Councillor Taylor-Gooby commented that the public will accept the changes to acute hospitals but will want to see the provision of additional local services. David Gallagher advised that one of the key principals is that NHS County Durham will not allow any changes to services until the alternative services are in place.

The Head of Overview and Scrutiny asked for further information about the Health Impact Assessments undertaken. Anna Lynch explained that it is likely that a 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.

7. Stakeholder Perspective – Adult and Community Services

The Working Group received a presentation from Marion Usher, Commissioning Manager on the Adult and Community Services perspective of Seizing the Future (for copy of slides see file).

It was explained that Adult and Community Services 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. Adult and Community Services would like to see a firm statement that these changes are sustainable for a certain period into the future.

Adult and Community Services 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. Adult and Community Services do not want to duplicate services offered by other organisations. It was noted that Professor Alberti had commented that this proposal would be inconvenient for patients and families. Adult and Community Services has no concerns if these are local intermediate care beds.

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. Adult and Community Services 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.

In response to the concern that people living in East Durham would have to travel to Bishop Auckland, David Gallagher explained that the public have a choice where they receive care and treatment and do not have to attend a prescribed hospital.

The Head of Overview and Scrutiny asked for a schedule of the community hospitals in the County to be provided.

8. Stakeholder Perspective – Integrated Transport Unit

The Working Group received a presentation from Richard Startup, Integrated Transport Manager Durham County Council. He explained the scope of evidence to be provided to the Working Group.

It was explained that a Working Group involving County Durham and Darlington Foundation Trust, NHS County Durham, NEAS, the County Council and Darlington Borough Council is identifying the needs created through Seizing the Future and other unmet need. It will try to find solutions to transport needs and will make better use of existing transport resources.

Reference was made to a number of maps which showed communities which were 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 deal with 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, Richard Startup 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.

Councillor Taylor-Gooby informed the Working Group that a local resident had queried the personal questions asked when they had contacted the TRC for assistance. Richard Startup explained that there is an eligibility criteria for the PTS. If they can't use the PTS service there are other options available to them.

The Head of Overview and Scrutiny suggested that it might be helpful if Members were to use the EDHL service and other public transport to test travel times to health services contained in the proposals. It was agreed that this should be arranged.

9. Date of Next Meeting

The next meeting which will take place at 2.00 p.m. on Thursday 27th November and will be held in Committee Room 1B at County Hall Durham.

APPENDIX: 10

DURHAM COUNTY COUNCIL

SEIZING THE FUTURE SCRUTINY WORKING GROUP

27 NOVEMBER 2008

Present

Councillor R Burnip (in the Chair)

Members of the Working Group
Councillors A Anderson, J Chaplow, T Cooke, P Crathorne, D Lavin, R Harrison and R Todd

Other Members
Councillors J Armstrong

Also Present
F Jassat, Head of Overview and Scrutiny, Durham County Council,
J Brock, Health Scrutiny Liaison Manager, NHS County Durham/Durham County Council
B Pike, Community Development Team, Durham County Council
J Rochester, County Durham LINk
S Jennings, Pioneering Care Partnership
E Lovell, County Durham and Darlington NHS Foundation Trust
D Gallagher and J Wood NHS County Durham
D Robertson, County Durham and Darlington Local Medical Committee
K Fawcett, Staff Side Chair, JSCC, County Durham and Darlington NHS Foundation Trust
I Briggs, Darlington PCT
D Turnbull, County Durham and Darlington Fire and Rescue Service
Councillor S Zair, C S Auld and C Heads, Save Our Hospital Group

1. Welcome and Introduction

Councillor Burnip thanked everyone for attending.

2. Declarations of Interest

Councillor Crathorne declared that she was an associate member of the County Durham Local Involvement Network and also knew Mr C Auld spokesperson of the Save Our Hospital group.
Councillor Anderson declared an interest as a member of the Save Our Hospital Group

3. Minutes of the Meeting held on 13 November 2008

The Working Group confirmed the minutes of the meeting held on 13 November 2008 as a correct record.

4. Matters Arising

Jeremy Brock informed the Working Group that work was ongoing on the collection of outstanding information from County Durham and Darlington Foundation Trust and NHS County Durham. The Health Gateway Review document and information on the Royal Colleges had been circulated.

The following issues were also raised:

- Note 5 – Feedback is requested on the arrangements being made for consultation with hard to reach groups
- Note 6 – Further information has been requested on health impact assessments process and criteria.
- Note 7 – Further information on community hospitals and the definition of intermediate care has been requested.
- Note 8 – It is proposed to arrange a number of journeys to test bus travel arrangements from the west of the County to A & E at Durham and Darlington and from the north of the County to Bishop Auckland. Councillors Armstrong, Chaplow, Crathorne, Cooke, Harrison and Lavin volunteered to participate in the two journeys.

5. Stakeholder Perspective – Save Our Hospital Group

The Working group received a presentation from Clive Auld, spokesperson on behalf of the 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.

- 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.

- The PCT spend too long explaining their 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.

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- 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 NHS 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 will 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.

6. Stakeholder Perspective – County Durham and Darlington Community Health Services

The Working Group received a presentation from Ian Briggs, Head of Organisational Development, Darlington PCT on the County Durham and Darlington Community Health Services (CDDCHS) perspective of Seizing the Future.

Ian Briggs explained that CDDCHS was established as the provider arm of the PCT's to offer a range of community services.

The following areas were identified as possible opportunities arising from Seizing the Future:

- For us to work collaboratively with CDDFT to move more services closer to the community.
- Focussed 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 – focussed clinical skills and pathways

The concerns and issues that have been identified include:

- 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.

Councillor Cooke asked whether the community hospitals in Teesdale and Weardale would be used to provide services closer to the community. Ian Briggs explained that consideration is being given to developing community hospitals and other facilities to provide services closer to the community.

Colin Heads pointed out that parking at Darlington Memorial Hospital was costly and difficult to access. Ian Briggs explained that there was an intention to devolve as many services as possible into the community.

Councillor Armstrong asked whether the proposals are clinically or financially led. Ian Briggs stated that the proposals are patient led.

In response to a question from the Head of Overview and Scrutiny, Ian Briggs explained that as part of the service development strategy, CDDCHS are developing services and are working with commissioners at present to maximise the use of community hospitals.

7. Stakeholder Perspective – 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 which represents GP's and Health Centres.

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.

8. Stakeholder Perspective – Joint Staff Consultative Committee County Durham and Darlington Foundation Trust

The Working Group received a presentation from Kath Fawcett, 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.

Kath Fawcett explained that she had been involved in the work preparing the Seizing the Future proposals. She was of the view 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.

Councillor Lavin asked whether two acute hospitals are sustainable in County Durham and Darlington and whether there will eventually be a need to move to one site. Kath Fawcett's personal view was that Darlington or Durham cannot accommodate all acute services and the move to one site would require the provision of a new centrally based hospital.

In response to a question from Councillor Burnip about the planned Wynyard Park Hospital, Doctor D Robertson explained that acute heart attack patients from the Darlington and Bishop Auckland area are currently treated at James Cook Hospital. This is because of the move to specialisation and the population size that is needed to support that specialisation. He stressed that it was important that a significant or technical intervention should be dealt with by a specialist in that field.

In response to a question from Councillor Chaplow about visiting times at Darlington, Kath Fawcett explained that flexible arrangements are made to accommodate family and friends if they are unable to attend during normal visiting hours.

Councillor Zair asked if the population in south Durham continues to increase will there be a need to re-open Bishop Auckland as an acute hospital. He also asked whether the closure of ward 3 was due to cost savings. In relation ward 3 Kath Fawcett explained that the PCT had predicted that there would be a reduction in demand for medical beds. This was not about cost improvements but about reacting to a predicted fall in demand. However because of national trends, admission rates have increased and this has been higher in the north of England

The Head of Overview and Scrutiny asked the representatives of the Save Our Hospital Group to clarify and summarise the requests they are making – and these

are: for local residents to have a choice; for people to be given the services they need; and for Bishop Auckland General Hospital to remain an acute hospital.

9. Stakeholder Perspective – County Durham and Darlington Fire and Rescue Service

The Working Group received a presentation from Dave Turnbull about the views of the County Durham and Darlington Fire and Rescue Service.

He explained 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.

10. 'Seizing the Future' - Update

David Gallagher informed the Working Group that since the last meeting three further consultation meetings had taken place at Darlington, Durham and Shildon. To date 710 paper responses and 141 online responses have been received to the consultation. Work has been undertaken to produce an easy-read version of the consultation document suitable for children and young peoples and others. Discussion is taking place on an event to consult with the deaf and the deafened and specialist facilities will be put in place for the event.

Dave Gallagher explained the format for the public meetings. The first third of the meeting is for colleagues from CDDFT to explain their proposals and the case for change, the next third is a discussion around a table in groups to formulate some questions to feed into the consultation process. The final third is questions submitted to the Panel. Information at the meetings is recorded in writing and electronically. A verbatim transcript is produced of the meetings and as they become available they are placed on the website.

David Gallagher reassured the Working Group that the proposals are not a "done deal" and that NHS County Durham will not sanction any change to services which will endanger life.
Edmund Lovell informed the Working Group that a public meeting will take place at Auckland Castle on the evening of 4th December and Professor Alberti will be in attendance. It was intended to hold a meeting earlier on 4th December but very few people have pre-registered and this has been cancelled. People will be contacted and informed of the cancellation and arrangements will be made to enable them to attend other venues if required.

Councillor Armstrong asked whether the public meetings are an open forum or just deal with prescribed questions. David Gallagher described the process of the meetings. A set of prescribed questions are asked by facilitators as part of the

consultation process. At the plenary session of the meeting, there is an open forum to allow the public to put questions to the Panel.

David Gallagher stressed that there was a need to hold public meetings across the entire County and whilst the meetings are an important part of the process they are one part of a process that has many other aspects including web based information, press 'wrap-arounds' and so on.

In response to a question from Councillor Burnip, David Gallagher explained that whilst guidance indicated that an acute hospital should serve a population of 500,000, because of the rural nature and geography of the County, one possible solution could be two acute hospitals as set out in the options.

Edmund Lovell informed the Working Group that under the Seizing the Future proposals, the majority of last year's admissions from the Stanhope area would have been treated nearer home at Bishop Auckland. Only 20 of last year's admissions from this area would have had to travel further.

Colin Heads asked why a new hospital was built at Bishop Auckland when within five years of it opening services are being withdrawn. David Gallagher explained that there is a need to ensure that services in the future are safe and sustainable. Edmund Lovell explained that since Bishop Auckland Hospital was planned many things have changed. As an example patients with acute heart attacks were formerly taken to their local hospital to be given thrombolysis treatment. However, since the introduction of primary angioplasty, patients are now taken directly to the James Cook or Freeman Hospitals for treatment.

Councillor Todd asked that with the continuing move to primary care and the provision of local services whether there would be further impact on the two remaining acute hospitals. David Gallagher said there was a balance to be achieved through the provision of local services, services at acute hospitals and the provision of specialised services at tertiary centres.

Jim Rochester asked for information about the attendance at public meetings. David Gallagher said he would provide information on attendance at meetings together with a breakdown of responses at the next meeting. Jim Rochester stated that as part of planning for developments of this scale there should be opportunities for stakeholders and others to be involved in the evidential base for the work. Edmund Lovell explained that CDDFT have 4,000 local people as members of the Trust and they elect 20 public governors. Three governors were co-opted onto each main group to ensure there was a patient perspective in the work and to provide a challenge to the clinical staff involved. Other stakeholders such as social care and the ambulance service were involved in the discussions.

Clive Auld asked whether it would be possible to extend the meeting at Auckland Castle on 4th December to allow for further questions. David Gallagher said this would be considered.

11. Any Other Business

Jeremy Brock informed the Working Group that visits to the three hospitals will be arranged in the very near future and dates will be notified as soon as possible.

Councillor Burnip reminded Members that Professor Alberti will be attending a meeting for all Members at County Hall tomorrow at 3.00 p.m.

12. Date of Next Meeting

The next meeting which will take place at 2.00 p.m. on Thursday 11th December 2008 and will be held in Committee Room 1B at County Hall, Durham.

APPENDIX 11

DURHAM COUNTY COUNCIL

SEIZING THE FUTURE

At a meeting held at County Hall, Durham on 28 November 2008 at 3:00 pm .

PRESENT

Chair: Councillors R Burnip and E Huntington

Durham County Council
Councillors J Armstrong, B Arthur, A Bainbridge, B Bainbridge, D Burn, P Charlton, M Dixon, , G Huntington, J Lethbridge, E Murphy, B Ord, G Richardson, J Shiell, J Shuttleworth, M Simmons, T Taylor, O Temple, L Thomson, E Tomlinson and S Zair.

Chester-Le-Street District Council
Councillor R Harrison

Derwentside District Council
Councillor D Lavin

Easington District Council
Councillor D Taylor-Gooby

Teesdale District Council
Councillor A Cooke

Department of Health
Professor G Alberti

County Durham and Darlington Foundation Trust
A Ali, R Aitken, S Eames, N Munro and ?

NHS County Durham
D Gallagher

1. Welcome and Introductions

Councillors R Burnip and E Huntington welcomed Members to the meeting and introduced the speakers.

2. David Gallagher Director of Corporate Strategies, Services & Relations NHS County Durham

David Gallagher explained the role and responsibility of NHS County Durham. NHS County Durham commissions health and healthcare services for the people of County Durham and spends around £1bn per annum. This includes all services including GP's, dentistry, acute services, mental health services etc. Today's discussion is about the provision of acute services provided by County Durham and Darlington Foundation Trust.

In terms of the consultation process it was explained that CDDFT came to NHS County Durham as commissioners of services, with a range of issues and convinced NHS County Durham that there is a need to change existing services.

3. 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 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.

4. Stephen Eames, Chief Executive County Durham and Darlington NHS Foundation Trust

Stephen Eames informed the meeting that he would comment on the following areas:

Transport – In terms of routine treatment the Trust is working with the County Council to create an integrated transport system that will connect up the proposals and which will take account of areas of deprivation. This will require substantial investment.

Bishop Auckland Hospital – The Trust is trying to design a long term future for the hospital. All of the Trusts hospitals are interdependent on each other and the Trust is trying to create centres of excellence in all of the hospitals. The Trust is proposing to create a centre of excellence for surgical activity, day surgery and rehabilitation.

Dr Foster Award - CDDFT has received an award from Dr Foster in their best Trust of the year awards. It was explained that the Trust cannot continue to improve unless it addresses the issues raised by Professor Alberti.

Questions

A
Why downgrade a new PFI hospital at Bishop Auckland? Two wards have already been closed. As someone who has recently been treated in Darlington hospital I can say that there is no comparison between Darlington and Bishop Auckland. Darlington is rundown.

Professor Alberti – It was explained that 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 didn't 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.

B
What about the people who live in the Dales? The extra 20 or 30 minutes will concern them.

Professor Alberti –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.

C
Councillor Taylor-Gooby – Local people will want to see clear evidence that better services are being provided before changes are made.

Professor Alberti – The Trust need to have a vision on where they want to be in 5 years time and the Trust need to have an implementation plan and this should be made available to the public. New facilities need to be in place before services are withdrawn.

D
Councillor Shuttleworth – It will 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. It is important that the Trust listens to the people.

Stephen Eames – The mistrust of the public is understood. 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.

Bob Aitken – Standards have changed. 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.

E
Councillor Shuttleworth – Why is it difficult to recruit staff?

Bob Aitken – 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.

David Gallagher – As commissioners we are very interested in using the community hospitals and it is our intention to provide more activity at those hospitals. We will listen to views raised through the consultation process. 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.

F
Councillor Charlton – People who are very sick want to be able to access services at the nearest hospital and not have to travel further. A mother with a sick child will want to go to the nearest hospital. Can you confirm that this is all down to cost? Why can't we recruit trained staff? If it is down to cost then something can be done.

Professor Alberti – 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.

Dr Ahmed Ali – Explained that he came to work in the UK because he was not seeing enough patients to gain experience.

Stephen Eames – 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.

G
Councillor E Murphy – Questioned the recent award made to the Trust.

Bob Aitken – The Trust was assessed as an organisation and Bishop Auckland plays an important role. In relation to critical care it was explained that because the Trust are unable to recruit staff that the sickest patients are being transferred to Durham and Darlington. The Trust was judged on all of its services not just A&E or critical care. It is expected that Trust will remain excellent.

H
Councillor Harrison – It is difficult to get ambulances to the more remote areas of the Dales. The North Air Ambulance is run as a charity and it is felt that is an Achilles heel for the health service.

Professor Alberti – Even though the Air Ambulance is a charity it is able to charge the PCT for its services. As it is used more it is likely that it will receive more government support.

I
Councillor Dixon – Felt that the proposals are the best way forward although the problem is selling this to the public.

J
Councillor Temple – He was of the view that the Seizing the Future consultation document does not fully explain all of the proposals for reconfiguring services as well as the NCAT report. He also explained that there needs to be more information about urgent care services.

Stephen Eames - Advised that the Seizing the Future consultation document follows the recommended style and contains the main points detailed in the NCAT report. There is an Urgent Care Strategy as advised by Professor Alberti.

K
Councillor E Huntington – Asked for comment on the point that there should be an appointment based urgent paediatric service.

Bob Aitken – Explained that there will be a paediatric rapid access clinic with extended hours at Bishop Auckland where GP's will be able to refer children for an urgent consultation opinion.

L
Councillor Lethbridge – Stated there is fear amongst local people of the hospital being downgraded and wards closed. There is no confidence in the process.

N Munro – The proposals have been drawn up by clinical staff and governors of the Trust. The Trust would not put forward proposals that are not suitable for themselves, their own families and patients.

M
Councillor G Huntington – Could other surgical procedures be carried out at Bishop Auckland. There is concern that the changes are being driven by the Royal College of Surgeons.
Professor Alberti – Patients will still be attending Bishop Auckland for day surgery but the hospital will not be carrying out complex cases. It was explained that it is important that surgeons have a critical mass of activity when carrying out specialised surgery in order to retain their skills.

Ian ? - He explained that when he arrived at Durham in 1999 there were eight consultants who each carried out seven or eight operations a year for bowel

cancer. Now the minimum carried out by a surgeon is fifty per year. This leads to better care for the patient. Day care surgery will be expanded at Bishop Auckland and at Shotley Bridge under the proposals. Bowel cancer screening now takes place at Bishop Auckland saving patients from having to travel to Gateshead or North Tees.
Bob Aitken – Made an offer to meet Members to fully explain the proposals.

N
Councillor Zair – Darlington and Durham hospitals are already under pressure. What will happen if the population of South Durham continues to grow – how will the Trust cope?

N Munro – There is a need to ensure that services are in place before any change takes place. This includes ensuring there is sufficient capacity at Darlington and Durham. The main change is the growth in the older population and many of the services are orientated towards this.

A Ali – Explained that there is insufficient capacity to move all services to Bishop Auckland.

O
Councillor Burn – This area has a population of about 100,000. People have a right to acute health care. Why can't we have acute surgery at Bishop Auckland.

Professor Alberti – Explained that it is not a downgrade to a care and rehabilitation centre. Other facilities will be enhanced and built up and more of the local population will be dealt with at Bishop Auckland. The existing system is not delivering optimum care.

Bob Aitken – He referred to the national guidelines of 2003/04 for emergency care. The guidelines say that nurse practitioners need to be trained to deal with emergencies to same standard as paramedics. Three quarters of the existing A&E patients will continue to be treated at Bishop Auckland.

P
Councillor Richardson – People are concerned that services are being deliberately run down. Teesdale is a large rural area and it is difficult to reach anywhere very quickly. People need a local A&E service.

Bob Aitken – Bishop Auckland hospital is not geared up to deal with people who self present and this delays appropriate treatment. A decision was made to transfer critical care services to Durham and Darlington was made on grounds of safety but not until efforts were made to find staff. The decision was made on meeting standards. The catchment population for a district general hospital has changed over the years and is now around 500,000.
Professor Alberti – Explained that this is a national problem. Any decision is a balance between access, quality of care and safety of care. Medicine is changing rapidly and it is important to provide high quality care. As an example the treatment of strokes has improved substantially.
Councillor E Huntington thanked everyone for attending.

APPENDIX 12

DURHAM COUNTY COUNCIL

SEIZING THE FUTURE SCRUTINY WORKING GROUP

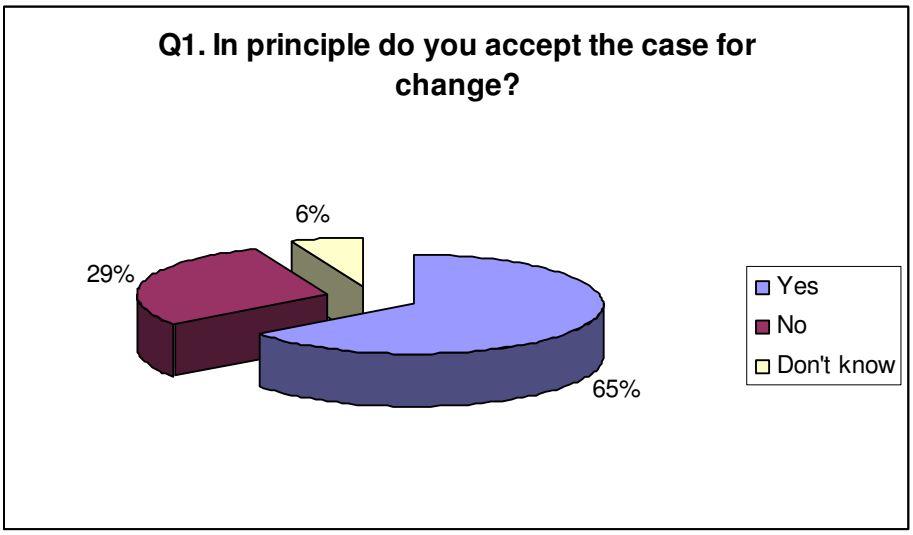
11th DECEMBER 2008

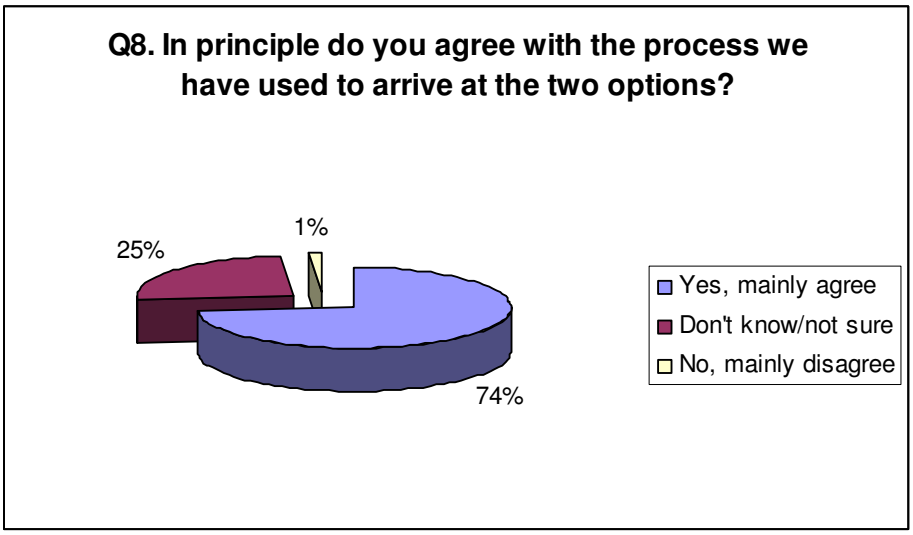
(To follow)

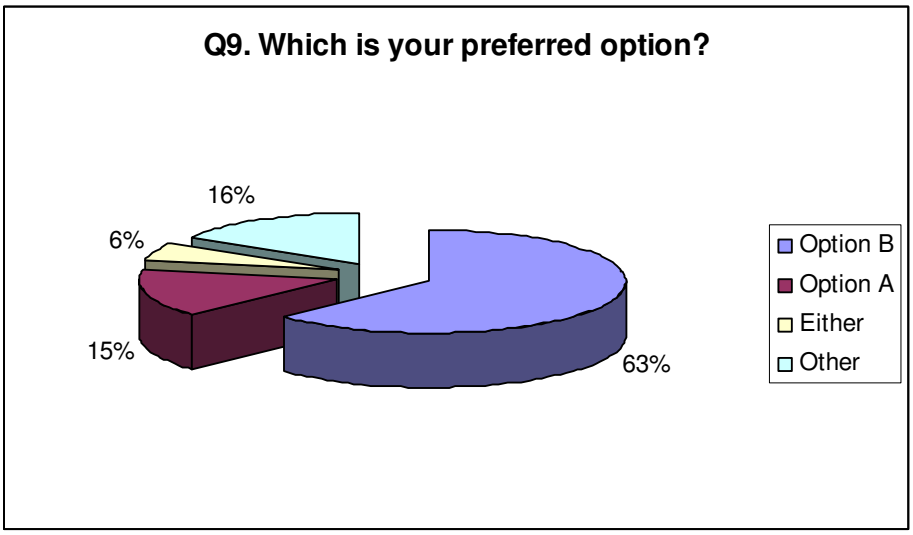
APPENDIX 13

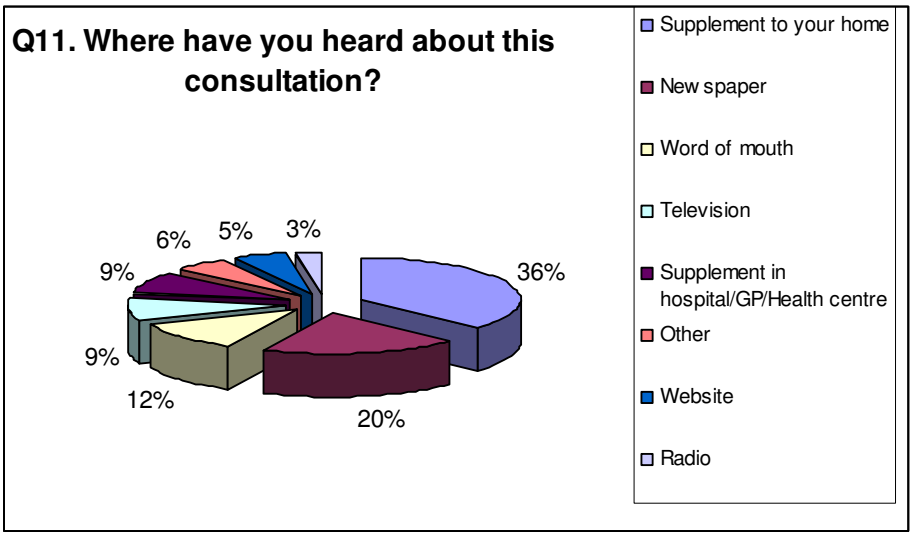
Interim report from NHS County Durham on consultation responses received at 11th December Working Group meeting

Seizing the Future

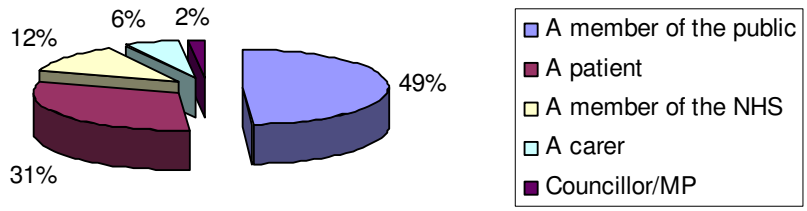




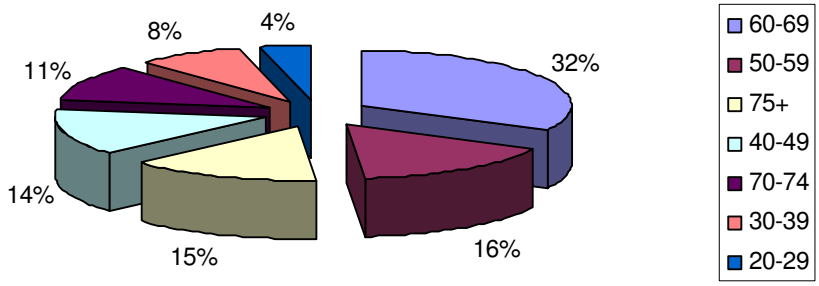

Q9. Which is your preferred option?
16%
6%
15%
63%
Option B
Option A
Either
Other

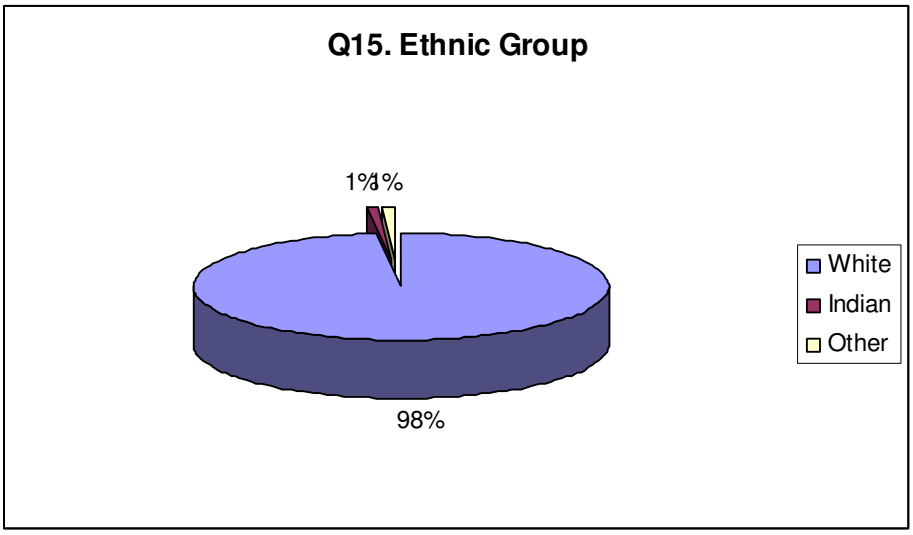

Q11. Where have you heard about this consultation?
6%
5%
3%
9%
36%
9%
12%
20%
Supplement to your home
New spaper
Word of mouth
Television
Supplement in hospital/GP/Health centre
Other
Website
Radio

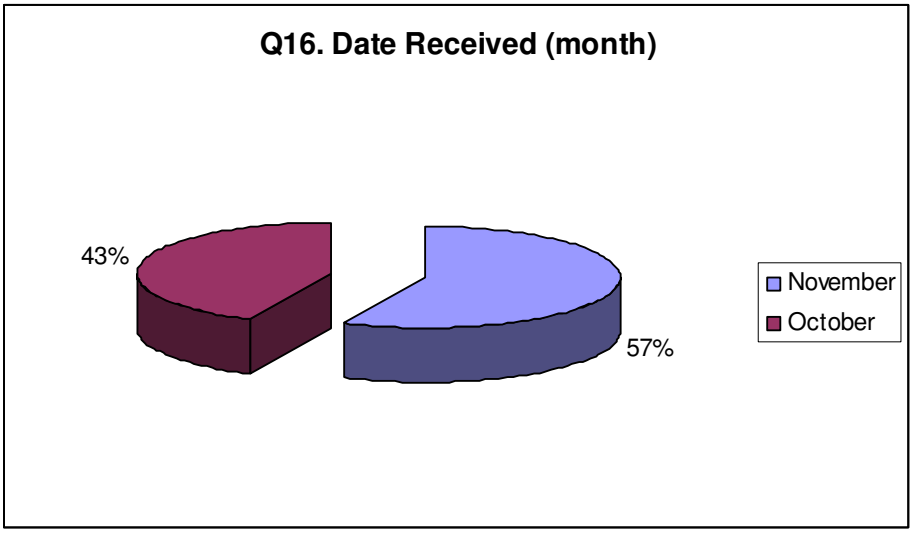
Q13. Are you completing this survey as an individual or are you representing an organisation?



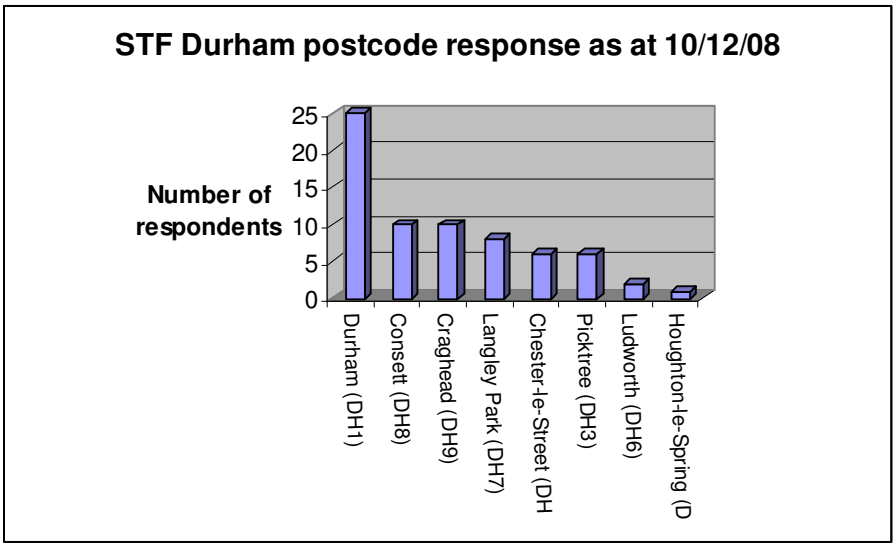
Q14. Age Group

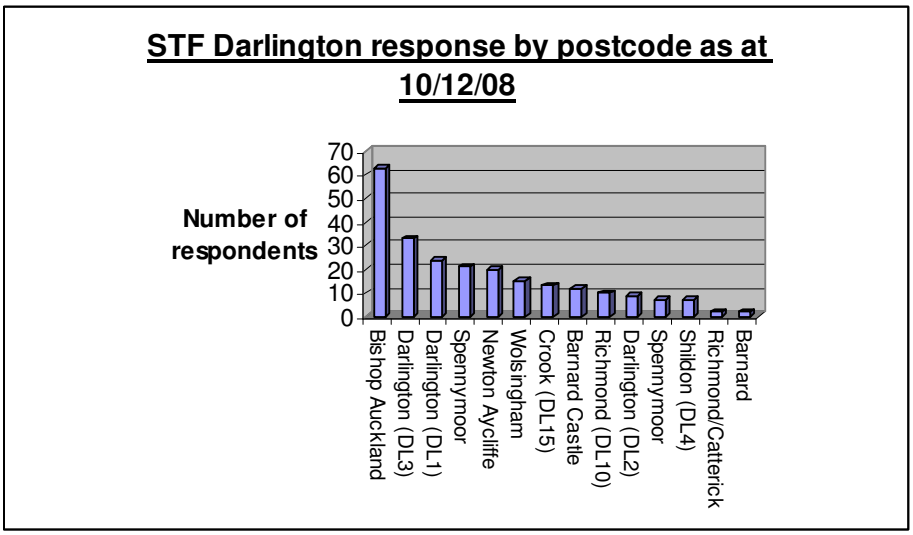


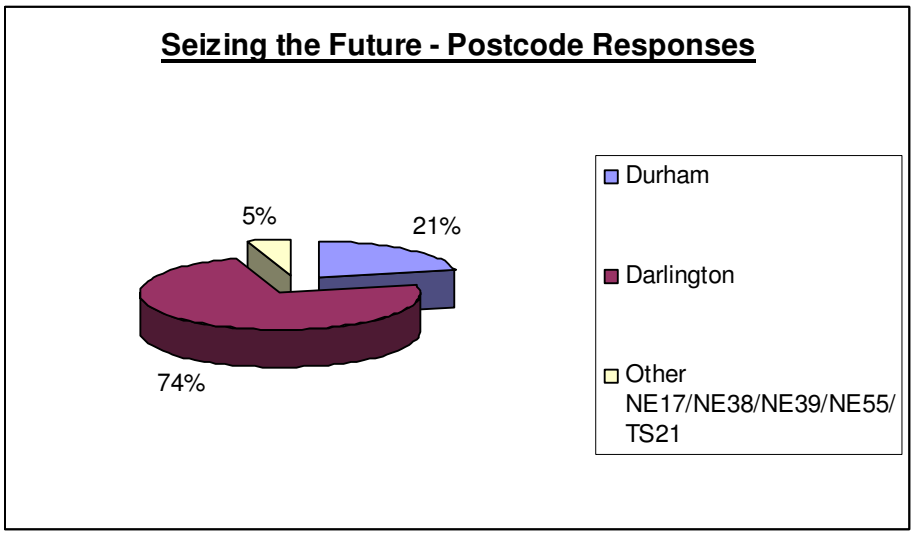

Q15. Ethnic Group
1%
1%
98%
White
Indian
Other


Q16. Date Received (month)
43%
57%
November
October

Postcode Response






Seizing the Future - Postcode Responses
5%
21%
74%
Durham
Darlington
Other NE17/NE38/NE39/NE55/TS21

APPENDIX 14

Study published in the European Heart Journal

European Heart Journal (2003) 24, 21–23

ELSEVIER

EUROPEAN SOCIETY OF CARDIOLOGY

Editorial

Angioplasty vs thrombolysis for acute myocardial infarction: a quantitative overview of the effects of interhospital transportation

F. Zijlstra

Department of Cardiology, Isala Klinieken, locatie Weezenlanden, Zwolle, The Netherlands

See doi:10.1053/S1095-668X(02)00468-2, for the article to which this editorial refers.

Primary angioplasty has been shown to be superior to thrombolytic therapy for treatment of patients with acute ST segment elevation myocardial infarction in randomized trials.[1–11] However, even in countries where large numbers of percutaneous coronary interventions are performed, thrombolytic therapy is still used far more often, in daily practice. This is caused by issues such as logistical difficulties, reimbursement, variability of angioplasty results and safety and feasibility of interhospital transportation. As the large majority of patients with acute ST elevation myocardial infarction are presented to hospitals without the capability to perform acute coronary angiography and angioplasty, interhospital transportation plays a central role. Although safety and feasibility of transportation of patients with acute myocardial infarction has been documented in case series,[12–14] many cardiologists have had doubts as to whether the potential benefits of angioplasty over thrombolysis would not be negated due to the additional time delay inherent in transportation.

In this issue, Widimsky et al. report the 30 day results of the PRAGUE-2 trial, a trial designed to compare nationwide the relative benefits and risks of thrombolysis on site, vs angioplasty after transportation, as treatment of patients with ST segment elevation myocardial infarction.[10] The results of this important study, as well as the results of other randomized trials reconfirm the safety and feasibility of the strategy of interhospital transportation to perform primary angioplasty.[2,5,9,11] To place these results in perspective it is necessary to look at all currently available evidence.

Angioplasty vs thrombolysis: a summary of the evidence

Currently data are available on 6478 patients randomized between primary angioplasty and thrombolysis.[1–11] Of 3241 patients randomized to primary angioplasty, 179 (5.5%) died, compared to 251 (7.8%) of 3237 patients randomized to thrombolysis, relative risk 0.70 with 95% confidence intervals of 0.57 to 0.85, $P<0.001$. This represents an additional 23 lives saved per 1000 patients treated. Major adverse cardiac events (MACE) defined as the combination of death and non-fatal reinfarction[1] or death, non-fatal reinfarction and non-fatal stroke,[2–11] occurred in 258 of 3241 (8.0%) angioplasty patients compared to 454 of 3237 (14.0%) thrombolysis patients, relative risk 0.53 with 95% confidence intervals of 0.45 to 0.62, $P<0.001$. This represents 60 fewer events per 1000

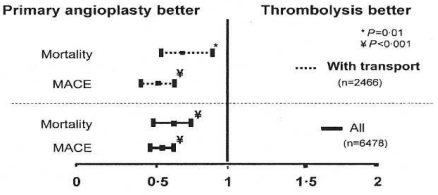


Figure 1 Primary angioplasty vs thrombolysis. Pooled analysis—RR (95% CI).

doi:10.1016/S0195-668X(02)00468-2

Table 1 Pooled data from randomized trials[1–11] of primary angioplasty vs thrombolysis

All patients n = 6478	Primary angioplasty n = 3241	Thrombolysis n = 3237
Mortality	179 (5.5%)	251 (7.8%)
Adverse events	258 (8.0%)	454 (14.0%)

Mortality and adverse events at 30 days or 6 weeks, adverse events defined as death and non-fatal reinfarction[1] and death, non-fatal reinfarction and stroke.[2–11]

Table 2 Pooled data from randomized trials[2,5,9–11] of primary angioplasty after interhospital transportation vs on-site thrombolysis

All patients n = 2466	Primary angioplasty n = 1242	Thrombolysis n = 1224
Mortality	84 (6.8%)	117 (9.6%)
Adverse events	106 (8.5%)	190 (15.5%)

Mortality and adverse events at 30 days or 6 weeks, adverse events defined as death and non-fatal reinfarction and stroke.

patients treated, and translates into a number of patients needed to treat to prevent an event of 17 (see also Table 1 and Fig. 1).

Angioplasty after interhospital transportation vs on-site thrombolysis: a summary of the evidence

Currently, data are available on 2466 patients randomized between primary angioplasty after interhospital transportation and on-site thrombolysis.[2,5,9–11] Of 1242 patients randomized to angioplasty, 84 (6.8%) died compared to 117 (9.6%) of 1224 patients randomized to thrombolysis, relative risk 0.69 with 95% confidence intervals of 0.51 to 0.92, $P = 0.01$. This represents an additional 33 lives saved per 1000 patients treated. MACE defined as the combination of death and nonfatal reinfarction and stroke, occurred in 106 of 1242 (8.5%) angioplasty patients compared to 190 of 1224 (15.5%) thrombolysis patients, relative risk 0.51 with 95% confidence intervals of 0.40 to 0.65, $P<0.001$. This represents 70 fewer events per 1000 patients treated, and translates into a number of patients needed to treat to prevent an event of 14 (see also Table 2 and Fig. 1).

The explanation of the finding, that primary angioplasty compared to thrombolysis offers comparable advantages even after transportation, is complex and multiple factors may interact. The time delay of interhospital transportation seems not to be of paramount importance, probably due to the fact that clinical outcome after primary angioplasty is less dependent on the time delay between symptom onset and therapy, compared to thrombolytic therapy.[15,16] Furthermore, as interventional centres treat large numbers of patients with acute myocardial infarction, these patients benefit from the fact that results of procedures as well as the optimal application of other therapies for acute myocardial infarction, are volume depended.[17–20]

The PRAGUE-2 and DANAMI-2[10,11] are especially important as they show that primary angioplasty therapy for acute myocardial infarction can be applied in large areas of partly urbanized Europe with good results. The time has come to implement these findings.

Acknowledgements

I would like to thank J. P. S. Henriques for the statistical analysis, and V. R. C. Derks for expert secretarial assistance.

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APPENDIX 15

Study published in the Emergency Medical Journal

PREHOSPITAL CARE

The relationship between distance to hospital and patient mortality in emergencies: an observational study

Jon Nicholl, James West, Steve Goodacre, Janette Turner

Emerg Med J 2007;**24**:665–668. doi: 10.1136/emj.2007.047654

See end of article for authors' affiliations

Correspondence to: Professor Jon Nicholl, Medical Care Research Unit, University of Sheffield, Regent Court, 30 Regent Street, Sheffield, S1 4DA, UK; j.nicholl@sheffield.ac.uk

Accepted 22 May 2007

Objectives: Reconfiguration of emergency services could lead to patients with life-threatening conditions travelling longer distances to hospital. Concerns have been raised that this could increase the risk of death. We aimed to determine whether distance to hospital was associated with mortality in patients with life-threatening emergencies.

Methods: We undertook an observational cohort study of 10 315 cases transported with a potentially life-threatening condition (excluding cardiac arrests) by four English ambulance services to associated acute hospitals, to determine whether distance to hospital was associated with mortality, after adjustment for age, sex, clinical category and illness severity.

Results: Straight-line ambulance journey distances ranged from 0 to 58 km with a median of 5 km, and 644 patients died (6.2%). Increased distance was associated with increased risk of death (odds ratio 1.02 per kilometre; 95% CI 1.01 to 1.03; $p<0.001$). This association was not changed by adjustment for confounding by age, sex, clinical category or illness severity. Patients with respiratory emergencies showed the greatest association between distance and mortality.

Conclusion: Increased journey distance to hospital appears to be associated with increased risk of mortality. Our data suggest that a 10-km increase in straight-line distance is associated with around a 1% absolute increase in mortality.

It has recently been suggested that reconfiguration of emergency care to concentrate services in a limited number of specialist centres could save thousands of lives each year in the UK, and that opposing the closure of local services could counterintuitively cost lives.[1] In opposition to this view, concerns have been raised that reconfiguration could lead to acutely ill patients having to be transported greater distances to hospital with an associated risk of increased mortality. Few published studies have addressed this issue, so there is a risk that policy-making may be driven by anecdote or supposition.

We have recently completed a study to assess the effect on mortality among patients with life-threatening emergencies of implementing response time standards in four ambulance services.[2] We have used these data to determine whether longer journey distances to hospital were associated with an increased risk of mortality.

METHODS

Call identification

Ambulance services use emergency medical dispatch (EMD) systems to prioritise 999 calls. Two systems were used during this study: the Advanced Medical Priority Dispatch System (AMPDS) and the Criteria Based Dispatch (CBD) system. Each provides structured protocols that allow trained emergency medical dispatchers to categorise 999 calls depending on urgency, and assigns each call a priority code based on condition and urgency. The Department of Health (DH) has identified a set of EMD codes for each system that correspond to conditions that are potentially life-threatening and to which the highest priority (category A) ambulance response should be made. We selected for inclusion in the study a subgroup of category A calls identified using the DH codes, in which the patient was reported as unconscious or not breathing or with acute chest pain. We termed these A* calls. Exclusion criteria were A* calls where patients were found dead at the scene, or were discharged at the scene and not conveyed to hospital, or were treated in hospitals other than those in our study areas; calls where no vehicle attended the scene; and out-of-hospital cardiac arrests (the last category was excluded because survival from out-of-hospital cardiac arrest has clearly been shown to depend upon the time from call to treatment that can be provided by ambulance staff, rather than time or distance from scene to hospital).[3]

Data collection

Consecutive, life-threatening category A ambulance calls were sampled annually from 1997 to 2001 from four ambulance services: the Royal Berkshire, Derbyshire, Essex and West Midlands. These services were representative of the types of environment typically encountered in England and included urban, mixed urban and rural, and very rural areas. In 1999, the Derbyshire, Nottinghamshire and Leicestershire ambulance services merged to become East Midlands Ambulance Service NHS Trust. Two services used CBD, one used AMPDS, and one used CBD at the beginning of the study and changed to AMPDS halfway through.

From all category A calls, we sampled approximately 1000 consecutive A* calls from each service in each year, using the same sampling period for each service for all years. The ambulance service dispatch system provided patient information (name, sex, age), grid reference for the incident, and dispatch category codes. This information was then used to identify the paper ambulance patient report forms (PRFs). From the PRFs, further information was obtained about the patient (name, date of birth and address), incident description, the patient condition on arrival of the crew (including vital signs), details of treatment given, disposal of the patient (left at

Abbreviations: AMPDS, Advanced Medical Priority Dispatch System; CBD, Criteria Based Dispatch; DH, Department of Health; ED, emergency department; EMD, emergency medical dispatch; GCS, Glasgow Coma Score; NHS, National Health Service; PRF, patient report form; REMS, Rapid Emergency Medicine Score

Table 1 Relationship between ambulance journey distance and survival to discharge

Distance category (km)	Outcome		Total
	Survived (%)	Died (%)	
0–10	7725 (94.2)	475 (5.8)	8200
11–20	1479 (92.3)	124 (7.7)	1603
21+	467 (91.2)	45 (8.8)	512
Total	9671 (93.8)	644 (6.2)	10315

the scene or transported to hospital) and outcome at this point (alive or deceased).

From the grid references of the incident and hospital, we calculated the straight-line ambulance journey distance from scene to hospital. These straight-line distances were preferred to journey times to hospital because journey times depend on the accuracy and consistency with which times of leaving the scene and arrival at hospital are recorded, and they can also be affected by "reverse causation". This occurs when the patient condition is a cause of the journey time rather than vice versa, such as when ambulances drive as fast as possible to hospital for critically ill patients but more slowly and with less risk for patients not critically ill.

If the patient was taken to hospital, the emergency department (ED) notes were identified and information recorded on time of arrival and discharge from the ED, patient condition including vital signs, cardiac rhythm (for cardiac patients), preliminary diagnosis, condition on leaving the ED and disposal. If admitted, details of the length of stay, final diagnosis and disposition were recorded. For any patient who died, details were recorded of the date, time, place and cause of death. If the patient died before reaching hospital and was taken directly to the mortuary, the cause of death was obtained by accessing death certificates from the coroner or the National Health Service (NHS) Central Registry.

Details of patients taken to hospital, for whom no records could be found, were also sent to the NHS Central Registry. For those identified as dead, the date, place and cause of death were obtained and used to identify those who had died as a result of the incident for which the call was made and those who had survived.

Ethics approval was obtained, covering 27 hospitals that patients could be taken to within the geographical boundary of each of the ambulance services.

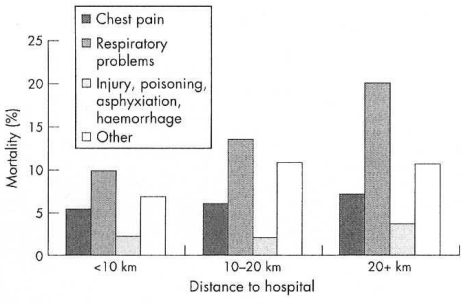

Figure 1 Variation in mortality with distance to hospital, by clinical category.

Analysis

We planned to test for an association between journey distance to hospital and mortality. Such an association could be confounded by illness severity. Patients living further from hospital may have a higher threshold for calling for help and may therefore be more ill and at higher risk of death. There is currently no widely validated system for risk-adjusting emergency medical cases, but the Rapid Emergency Medicine Score (REMS) has been validated in a local setting[4] and shown to predict mortality in our cohort.[5] This score uses six variables (age, Glasgow Coma Score (GCS), oxygen saturation, pulse, blood pressure and respiratory rate) to give each patient a score between 0 (lowest predicted mortality) and 20 (highest). We therefore planned to examine whether patients with a longer journey distance had higher REMS scores and determine whether any association between distance and mortality was confounded by illness severity by testing the association in a multivariate analysis, with REMS score included as a covariate. Because full REMS scores were only available for a small number of patients, we also tried adjusting for partial scores based only on age and GCS, which were available for 80.8% of patients. We also tried adjusting for sex, categorical age, and clinical category coded as chest pain (any cause), respiratory disease or symptoms, and injury, poisoning, asphyxiation or haemorrhage, or other and unknown. By including "other and unknown" as a category all cases were included in this analysis. All analyses were undertaken using SPSS V.11.0 (SPSS Inc, Chicago, Illinois, USA).

RESULTS

Numbers

During the 5-year period, A* calls resulted in ambulance attendance for 11 794 patients who met the study inclusion criteria and who were followed up to discharge or traced through the NHS Central Register. Of these, we excluded 1479 from this analysis because distance to hospital could not be calculated. This resulted in a study sample of 10 315 (58.3% male, with a median age of 61 years).

Analyses

Ambulance journey distances ranged from 0 to 58 km, with a median of 5 km. Overall, 644 patients died (6.2%). Table 1 shows how mortality varied with straight-line distances, categorised as short (<10 km), medium (10–20 km) or long (>20 km). Longer distances were associated with higher mortality ($p<0.002$, χ^2 test for trend). Logistic regression showed that mortality increased with each additional kilometre of distance travelled, with an odds ratio (OR) of 1.02 per kilometre (95% CI 1.01 to 1.03; $p<0.001$). Some association was observed in all four clinical categories, but it was particularly striking for patients with respiratory problems (fig 1).

A full REMS score could be calculated for 3882 patients (37.6%). The mean REMS score was 6.79 (95% CI 6.67 to 6.91) for those with a short journey distance, 7.22 (6.92 to 7.51) for those with a medium journey distance and 7.33 (6.78 to 7.88) for those with a long journey distance. The association between journey distance and mortality remained significant after inclusion of REMS score in the logistic regression to adjust for potential confounding by disease severity (OR = 1.03; 95% CI 1.01 to 1.05; $p = 0.006$).

Missing oxygen saturation information was the main reason why a full REMS score could not be calculated, so we repeated the analysis using only the age and GCS components of REMS. We have previously shown that age, GCS and oxygen saturation are the only components of the REMS score that are independent predictors of mortality in our cohort.[5] We were able to include 8335 (80.8%) cases and found that the

association between journey distance and mortality remained significant (OR = 1.018; 95% CI 1.005 to 1.03; p = 0.005).

Adjusting for age, sex, and clinical category, and including all 10 315 patients in the analysis, strengthened the evidence for the observed association (OR = 1.02; 95% CI 1.01 to 1.03; p<0.001).

DISCUSSION

Increased journey distance to hospital seems to be associated with increased risk of mortality, even after potential confounding by illness severity is taken into account. Our data suggest that each additional kilometre is associated with a 2% relative increase in mortality. This equates to an approximate 1% absolute increase in mortality associated with each 10-km increase in straight-line distance. Our results show a sharp increase in mortality in patients with respiratory problems, but less change in patients with chest pain. This is clinically plausible. This means that, other things being equal, closing local EDs could result in an increase in mortality for a small number of patients with life-threatening emergencies, who have to travel further as a result.

Other evidence

Our results concur with a number of studies from around the world that have shown increased mortality in rural compared with urban trauma. However, much of this can be explained by the increased severity of road traffic crashes and increased ambulance response times in rural areas. Furthermore, results may not be generalisable from trauma to other emergency medical conditions nor from one emergency system to another. Only a few studies have examined hospital accessibility and outcomes in the UK. Studies of road traffic crashes in Norfolk,[6] all serious trauma in Scotland,[7] and ruptured abdominal aortic aneurysms in West Sussex[8] all failed to find any relationship between time to hospital and mortality. However, in line with our findings, two studies of the relationship between accessibility and mortality in asthma patients have found a 10% increase in the relative risk of death for each 10-km increase in distance,[9] and a 7% increase for each 10-minute increase in journey time.[10]

Limitations

A number of potential limitations of our study should be considered when interpreting these results. First, this is an observational study, and inferring causality from our observed associations is fraught with difficulties, most notably by confounding. Although we attempted to adjust for confounding by illness severity and case mix, it is possible that at least some of the observed association may be explained by residual confounding. Second, we deliberately selected ambulance service calls that suggested patients might have life-threatening conditions and a high risk of mortality. Our findings should not be applied to the vast majority of patients transported to hospital by ambulance, who have a much lower risk of death. Third, our results reflect associations between distance and outcome within the emergency care system as it performed between 1997 and 2001. Changes in performance in recent years or new policies that have changed to both increase distances and either improve care at the more distant facilities or improve the effectiveness of prehospital care could attenuate the potential effect of increased journey distance upon mortality.

The emergency medical system and future research

There is good evidence for some groups of emergency patients that care provided in specialist centres improves outcomes.[1] Examples include primary angioplasty for acute myocardial infarction,[11] and care for major trauma patients with multiple injuries.[12] In these cases we can be reasonably confident that with appropriate pre-hospital care and at distances typical in the UK, the benefits of specialist care, which is only available in certain centres, would outweigh any detriments resulting from the increased travel distances to the centres. However, there are also some groups of critically ill patients who need urgent but not specialist care. For example, patients in anaphylactic shock, choking, drowning, or having acute asthma attacks need urgent care that would be the same wherever it is provided. For these patients, there may be a detriment in having to travel increased distances. Of course, if care for these types of patients, although the same wherever it is provided, were to be of higher quality in high-volume centres, there might be other arguments for concentrating emergency care in some centres by closing local EDs. However, although the evidence for improved outcomes at higher volumes is reasonably robust for a few conditions,[13] it is almost non-existent for ED care.[14]

The debate between local emergency care and more distant, high-volume or specialist centre care has also confused the issue of hospital bypass with the issue of ED closure. The evidence that some critically ill patients have the capacity to benefit from specialist care is an argument for bypass, not an argument for closure or restriction of hours of non-specialist centres. Patients with specialist needs such as burns and serious head trauma are already taken directly or indirectly to specialist centres. The current debate should be about extending the list of patient conditions that should bypass local hospitals and be taken to specialist centres, rather than about the closure of locally accessible 24-hour EDs. Closure enforces bypass for those patients who would benefit but at a cost for any patients who will not benefit.

Nevertheless, the optimum configuration of local and specialist emergency care centres for an effective and efficient emergency care system is unclear. Research is needed to investigate the benefits of different system configurations rather than the effectiveness of different services. One potentially fruitful avenue for future research aimed at resolving these issues would be to model the emergency medical system, populating the model based on the epidemiology of emergencies in the UK, and using the available evidence on risks and benefits by distance or time and setting.

CONCLUSION

Decisions regarding reconfiguration of acute services are complex, and require consideration of many conflicting factors. Our data suggest that any changes that increase journey distances to hospital for all emergency patients may lead to an increase in mortality for a small number of patients with life-threatening medical emergencies, unless care is improved as a result of the reorganisation. However, even then it is not certain that it would be acceptable to trade an increased risk for some groups of patients, such as those with severe respiratory compromise, for a reduced risk in other groups such as those with myocardial infarction.

Authors' affiliations

Jon Nicholl, James West, Steve Goodacre, Janette Turner, Medical Care Research Unit, University of Sheffield, Sheffield, UK

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Appendix 16

BRIAN ALLEN, C.P.F.A.
Chief Executive

Council Offices,
Spennymoor,
Co. Durham.
DL16 6JQ

E-Mail: exec@sedgefield.gov.uk

Telephone: (01388) 816166
Fax: (01388) 817251

Minicom (01388) 815613

David Gallagher,
Director of Corporate Strategies, Services & Relations,
County Durham Primary Care Trust,
John Snow House,
Durham University Science Park,
Darlington Memorial Hospital,

Durham, DH1 3YG

Our Ref: DA/JA

Your Ref:

This matter is being dealt with by:
David Anderson – Extension 4109

1st August, 2008

Dear Mr. Gallagher,

NHS CONSULTATIONS: BIG CONVERSATION, SEIZING THE FUTURE

Thank you for attending the Healthy Borough with Strong Communities Overview and Scrutiny Committee on the 1st July, 2008. Health inequalities and health deprivation within the Borough are of major concern to the Council and therefore Members were grateful for the opportunity to contribute directly to these debates.

The Overview and Scrutiny Committee's comments have now been considered by Cabinet and the Council's response to the above consultations is set out below.

> "Members welcomed 'Seizing the Future' and 'A Big Conversation' as they sought to improve healthcare in the locality.
>
> **Patient Choice**
> Increased choice for patients, including treatment in independent hospitals, could be seen as a means of minimising delays in patients receiving treatment and possibly raising standards of care. However, concerns were expressed about creeping privatisation and potential drift towards further fragmentation of the NHS. Members felt strongly that the

NHS ethos of 'treatment free at the point of delivery' should remain a fundamental principle. Patients should not feel pressurised into making financial contributions for their healthcare.

Development of Specialised Services
In recent years Bishop Auckland General Hospital has lost a number of services, such as general surgery, fracture clinic, consultant led maternity services, 24 hour paediatric services, general medicine, gynaecological services.

Members appreciated that the Foundation Trust needed to view services provided by hospitals within County Durham and Darlington as a combined resource, to look at specialist treatment offered within the region and develop services accordingly. Members were however concerned about potential accessibility issues related to the distance and time taken for patients to receive treatments, particularly in emergency situations, e.g. related to heart attacks and strokes which had a high prevalence in the Borough.

Concern was also expressed regarding transport issues for the relatives of patients receiving treatment, particularly those on low incomes. Shuttle bus services between hospitals had been proposed as a possible means of assisting non-urgent patients and visitors with transportation, however there had been no further developments on this issue. In addition there were similar concerns about accessibility of Out of Hours Urgent Care Centres at times when public transport was unavailable.

GP Led Health Centres
A GP Led Health Centre is to be established within County Durham to address inequalities and improve access to health care. Durham PCT were proposing that this Health Centre be located in Easington. Whilst Members appreciated that there were health inequalities in Easington that needed to be addressed, there were also similar health issues within Sedgefield Borough. Members had concerns that a single additional Health Centre located in Easington would not address health issues across County Durham and particularly within Sedgefield Borough. There were major accessibility issues, particularly for lower income groups, which tended to suffer most from health inequalities.

A programme of LIFT funded health centres had been agreed for the area, however these had yet to be delivered. Members were concerned about the apparent lack of clarity on the delivery of this programme.

In addition the introduction of evening and weekend appointments at GP Surgeries had not yet materialised.

NHS Consultations
A number of consultations were being undertaken concurrently by various parts of the NHS. Durham PCT was conducting 'A Big Conversation' with a view to developing a 5 year strategy for improving

health and healthcare. Durham and Darlington Foundation Trust was developing its own 5 year strategic plan under the banner of 'Seizing the Future'. In addition Hartlepool PCT, North Tees PCT and North Tees & Hartlepool NHS Foundation Trust were undertaking a review of healthcare within Hartlepool and Stockton, which would also impact on parts of Easington District and Sedgefield Borough. Members were keen to encourage those involved in these reviews to consult with each other on the outcomes of their consultations and proposals in order to ensure that maximum benefits could be gained from collaboration and the development of an integrated NHS service within the locality."

Thank you once again for your attendance and contribution.

Yours sincerely,

D. Anderson
Democratic Services Manager

cc : Diane Murphy, Project Manager, Seizing the Future, County Durham and Darlington Foundation NHS Trust, Darlington Memorial Hospital, Darlington.

Feisal Jassat – Head of Overview and Scrutiny, Durham County Council

Appendix: 17

Report to Overview and Scrutiny Committee

Seizing the Future – Report on Consultation to Date

11th December 2008

County Durham LINk (Local Involvement Network) have completed the following consultation to date:

- **LINk Members Meeting** - A meeting of LINk members who had expressed an interest in Seizing the Future took place in November to look at their views and opinions on "gaps" in the consultation process:

  - Members looked at the stakeholders who had been consulted and agreed that there were a number of omissions from this group.
  - The group also identified some accessibility issues with the documentation that is being used for the consultation, particularly for people with visual impairments.
  - Members identified that there are gaps in consulting with certain groups within the community, for instance, people with hearing impairments.
  - The group also felt that there could have been more public consultations and that these could have been at different times of the day (ie in the morning) and in more locations.

  All of this information has been fed back to NHS County Durham. This group was jointly facilitated by County Durham LINk and the Community Development Team from Durham County Council.

- **Other Consultation –** Other LINk members with hearing impairments, visual impairments and mental health issues have been contacted to see how they feel about the consultation process and whether it has been accessible to them. All agreed that it needed to be more accessible for people with specific disabilities and again, this has been fed back to NHS County Durham who are in the process of organising several more events to ensure the consultation process has been inclusive.

- **Other Comments** – LINk members also had the following comments:

  - Seizing the Future isn't a consultation as members of the public and users were not involved at the formative stage – only when the final two options were left.
  - The Trust has highlighted their preferred choice and therefore this is indicative of what is going to happen.
  - Members felt that there hasn't been enough information supplied on what is actually going to happen with Bishop Auckland General Hospital and what the changes actually mean.
  - Members wondered whether in a couple of years time there would be another Seizing the Future on Bishop Auckland General Hospital closing which the Trust haven't commented on.
  - There was also a number of concerns over the proposed new hospital in Teesside and what the implications will be for Darlington Memorial Hospital.

LINk Members' consultation – LINk members are to be brought together in early January to look at the Seizing the Future consultation and a paper will be produced which it is hoped will be fed in to the Overview and Scrutiny process later on in January 2009.