Better Health Programme Joint Health Scrutiny Committee

Meeting on Thursday 8 September 2016 at 2.00 pm in The Mandela Room, Middlesbrough Town Hall

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Agenda

1. **Apologies for Absence**
2. **Substitute Members**
3. **To receive any Declarations of Interest by Members**
4. **Minutes (Pages 1 - 8)**

   To receive and approve the minutes of the Better Health Programme Joint Health Scrutiny Committee held on 21 July 2016
5. **Better Health Programme - Phase 3 Engagement**

   Presentation – Representatives of the Better Health Programme will give a presentation to the Joint Committee updating members in respect of the Phase 3 Engagement process including further information regarding the potential long list scenarios/options and evaluation criteria to be used during options appraisal
6. **Better Health Programme - Evidence requested by the Better Health Programme Joint Health OSC**

   Presentation – Representatives of the Better Health Programme will give a presentation to the Joint Committee providing information in respect of performance across those key specialties within the Better Health Programme and which will include key performance challenges regarding staffing, outcomes and resources; how existing services compare with service standards elsewhere and performance information regarding patient flows and capacity across the BHP specialities including A&E
7. **Better Health Programme - Terms of Reference and Membership (Pages 9 - 14)**

   Report of the Better Health Programme Executive for information and comment
8. **Transforming Urgent and Emergency Care in England - The Keogh Report (Pages 15 - 46)**

   Members of the Joint Committee have previously requested details of Sir Bruce Keogh's report into Urgent and Emergency Care and the establishment of Major Trauma Centres across England. A copy of the report is attached for members' information as well as a location map detailing the location of existing major trauma centres across England
9. **Better Health Programme - Community representations from North East Empowerment and Diversity (Pages 47 - 100)**

   To consider the attached submission by North East Empowerment and Diversity
10. **Notice of Motion from Richmondshire District Council (Pages 101 - 102)**

Members of the Joint Committee are requested to receive and note the attached Notice of Motion passed by Richmondshire District Council at its Council meeting held on 19 July 2016 in respect of the Better Health Programme

11. Chairman's urgent items

12. Any other business

13. Date and time of next meeting

Thursday 13 October 2016 at 1.00 p.m. – The Jim Cook Conference Suite, Municipal Buildings, Church Road, Stockton

Please note the start time of this meeting is 1.00 p.m.

Published:

31 August 2016

Contact Officer: Stephen Gwillym, Principal Overview and Scrutiny Officer, Durham County Council **Tel:** 03000 268 140

Membership:

DARLINGTON BOROUGH COUNCIL
Councillor Wendy Newall
Councillor Jan Taylor
Councillor Heather Scott

DURHAM COUNTY COUNCIL
Councillor John Robinson
Councillor Jan Blakey
Councillor Watts Stelling

HARTLEPOOL BOROUGH COUNCIL
Councillor Ray Martin-Wells
Councillor Stephen Akers-Belcher
Councillor Rob Cook

MIDDLESBROUGH COUNCIL
Councillor Eddie Dryden
Councillor Bob Brady
Councillor Jeanette Walker

NORTH YORKSHIRE COUNTY COUNCIL
Councillor John Blackie
Councillor Jim Clark
Councillor Caroline Dickinson

REDCAR AND CLEVELAND BOROUGH COUNCIL
Councillor Ray Goddard
Councillor Mary Ovens
Councillor Norah Cooney

STOCKTON-ON-TEES BOROUGH COUNCIL
Councillor Sonia Bailey
Councillor Allan Mitchell
Councillor Lynn Hall

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Better Health Programme Joint Health Scrutiny Committee

At a Meeting of **Better Health Programme Joint Health Scrutiny Committee** held in Committee Room 2, County Hall, Durham on **Thursday 21 July 2016 at 2.00 pm**

Present:

Councillor J Robinson in the Chair

Councillors –

Councillors W Newall, J Taylor and L Tostevan (Darlington Borough Council)
Councillor J Blakey (Durham County Council)
Councillors R Cook and R Martin-Wells (Hartlepool Borough Council)
Councillors B Brady and E Dryden (Middlesbrough Council)
Councillors J Blackie, J Clark and C Dickinson (North Yorkshire County Council)
Councillors N Cooney, R Goddard and M Ovens (Redcar & Cleveland Borough Council)
Councillors S Bailey and L Hall (Stockton-on-Tees Borough Council)

Officers –

Stephen Gwillym (Durham County Council), Joan Stevens (Hartlepool Borough Council), Bryon Hunter (North Yorkshire County Council), Alison Pearson (Redcar & Cleveland Borough Council) and Peter Mennear (Stockton-on-Tees Borough Council)

Better Health Programme –

Nicola Bailey, Derek Cruikshanks, Edmund Lovell, Dr Boleslaw Posmyk and Dr Neil O'Brien

Also in attendance –

Councillor L Hovvels – Cabinet Portfolio Holder for Adult and Health Services and Chairman of Health and Wellbeing Board (Durham County Council)
Peter Appleton – Head of Planning and Service Strategy, Children and Adult Services (Durham County Council)

Representatives from North East Empowerment and Diversity Group.

1 Apologies for Absence

Apologies for absence were received from:-

Councillors –
Councillor Scott – Darlington Borough Council
Councillor Stelling – Durham County Council

Councillor S Akers-Belcher – Hartlepool Borough Council
Councillor Walker – Middlesbrough Council
Councillor Mitchell – Stockton-on-Tees Borough Council

Officers –
Elise Pout – Middlesbrough Council

2 Substitute Members

Councillor L Tostevan for Councillor H Scott (Darlington Borough Council)

3 Declarations of Interest

There were no declarations of interest declared.

4 Minutes

The minutes of the meeting held on 7 July 2016 were confirmed by the Committee as a correct record and signed by the Chairman (for copy see file of Minutes).

The Chairman advised that the ten decisions outlined in Item 7 would be re-visited following the BHP presentation.

As a matter of clarity, it was agreed that Councillors would be identified by name within the minutes.

5 Better Health Programme (BHP) - Phase 3 Engagement

The Committee considered a report and presentation of the Communications and Engagement Lead, Better Health Programme (BHP) that shared information from a stakeholder forum event held on 29 June 2016 and highlighted the long list of possible scenarios and evaluation criteria to be used for decision making (for copy see file of Minutes).

The Better Health Team gave a detailed presentation that included information on the following:-

- Better Health Programme Governance Structure
- Executive Membership
- Board Membership
- Engagement with Stakeholders
- Deciding what to consult on
- Workshop discussions – format
- Possible Solutions
- Proposed weighting criteria for engagement
- Key questions – discussion
- Key Services
- Combination of Services and Long list of Solutions
- NHS England Guidance

- Next Steps & Timeline

The Chairman referred to the focus on NHS Sustainability and Transformation Plans (STP) and the fact that nothing has been provided to the Joint OSC in this respect. Councillor Clark asked about funding through the STP and that further clarification was required. Councillor Martin-Wells asked who the STP were answerable to.

Dr O'Brien explained that the BHP was a focused piece of work and that the STP was about a combined planning approach to look at the financial gaps within the NHS over the next 5 years. He indicated that the BHP was a programme that sits under the STP and stressed that there were close links between the two projects. Dr Brien added that Mental Health and Hambleton and Richmondshire were not part of the BHP but did form part of the STP. He also pointed out that the work of the BHP commenced before the work of the STP.

Councillor Martin-Wells re-iterated his point about who the STP was responsible to and was advised that there are a number of professional people and bodies who judge the plan including representatives from NHS England, NHS Improvement, the Local Government Association and the Care Quality Commission. Dr O'Brien also advised that financial bodies and the department of health also feed into the plan. He went on explain that funding through the STP would be directed to NHS Foundation Trusts.

Moving on to the membership of the board, the Chairman was advised that there were no elected members involved. The Committee was, however, assured that there is Local Authority involvement in the Programme Board in terms of a nominated Chief Executive and Director of Social Care.

Referring to the stakeholder events, and in particular the ones held in Hartlepool, Councillor Cook asked how it had been decided who to invite, how the events were advertised and how people became involved in the process. Mr Lovell explained that the meeting in Hartlepool had been well attended and that those who had attended were from the local community including the Patient Reference Group. He informed Members that adverts had been placed in local newspapers, leaflets and been placed in GP practices and libraries and social media had been used to promote the events. He added that there had been varied attendances but that they had strengthened as the process developed. He went on to explain that there were a group of people who did come back to meetings and that were sharing the journey in terms of the development approach. Healthwatch had also been involved and had been e-mailing interested groups.

Councillor Martin-Wells said that as a cross-section of people had been attending the events there was no neutral base and therefore no consistency in terms of feedback. Mr Lovell explained that there had been similar attendances with the background being explained at each meeting. He felt that there had been a shared sense across all meetings that included concerns about travel, care outside of the hospital, community service and therefore believed the meetings to be consistent.

The Chairman had attended an event at Sedgefield racecourse and a follow up event at the Excel Centre and felt the audience to be very consistent.

Councillor Bailey had also been to a well-attended event in the Stockton area.

Councillor Tostevan asked for clarity regarding the proposed weighting criteria. Mr Lovell explained that it was about how much weight we give to one thing over another. For example, do we give 'Quality' 30% or 50%.

Councillor Martin-Wells said that option 4 was the favoured option with deliverability at 15% and pointed out that if the service could not deliver then this exercise was meaningless. He stated that surely the deliverability of any option must be a paramount consideration.

Councillor Ovens asked how Councils could become involved with regards to reducing the wait for delays and discharges. She said that unless we link closely with social services there would be a knock on effect for the level of care.

Dr O'Brien said that every local authority have officers within the Adult Social care environment that were working closely with the Better Health Programme.

Dr Posmyk explained that there was a level of importance when looking at different ways of delivery service. The feedback during the engagement process about accessibility was very important and the weighting factors were not set in stone. The Better Health Programme Executive Group preferred option 4.

In relation to the score for 'Deliverability', it was clarified that this referred to whether options would ensure that NHS Constitutional standards would be met.

The Principal Overview and Scrutiny Officer, DCC said that the comments made today would be reflected in the minutes and said that the Committee needed to have sight of information requested.

Mr Hunter referred to the existing resources and affordability and asked if there was potential to make savings working within the financial environment. Dr O'Brien said that the programme was about efficiency rather than making savings. The range of costs differ in each hospital environment and if this could be changed it would allow the money to be spent in a better way.

Moving on to the population figures, Councillor Blackie said that there were concerns with regards to the cuts and as people travel to Darlington from North Yorkshire it would have been helpful to see an estimate of figures. He went on to ask why Hambleton and Richmond were not full members of the BHP board as this could have an impact on decisions being made. Dr O'Brien informed Councillor Blackie that they had been invited on a number of occasions and had chosen to be associate members. Councillor Clark expressed concerns as they had received assurances regarding Darlington hospital in the past. He said that he would talk to Hambleton and Richmond about taking up full membership of the board.

Members requested sight of patient flows such as from Durham to Newcastle, North Yorkshire to Leeds/Bradford and for the Tees Valley area.

Councillor Cook said that the information needed to be clearer and asked which areas Bishop Auckland planned surgeries would cover. Mr Cruikshanks said that Bishop Auckland had a good reputation for outcomes for elective surgery. Councillor Cook asked what we could expect after this exercise.

Dr Posmyk said that one of the big drivers for the BHP is to ensure excellent services. He said that the board had no preconceptions but would use all of the information gathered so far to go out to consult upon. He added that a small number of patients would not be able to be seen as planned surgeries but as many patients as possible would go down this route. The BHP would concentrate on the best possible outcomes for patients.

With regards to planned surgery, Councillor Dryden was informed that some patients may need to be transferred to emergency care facilities, as happens now. It was hoped that better planning would ensure patients would be selected for surgery and would less likely need to be transferred.

Councillor Bailey asked if high risk units such as intensive care would run alongside midwifery units and if there would be guarantees that the mother could travel with the baby should the need arise. Dr Posymk informed her that the neonatal unit would run in parallel and that the mother would always be able to go with the baby, preferably being transferred to specialist care with the baby in the womb.

Councillor Clark said that as status quo was not an option he believed it to be a done deal.

The Chairman pointed out that the Committee would require evidenced based decisions.

Mr Lovell advised that there were 133 possible combination of services and that work was ongoing on prioritising possible solutions. All possible combinations would be explored together with patient flows.

Councillor Cook asked if one possible combination would be for North Tees to lose emergency care and was astounded to hear that this could be the case. He expressed concerns as Hartlepool had already closed. Dr O'Brien explained that all options would be looked at and decisions would be made using patient flows across the whole population and the services required. He stressed that no decisions had been made at this point.

The Chairman expressed similar concerns should Durham or Darlington lose out. He reminded Members that no decisions were being made today and asked again that evidence be provided for each option.

Mr Lovell said that the BHP were not looking for a recommendation from the Committee at this stage. They were analysing possible solutions and a lot of

detailed work still needs to be carried out. He added that over the next few months the board would be talking the Committee through the process.

Councillor Dryden asked if with planned care were the BHP building assumptions that private hospitals would take up capacity. Dr Posmyk gave the Committee assurances that patient flows would be taken into account and some volume of planned care would go to the private sector.

Mr Lovell explained that in order to create space in the emergency hospitals some planned care would need to move. Councillor Dryden asked if staff would also move and was advised by Mr Cruikshanks that the workforce would be networked and available to provide a service at more than one site. The benefit of a bigger workforce would enable planned care to be more effective. Mr Cruikshanks further explained that cancelled operations and delays due to beds being blocked by emergency care would be managed and would create capacity to plan more.

Councillor Newall said that Darlington residents would be equally as angry at losing emergency care. She referred to the urgent care facility at Darlington and the proposal for a £5m investment that had now been reduced to £½m. With £27m for an extension at University Hospital of North Durham (UHND) she felt that it was already a done deal.

Dr O'Brien said that it was not a done deal and no decisions had been made. Decisions for the plans to extend UHND had been made before the BHP commenced.

Councillor Taylor said that people were drawing conclusions from the information received as £5m had been promised to be spent at Darlington. Dr O'Brien said that the refurbishment for Darlington would happen but he assured the Committee that this was an open and honest engagement and consultation exercise and that no decisions had been made on where services would be delivered from.

Councillor Martin-Wells said that he hoped he would be proved wrong but that he had to listen to the people he represented and they were saying that decisions had already been made.

Mr Cruikshanks suggested that they could look at the current activity of accident and emergency and look to see what does happen at A and E, compared to what should happen. The Chairman welcomed this.

In relation to the feedback, Councillor Martin-Wells was concerned that only 5% had been received about A&E. He asked what questions had been asked of the public. Mr Lovell advised that the questions asked were 'What do the NHS do well?' and 'Where it could be improved'. An outside organisation had compiled a report and analysed the feedback. In the early stages of the BHP people started feeding back that they were more concerned about travel, having care closer to home, community social care, GP appointments, 111 service and ambulance response times. Mr Cruikshanks added that the public wanted to spend more time at home and have earlier integration back into the community.

Councillor Cook felt that the two questions asked have left the consultation wide open and felt that there should have been more specific questions asked.

Councillor Tostevan felt that the information was not clear enough about what was being consulted upon. She felt that the information needed to be more explicit so that the public could understand.

Mr Lovell reminded Members that at present this exercise was about engagement not consultation. Conversations were still taking place with people about their concerns over services and specialist care.

The Principal Scrutiny Officer reminded Members of the recommendations made at the last meeting and what further action and evidence needs to be provided to the Better Health Programme Joint Health OSC by the BHP representatives.

Referring to the previous set of minutes he said that paragraph 4 had been addressed as Members had received a presentation and had an in-depth conversation about the appraisal criteria and the weightings to be applied.

Further information was still required as outlined in recommendations 3, 5, 7, 8, 9 and 10.

In mitigating on behalf of the Programme Board, the Principal Overview and Scrutiny Officer explained that they had a very short timescale from the last meeting to collate all of the information that had been requested by members and it was not the intended for Members to receive that today. As some Councils have a recess period during August it was unlikely that a special meeting would be arranged and therefore he requested that all information be provided for the 8 September meeting.

He pointed out the importance of the Committee receiving the information requested and the requirements placed upon the NHS in respect of the provision of information and evidence requested by Health Scrutiny Committees as set out in Department of Health's Local Authority Health Scrutiny Guidance. The Committee would need all information before they could offer informed opinions leading up to the start of the consultation period in November.

He advised that all Better Health Programme Joint Health Scrutiny Committee meeting papers were available on Durham County Council's website.

The Chairman thanked everyone for attending and for their contribution.

Resolved that:-

(1) The contents of the presentation and the comments of the Committee thereon be noted;

(2) The Better Health programme Executive provide the requested information and evidence set out in the minutes of the Joint OSC meeting held on 7 July 2016 to the meeting scheduled for 8 September 2016;

(3) Data be provided in relation to current activity at each of the A&E units within the Programme footprint; and

(4) The comments made by the Joint OSC in respect of the long list options evaluation criteria weightings be noted.

6 Date and time of next meeting

The next meeting would be held on Thursday 8 September 2016 at 2.00 p.m. in the Mandela Room, Middlesbrough Town Hall.

Better Health Programme (BHP)

Programme Board

Terms of Reference.

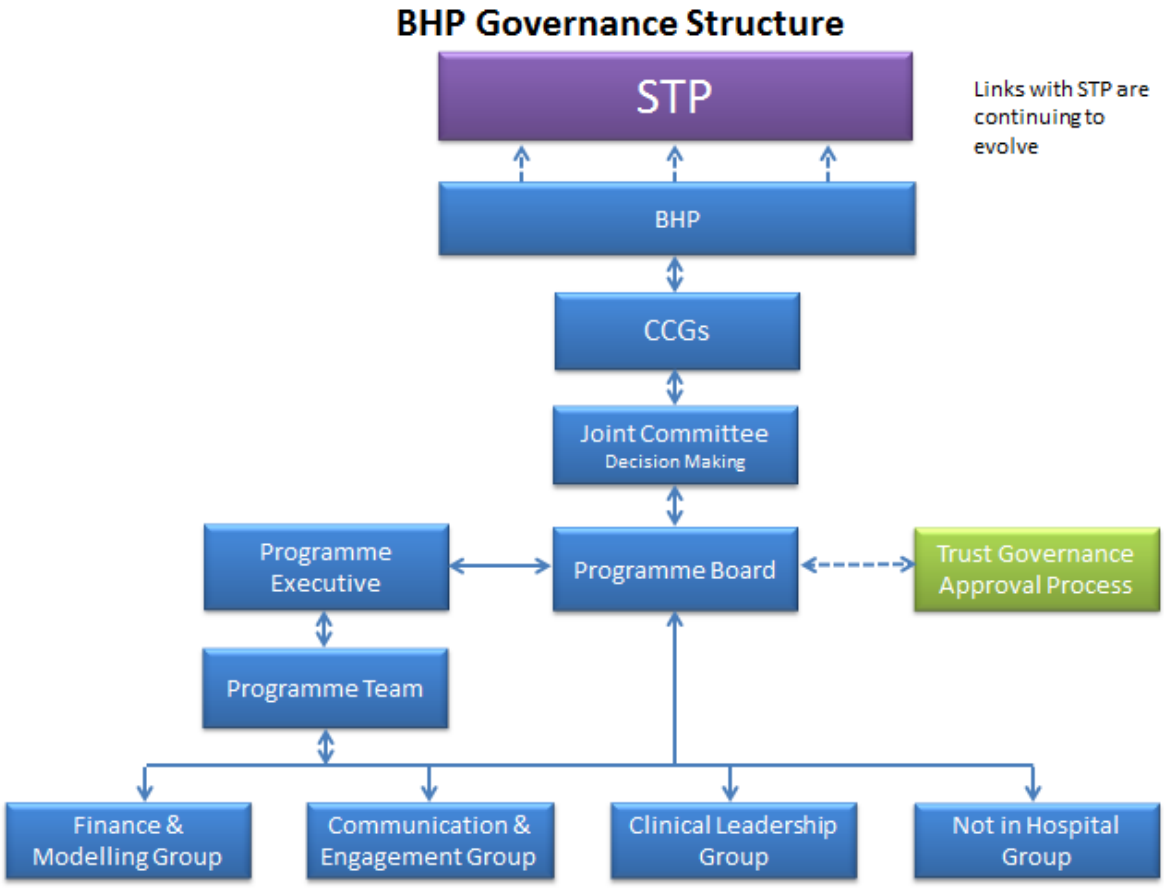
1. Background

This document has been prepared to act as discussion draft for the development of the Terms of Reference for the Chair and Membership of the Programme Board for the Better Health Programme.

In particular, this document articulates the Purpose, Responsibilities, and Authority of the Working Group and the individuals who will constitute its Membership.

2. BHP Governance Arrangements

The group forms part of the wider programme governance arrangements as summarised below.



Each Clinical Advisory Group reports into the Clinical Leadership Group and will be responsible for working together and with the Not in Hospital Group to develop local pathways of care, transfer and services.

There is a total of 7 Clinical Advisory Groups in the programme;

- Acute Medicine
- Acute Surgery
- Urgent and Emergency Care
- Critical Care
- Acute Paediatrics. Maternity and Neonates
- Radiology Services
- Elective Care.

This is also one Interface Group which includes members of the Clinical Leadership Group and the Not in Hospital Working Group.

3. Responsibilities

The specific responsibilities of the Board will be

- To steer the programme in line with the agreed mandate ensuring through public consultation to implementation of system wide transformation within agreed resources, timelines, governance arrangements and to provide external assurance
- Ensure decisions requiring formal CCG Governing Body agreement will take the form of recommendations to the Joint Committee
- Where an organisation's board raises concerns, the Programme Board shall support the member in engaging their organisation in addressing the concerns
- Responsible for approval and to sign-off key documents for the programme
- Responsible for the setting and management of the programme budget
- Approve the establishment of any required Working Groups
- Approve the Terms of Reference and work plans for the Programme Executive
- To receive the progress and update reports from the BHP Working Groups
- To agree update reports to be presented to the Joint Committee

4. Consultation, Decision-making and Behaviours

- The Programme Board is established by the Senior Responsible Officer and has no powers other than those included in its terms of reference;
- The Board will seek to reach consensus in its decision – making. Where consensus cannot be reached, views which are divergent from the majority view will be recorded and presented with the report/advice to the Joint Committee
- Members are expected to act as ambassadors for the programme and engage others within their organisations in the development of the programme.
- Members are expected to provide information to the Programme Board to support the development of a Model of Care to make well informed decision-making

- The Programme Board shall be dissolved when it has confirmed that the service configuration and operational option(s) has been decided, and any formal reviews or challenges of that decision have been completed.

5. Accountability and Authority

- The agenda and minutes of meetings will be agreed by the Chair and circulated to all members for approval and ratification.
- The Chair of this Group is a member of the Joint Committee.
- The Board is authorised to instigate any activity within its terms of reference and to seek information as necessary ensuring delivery within agreed budgets and governance arrangements.
- The Programme Board is authorised to secure the attendance or advice of such persons, including external organisations with relevant experience and expertise, as it considers necessary.

6. Quorum

- Where the Chair has determined – and has given two weeks' notice to members – that a key decision will be made then the quorum shall include members (or their proxies) of all organisations that the Chair determines should be present unless that organisation has instead chosen to make a written submission.

- The Programme Board will be quorate with a minimum of 10 members attending of which there must be as a minimum:

    - 2 x CCG Chief / Accountable Officers
    - 1 x Acute Trust CEO
    - 1 x Local Authority representative
    - 1 x Healthwatch or Voluntary Sector representative

7. Task and Finish Groups

Task and Finish Groups to support time limited pieces of work may be established as required by the Chair of the Programme Board.

8. Membership

The membership of the Programme Board shall be:

A nominated Clinical Lead representative for each of the Clinical Commissioning Groups:

- NHS Darlington CCG
- NHS Durham Dales, Easington and Sedgefield CCG
- NHS Hartlepool and Stockton-On-Tees CCG
- NHS North Durham CCG
- NHS South Tees CCG

A nominated Chief / Accountable Officer representative for each of the Clinical Commissioning Groups:

- NHS Darlington CCG
- NHS Durham Dales, Easington and Sedgefield CCG
- NHS Hartlepool and Stockton-On-Tees CCG
- NHS North Durham CCG
- NHS South Tees CCG

Associated CCGs – Clinical Lead and a Chief / Accountable Officer

- NHS Hambleton, Richmondshire and Whitby CCG

BHP Working Group Leads

- Communication and Engagement Lead
- Finance and Modelling Lead
- In-Hospital Lead
- Not-in Hospital Lead

Chief Executive for each Acute Provider Trust

- County Durham and Darlington NHS Foundation Trust
- North Tees and Hartlepool NHS Foundation Trust
- South Tees Hospitals NHS Foundation Trust

Associated Provider Trusts

- Tees Esk and Wear Valley NHS Foundation Trust - Mental Health
- North East Ambulance NHS Foundation Trust

A nominated chief executive and a nominated director of social care to represent the Local Authorities

- Hartlepool Council
- Stockton-On-Tees Borough Council
- Middlesbrough Council
- Redcar and Cleveland Borough Council
- Darlington Council
- Durham County Council

Other attendees

- NHS England;
- Healthwatch representatives (Durham and / or Tees)
- Better Health Programme Directory
- North East Commissioning Support Services;
- Health Education North East,
- Voluntary Sector representatives (Durham and / or Tees)
- Others as invited as appropriate to specific agenda items

When a consensus decision is needed, the core members will undertake a vote. The consensus decision that is reached will constitute an update to the Joint Committee.

9. Meetings

There will be a minimum of 6 formal meeting in any 12 month period – with the option of additional informal workshops in addition. A meeting note will be supplied by the Secretary and circulated within 10 working days of the meeting being held.

All members of the Programme Board will be sent all meeting papers and minutes.

Support and advice will be provided by the BHP Programme Office. This support shall include:

- Agreement of the agenda with the Board Chair;
- The proper and timely preparation and circulation of papers;
- Ensuring minutes and papers for meetings are stored on the central file storage facility; and
- Monitoring progress of actions to be taken forward.

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NHS England

Transforming urgent and emergency care services in England

Urgent and Emergency Care Review

End of Phase 1 Report

High quality care for all, now and for future generations

THE NHS CONSTITUTION

the NHS belongs to us all

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Publications Gateway Reference:	**00691**
Document Purpose	---
Document Name	High quality care for all, now and for future generations: Transforming urgent and emergency care services in England - Urgent and Emergency Care Review End of Phase 1 Report
Author	NHS England
Publication Date	13 November 2013
Target Audience	CCG Clinical Leaders, CCG Chief Officers, CSO Managing Directors, Care Trust CEs, Foundation Trust CEs , Medical Directors, Directors of PH, Directors of Nursing, Local Authority CEs, Directors of Adult SSs, NHS England Regional Directors, NHS England Area Directors, NHS Trust Board Chairs, Special HA CEs, Directors of HR, Directors of Finance, Allied Health Professionals, GPs, Communications Leads, Emergency Care Leads, Directors of Children's Services, NHS Trust CEs, All NHS England Employees, Patients and the Public
Additional Circulation List	
Description	This document describes the outcomes of the NHS England Urgent and Emergency Care Review's engagement exercise.
Cross Reference	End of Phase 1 report and appendices 1-3 Gateway Reference 00691-00694
Superseded Docs (if applicable)	
Action Required	For review
Timing / Deadlines (if applicable)	**N/A**
Contact Details for further information	Urgent and Emergency Care Review Team NHS England Quarry House (Rm 5W52) Leeds LS2 7UE

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Transforming urgent and emergency care services in England

Urgent and Emergency Care Review

End of Phase 1 Report

High quality care for all, now and for future generations

First published: November 2013

Prepared by Urgent and Emergency Care Review Team

Contents

Letter to the Secretary of State for Health and the Chairman of NHS England

Dear Secretary of State and Sir Malcolm,

Earlier this year, I agreed to conduct a comprehensive review into how we organise and provide urgent and emergency care services in England. We all shared the same anxiety that, up and down the country, A&E Departments, the hospital services that support and sit behind these departments and our ambulance services were under intense, growing and unsustainable pressure. This pressure is very real and whilst the NHS is coping, it needs addressing urgently so patients can continue to receive high quality urgent and emergency care in the future.

This letter and accompanying report present the findings from the first phase of my review. The report sets out proposals for a fundamental shift in how and where we meet the urgent and emergency care needs of people in this country. I am confident that, if fully implemented, within a few years we can create a service that is more responsive and personalised for patients and delivers even better clinical outcomes. It is essential that we transform the whole urgent and emergency care pathway, from end to end. This system-wide approach is the only way to create a sustainable solution and ensure that future generations can have peace of mind that when the unexpected happens, the NHS will still be able to provide a rapid, high quality and responsive service, free at the point of need.

Our Vision

Our vision is simple. Firstly, for those people with urgent but non-life threatening needs we must provide highly responsive, effective and personalised services outside of hospital. These services should deliver care in or as close to people's homes as possible, minimising disruption and inconvenience for patients and their families. Secondly, for those people with more serious or life threatening emergency needs we should ensure they are treated in centres with the very best expertise and facilities in order to reduce risk and maximise their chances of survival and a good recovery. If we can get the first part right then we will relieve pressure on our hospital based emergency services, which will allow us to focus on delivering the second part of this vision.

The case for change, opportunities for improvement

The reasons for the growing pressures our A&E departments are experiencing have been well rehearsed. Two things in particular are often cited. Firstly, an ageing population with increasingly complex needs is leading to ever rising numbers of people needing urgent or emergency care. Secondly, we know that many people are struggling to navigate and access a confusing and inconsistent array of urgent care services provided outside of hospital, so they default to A&E. While both these things are true, they arguably underplay the fact that A&E departments have become victims of their own success. The A&E brand is trusted by the

public and, despite increasing pressure, continues to provide a very responsive service with an average wait for treatment of only 50 minutes and the overwhelming majority of patients being treated within 4 hours. So, we should not be surprised that people choose to go to A&E.

But, the reality is that millions of patients every year seek or receive help for their urgent care needs in hospital who could have been helped much closer to home. The opportunities for bringing about a shift from hospital to home are enormous. For example, we know that 40% of patients attending A&E are discharged requiring no treatment at all; there were over 1 million avoidable emergency hospital admissions last year; and up to 50 per cent of 999 calls requiring an ambulance to be dispatched could be managed at the scene. To seize the opportunities these numbers present, we will need to greatly enhance urgent care services provided outside of hospital. This forms a key part of our proposals.

The second part of our vision relates to those people with the most serious or life threatening emergency care needs who do require treatment in hospital. In the 1970s most A&Es and their hospitals could offer people the best treatment of the day for most conditions. Clinical practice has taken great strides forward in the last four decades, and this is no longer the case.

Take heart attacks for example. In the 1970s, heart attacks were treated with bed rest. The hospital mortality rate was about 25 per cent. Today, as a result of advances in medical science, we now mechanically unblock the culprit coronary artery which was causing the heart attack. This treatment has seen mortality rates fall to just 5 per cent. But this improvement has required very expensive diagnostic equipment and cardiologists with special skills. This highly effective, advanced treatment of serious heart attacks cannot be provided by every hospital; it is currently delivered by half the hospitals in England, with about a third providing a comprehensive 24/7 service. We have very good results by international standards because the diagnosis can be made in the ambulance and the right patients are taken to the right hospitals for the most advanced treatment. This means that for paramedics to get patients to the best and most appropriate services, they will sometimes drive past the nearest A&E to get the patient to the right place. This is a good thing. The recent national reorganisation of major trauma services which resulted in the designation of 25 major trauma centres has produced, in its first year, a 20% increase in survival despite increased travel time for patients who now bypass A&Es that previously treated only a handful of these very serious and complicated cases.

Similarly, the treatment of strokes which occur when the blood supply to part of the brain is blocked, has evolved. Effective treatment requires rapid transfer to a highly specialised unit with expensive diagnostic scanners and clinical expertise so that drugs can be given to minimise the brain damage that occurs. Stroke services in London have been reorganised to offer this high level treatment, but this required redirecting patients with suspected strokes from 32 admitting hospitals to only 8. The end result is that London has the best stroke services of any capital city in the world, saving more lives and returning more patients to independent living.

We have made good progress on treating heart attacks and strokes, although there is still more to do in these and other areas in order to reduce risks and improve outcomes. Advancing science has directed the way we deliver services to achieve the best results, but it also exposes the illusion that all A&Es are equally able to deal with anything that comes through their doors. We now find ourselves in a place where, unwittingly, patients have gained false assurance that all A&E's are equally effective. This is simply not the case.

We also know that the likelihood of recovering from a particular illness or injury varies considerably between hospitals. Despite the best efforts of the staff who work there, many hospitals and their A&E departments do not have consistent consultant presence overnight or at weekends. The support services available also vary considerably, with 1 in 7 lacking at least one "essential" on-site service, such as critical care, acute medicine, acute surgery or trauma and orthopaedics. As you know, I have also been leading the NHS Services, Seven Days a Week Forum which has been considering potential solutions to some of these issues and will report shortly.

So, A&E departments up and down the country offer very different types and levels of service, yet they all carry the same name. We need to ensure that there is absolute clarity and transparency about what services different facilities offer and direct or convey patients to the service that can best treat their problem. Most importantly, we need to ensure that anywhere that displays a red and white sign is a place that will provide access to the very best care for the most seriously ill and injured patients, 24 hours a day and 7 days a week. A place that can resuscitate, make a diagnosis, start treatment and ensure rapid transfer to the right place if it can't offer the very best care.

The Future of Urgent & Emergency Care Services in England

The challenges facing our urgent and emergency care system are clear, as are the opportunities for improvement. We now need to take action. Our report sets out our proposals for the future of urgent and emergency care services in England. There are five key elements, summarised below, all of which must be taken forward to ensure success:

- **Firstly, we must provide better support for people to self- care.** This is by far the most responsive way of meeting people's urgent but non-life threatening care needs. Millions of people already do this, but millions more could be better supported to take control of their own health. To achieve this, we will need to provide better and more easily accessible information about self-treatment options so that people who prefer to can avoid the need to see a healthcare professional. We will also need to accelerate the development of comprehensive and standardised care planning, so that important information about a patient's conditions, their values and future wishes are known to relevant healthcare professionals. This way, patients will be better supported to deal with that condition before it deteriorates, or if additional help is required.

- **Secondly, we must help people with urgent care needs to get the right advice in the right place, first time.** To achieve this, we will greatly enhance the NHS 111 service so

that it becomes the smart call to make, creating a 24 hour, personalised priority contact service. This enhanced service will have knowledge about people's medical problems, and allow them to speak directly to a nurse, doctor or other healthcare professional if that is the most appropriate way to provide the help and advice they need. It will also be able to directly book a call back from, or an appointment with, a GP or at whichever urgent or emergency care facility can best deal with the problem.

- **Thirdly, we must provide highly responsive urgent care services outside of hospital so people no longer choose to queue in A&E.** This will mean providing faster and consistent same-day, every-day access to general practitioners, primary care and community services such as local mental health teams and community nurses for patients with urgent care needs. It will also mean harnessing the skills, experience and accessibility of a range of healthcare professionals including community pharmacists and ambulance paramedics. By extending paramedic training and skills, and supporting them with GPs and specialists, we will develop our 999 ambulances into mobile urgent treatment services capable of dealing with more people at scene, and avoiding unnecessary journeys to hospital.

- **Fourthly, we must ensure that those people with more serious or life threatening emergency care needs receive treatment in centres with the right facilities and expertise in order to maximise chances of survival and a good recovery.** Once we have enhanced urgent care services outside hospital, we will introduce two levels of hospital emergency department – under the current working titles of Emergency Centres and Major Emergency Centres. In time, these will replace the inconsistent levels of service provided by A&E Departments. The presence of senior clinicians seven days a week will be important for ensuring the best decisions are taken, reassuring patients and families and making best use of NHS resources. Emergency Centres will be capable of assessing and initiating treatment for all patients and safely transferring them when necessary. Major Emergency Centres will be much larger units, capable of not just assessing and initiating treatment for all patients but providing a range of highly specialist services. These centres will have consistent levels of senior staffing and access to the specialist equipment and expertise needed to deliver the very best outcomes for patients. We envisage there being around 40-70 Major Emergency Centres across the country. We expect the overall number of Emergency Centres (including Major Emergency Centres) carrying the red and white sign to be broadly equal to the current number of A&E departments.

- **Fifthly, we must connect all urgent and emergency care services together so the overall system becomes more than just the sum of its parts.** Building on the success of major trauma networks, we will develop broader emergency care networks. These networks will dissolve traditional boundaries between hospital and community based services and support the free flow of information and specialist expertise needed to achieve the delivery of patient care in the most appropriate and convenient setting. Major Emergency Centres will have a lead responsibility for the quality of care and operational performance of

services across the network they support, including linked Emergency Centres. These networks will also support the introduction of an efficient critical care transfer and retrieval system so that patients requiring specialist help reach the best possible facility in a timely fashion.

The system-wide transformation of urgent and emergency care services we envisage is a major undertaking. There will be many challenges along the way. Traditional barriers and vested interests will need to be tackled and broken down. We know that many parts of the system are already coping with sustained pressure and multiple demands, particularly GP practices which have themselves experienced significant increases in patient consultations in recent years. So, it will be important that we create the right conditions and environment to allow the new services to be developed safely. But, the truth is that if we don't change the whole urgent and emergency care pathway, from start to finish, we will simply repeat the mistakes of the past: timid, limited or disjointed initiatives will be insufficient.

Let me be clear that there is no simple solution. This report sets out some principles. How they are developed locally will, and must, vary to suit local circumstances and wishes. We will need different approaches in metropolitan, rural or remote areas. The majority of people needing urgent care do not have life threatening problems so we must focus our attention on bringing the best care to people as close to home as possible, wherever they live. When patients have serious problems we must equally ensure they are treated by clinical teams that offer them the best chance of recovery.

I would like to thank Professor Keith Willett for the vision and clinical leadership he has provided to this review as well as the thousands of people, particularly patients and their representatives, who have engaged with us and helped get us to this point. The second phase of the review will now focus on implementing their vision and the proposals set out in this report. The NHS belongs to us all. Many people will have many ideas, some will have fears. We will listen and continue to conduct and build this review in public and will report again on progress in Spring 2014.

Professor Sir Bruce Keogh KBE, MD, DSc, FRCS, FRCP
National Medical Director

Foreword

I have been a consultant trauma surgeon for over 20 years, and believe passionately in providing my patients with the most responsive and professional urgent and emergency care the NHS can offer. I therefore relish the opportunity to lead this review knowing that, for the many reasons Professor Sir Bruce Keogh has outlined, we must transform services now to ensure that we and our families can absolutely rely on the NHS whenever and wherever we may need help urgently.

I also appreciate, as an NHS doctor and now as a Director in NHS England, just how often in the past we have been told what was right for us and our patients without reference to those of us who live and breathe these issues on a daily basis, or experience services as patients or carers. I fully understand how important urgent and emergency care services are to local people, and how strongly NHS staff strive to secure the best results for their patients. It is for those reasons we have set about this review very differently; we have built it in public, and will continue to do so as the review progresses.

We started the first phase by compiling the evidence of what works from published research and, building on the views of patients and clinicians from the frontline of urgent services, drafted a set of core principles and objectives that we felt everyone should expect any new system to meet. Importantly we then put all of our findings out into the public domain with an expectation that they would be discussed, criticised and improved, and they were. Over 1,000 people, including members of the public, NHS staff, commissioners of services and organisations representing patients and professionals, have taken their time to give their views and help us improve the review.

We have listened to everyone who sent us their feedback, either on our website, by letter, or at events that we conducted. The resulting evidence base (Appendix 1) and the principles and objectives (Appendix 2) are a part of this report. Powerfully, almost everyone in our engagement exercise (97% of respondents) accepted that things had to change. Indeed, many said change needed to be fundamental with no more tinkering at the edges. People described how NHS urgent care has become disjointed between GPs and specialists, between the community services and hospitals - resulting in many patients feeling they had no control and confused as to what they should do and where they should go. Urgent care has become out of step with how people live their lives.

I am confident that we are now harnessing the combined clinical wisdom and experience of the NHS and its patients, and that we can address these issues. Indeed, we owe it to the staff working in our urgent and emergency care system and each and every one of our own family members to get this right.

We have good evidence to guide us, and working examples of the key components of a new urgent and emergency care system. This report outlines the changes we intend to make in our community, general practice, ambulance, and hospital services. These changes range from improving the ability of patients to self-care for minor illnesses, all the

way through to priority access to specialist services for life-threatening emergencies. The report clearly recognises the need for end to end whole system transformation. It also describes the importance of a supporting network, so no patient or clinician is consulting in isolation.

Phase 2 of this review will take these proposals and determine the commissioning, workforce and cost implications of the new clinical models, developing the tools and guidance that will support successful implementation. We will specifically test to ensure that our proposals offer effective care for children, for those who are elderly or frail, and for those with mental health needs. As we progress, it remains essential that we continue to explore every aspect in public because there are important issues of quality and sustainability that can only be resolved through the engagement and cooperation of clinicians, commissioners and patients.

These are vital times for urgent and emergency care in the NHS. Change is required now, right across the system, and we must all work together to deliver it. I look forward to you joining me on this journey.

Professor Keith Willett FRCS
National Director for Acute Episodes of Care, NHS England

Chapter 1: Introduction

The fundamental principles upon which the NHS is founded - the provision of a comprehensive service, with access based on clinical need not ability to pay - are at their most precious when we or someone we care about needs urgent or emergency care. Every year, the NHS responds to hundreds of millions of contacts from members of the public with such needs. At one end of the spectrum these contacts relate to people seeking help and advice around options for self-care. At the other end, they relate to people needing life-saving treatment for the most serious conditions such as major trauma and heart attacks.

Whilst we should celebrate the fact that the fundamental principles upon which the NHS was founded still endure, it is concerning that the way in which we organise and provide urgent and emergency care services today still resembles the system put in place over five decades ago. We now have an outdated model, too focused on 'bricks and mortar' rather than the provision of services where and when patients need them. It is struggling to cope with ever increasing demand and changing patterns of disease and which, in some instances, has failed to keep pace with advances in medical science and technology as well as changing public expectations.

An emergency service at its limit

The demands being placed on our urgent and emergency care services have been growing very significantly over the past decade. Over the last three years alone, attendances at all types of urgent and emergency care facilities (officially termed type 1, 2 and 3 A&E departments) have risen by one million. NHS organisations and staff are continuing to work very hard to ensure that performance against key standards (such as the percentage of A&E patients discharged, admitted or transferred within 4 hours) are maintained, but it is clear that the service is at the limit of its capacity.

Every winter this pressure increases further and the signs are most visibly seen in our A&E departments, where last year's cold snap resulted in very considerable strain. The Government has announced a significant two year investment in A&E departments to help them with the further pressures that are anticipated during the forthcoming winter. This will be beneficial but it is not the sustainable long-term solution. It is also important to recognise that the pressures facing our urgent and emergency care services are not simply a phenomenon of winter. They are present all year round and require a systemic not just a seasonal response, although preparations have started earlier than ever before this year.

We know that if we do not provide an adequate or responsive service to those with less serious, but nevertheless urgent, care needs we risk allowing such problems to become worse. We also know that a failure to meet people's needs outside of hospital results in them seeking help from those services that are highly responsive - particularly A&E departments and 999 ambulances - but are intended to help those with the most serious, complex and life threatening needs. The reality is that the pressure our A&E departments and ambulance services are experiencing is absolutely not a sign of failing services, but

that these services have become victims of their own success. The unsustainable demands being placed upon them have been fuelled by their own responsiveness but also the difficultly patients experience in navigating and securing help for their urgent care needs elsewhere.

Be assured, it is not that the NHS has not modernised. Indeed, the hospital service has become very efficient. Over the last 15 years patients admitted to hospital as an emergency have increased by almost 50 per cent yet the NHS has managed to not only improve survival rates year on year, but also achieved a reduction in annual bed-days from 37 million to 32 million by almost halving the length of stay. But the options to improve hospital efficiency are ever more challenging and when it is estimated that one in five patients could be treated equally well or better out of hospital it becomes clear that we need to address the whole urgent and emergency care system. The Government's £3.8bn health and social care integration fund has the potential to make an important contribution to ensuring people are treated closer to home.

However, we must recognise that we cannot rely on spending increasing amounts of money on a system that needs to be improved, and which is already approaching its limits. We have to be more radical than this if we are to deliver lasting solutions.

Scope and purpose of the review

In response to these challenges, Professor Sir Bruce Keogh announced a comprehensive review of the NHS urgent and emergency care system in England. The overall objective of the review was to consider how to improve services for patients right across the spectrum of urgent and emergency care, and to identify potential solutions.

This Review is being conducted in two phases.

Phase 1 of the review aimed to understand the way in which the NHS responds to patients who have urgent and emergency care needs, with a view to developing an authoritative summary of the research evidence and a set of underpinning principles and objectives on which to base the design of a new system. This report, which marks the conclusion of phase 1, sets out:

- the case for change and the opportunities for improvement - **Chapter 2**
- our proposals for improving urgent and emergency care services in England - **Chapter 3**
- next steps towards implementing our proposals - **Chapter 4**

The findings and conclusions set out in this report have been informed by extensive engagement with patients, clinicians and commissioners across the NHS, including a formal period of engagement between June and August 2013 on our research evidence base and emerging principles and objectives for how an improved service should be designed. Our updated **evidence base (Appendix 1)**, revised **principles and objectives (Appendix 2**)

and a full **summary of engagement responses (Appendix 3)** all form an important part of this report.

Phase 2 of the review will focus on improving these proposals in the light of further public debate, and putting in place mechanisms for realising the ambition of the proposals set out in this report. This will include establishing groups to develop and test: the clinical standards, skills and workforce needs, financial impact and commissioning support that will be required to deliver the new system. An update on progress will be published in Spring 2014.

Chapter 2: The case for change, opportunities for improvement

We have tried to base this review, where possible, on hard research evidence to build a clear picture of how people currently access urgent and emergency care services, and to help us understand how effectively we use our NHS infrastructure.

We started by publishing a detailed summary of the available research, which has been updated in the light of comments and contributions received during our engagement exercise, and is published alongside this report. We are very grateful to all those who responded to our engagement exercise for assisting us in making this document more comprehensive and, we believe, authoritative.

This chapter draws heavily on that evidence, and sets out both the case for change and the opportunities that exist for making urgent and emergency care services more responsive, more efficient and clinically more effective.

Rising demand, rising expectations

Every year the NHS supports hundreds of millions of contacts from members of the public who need urgent or emergency care. The reasons vary. Some people simply need advice or treatment for relatively minor illnesses, others need help with pre-existing long term health problems which fluctuate or deteriorate. A smaller number need treatment for a serious illness or have a major event or injury which requires swift access to highly-skilled, specialist care to give them the best chance of survival and recovery.

Every year the NHS deals with:

- 438 million visits to a pharmacy in England for health related reasons;
- 340 million GP consultations;
- 24 million calls to NHS urgent and emergency care telephone services;
- 7 million emergency ambulance journeys;
- 21.7 million attendances at A&E departments, minor injury units and urgent care centres;
- 5.2 million emergency admissions to England's hospitals.

Importantly, demand for these services has been rising year on year:

- The average number of consultations in general practice per patient rose from 4.1 to 5.5 per year between 1999 and 2008 indicating greater demand and complexity in primary care.

- There were 6.8 million attendances at walk-in centres and minor injury units in 2012/13, and activity at these facilities has increased by around 12 per cent annually since data was first recorded a decade ago.
- Attendances at hospital A&E departments (officially referred to as Type 1 and Type 2 A&E) have increased by more than two million over the last decade to 16 million.
- The number of calls received by the ambulance service over the last decade has risen from 4.9 million to over 9 million.
- Emergency admissions to hospitals in England have increased year on year, rising 31 per cent between 2002/03 to 2012/13.

This growth in demand is set to continue as people live longer with increasingly complex, and often multiple, long-term conditions.

These facts have led to an overwhelming consensus that our current services are unsustainable.

There have also been societal and technological changes. Most notable is the way we run our lives. Social, financial, retail and travel transactions are conducted online. Information is a couple of clicks away on a mobile device. Younger generations live in a world of rapid knowledge transfer, a world of immediacy, a world of rising expectations. We must respond – not just to the increasing demand but also to societal and technological trends.

A confusing system

Previously we have tried to deal with increasing demand by developing new facilities. Although well-conceived and well-intentioned, these have created additional complexity and confusion, not just for patients but also for those working in the NHS.

Starting from scratch, nobody would design the current array of alternatives and their configuration. A short history of the last 30 years reveals that we have opened ‘walk-in centres’, ‘minor injury units’, ‘urgent care centres’ and a vast range of similarly named facilities that all offer slightly different services, at slightly different times, in different places. A telephone service, NHS Direct, was introduced in 1998, and last year was replaced by NHS 111. Even the simple task of ringing a GP practice to request an appointment can result in a frustrating assault course on a telephone keypad.

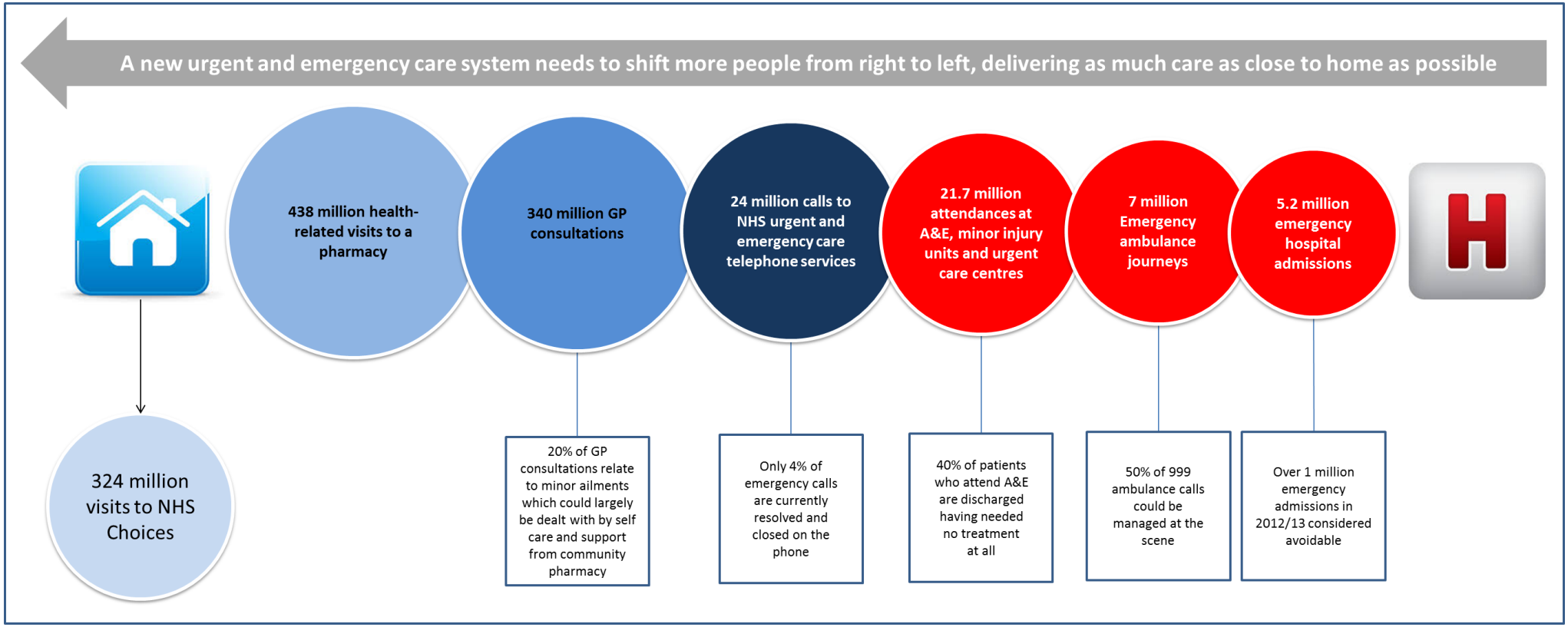
All the public want to know is that if an urgent care problem ever arises, they can access a service that will ensure they get the right care when they need it. They do not want to decide whether they should go to an MIU, a WIC or A&E, or whether they should ring their GP, 111 or 999. We shouldn’t expect people to make informed, rational decisions at a crisis point in their lives: the system should be intuitive, and should help people to make the right decision. We have created a complicated system which in itself has contributed to increasing demand by sending people around various services, confused about who to call and where to go.

Opportunities for meeting people’s urgent care needs closer to home

Most urgent care problems are not life-threatening. For these problems patients need help, advice and simple treatments delivered as close to home as possible. The vast majority of people already seek and receive treatment and care for their urgent and emergency care needs in the most appropriate setting. However, we know from our analysis that millions of people every year could receive advice and treatment closer to home. There is a huge opportunity to shift treatment and advice from acute hospital based services to home or close to home as highlighted by Figure 1 and the supporting text below:

- Last year, there were 5.2 million emergency admissions to hospital, yet we know that up to 1.2 million of these admissions could have been avoided. Hospitals can be harmful to some people. Frail and elderly people may be made worse by hospital admission, which takes them from a familiar home environment to a confusing and noisy place where they are also at risk of harm from infection and falls. Very often their medical need is small and they just need a bit more care to help them through. With improving technologies it is now possible to manage many problems in a patient’s own home or local community that would have required hospital admission 10 years ago. Innovative schemes have shown how early assessment, with good communication between primary and community health services and hospital specialists, can improve outcomes by keeping people out of hospital. These should be developed and expanded.

Figure 1: Opportunities for meeting people's urgent and emergency needs closer to home



- Of the 9 million emergency “999” calls made last year, 7 million resulted in an emergency ambulance journey. Ambulance services are highly valued for the speed of their service and the skills of paramedics, but these skills are incompletely used when, in some cases, an ambulance simply drives a patient to hospital. By supporting and developing paramedics, and providing direct access to the expertise of general practitioners and specialists, around half of all 999 calls which require an ambulance to be dispatched could be managed at the scene, avoiding an unnecessary trip to hospital. However, there is a great deal of variation around the country in the number of paramedics available, access to GPs and the frequency with which patients are transported to hospital. This must be improved so that ambulances can become and are seen as a community-based mobile urgent treatment service, rather than solely a means of transportation.

- 40 per cent of patients who attend an A&E department are discharged requiring no treatment. Many of these individuals could have been helped just as well closer to home, for example at their own GP’s surgery or a local GP run Urgent Care Centre, provided the services were accessible and convenient. The NHS should ensure that primary care services, close to home, are consistently available to help patients with urgent care needs. At the moment, patients contacting their GP’s surgery with an urgent problem receive a very variable response, and may be directed elsewhere. This places extra pressure on other services such as A&E, and we know that when A&E departments get crowded safety becomes compromised. It is therefore essential that we find ways to improve access to primary care without significantly increasing the overall workload of these already busy services. This will mean reducing bureaucratic burdens on primary care. There is strong evidence that a significant proportion of the urgent work done by GPs can be handled over the phone. An efficient telephone service is more convenient for patients, allows more people to be helped and also frees up face-to-face appointment slots for those who need or prefer them. Patients also tell us they are less worried about seeing their own GP for one off advice and treatment.

- Community pharmacies are an under-used resource: many are now open 100 hours a week with a qualified pharmacist on hand to advise on minor illness, medication queries and other problems. We can capitalise on the untapped potential, and convenience, that greater utilisation of the skills and expertise of the pharmacy workforce can offer.

- We can also do much more with the telephone. NHS 111 has the potential to provide a fast and effective service that decides how serious a problem is, how it should be dealt with and how soon. This is important because without a single, clear point of advice it has been shown that people “bounce around” the system, being sent from one place to the next and being given conflicting information and advice. Telephone services such as NHS 111 can be made even more effective when there are doctors, nurses, mental health teams, dentists and other professionals on hand to advise

patients over the phone, and where necessary book the appointment or further care that a person needs. This type of approach has been shown to be effective in other countries, and would also work for the NHS. More modern forms of communication, for example via the internet, can also improve the speed and convenience of access to urgent healthcare.

- For the vast majority of patients, their nearest source of help will be at home; from family, friends and their own knowledge. Many individuals will use the telephone or internet to get advice. Research tells us that where patients are properly informed, empowered and supported they are quite capable of managing many problems themselves. This is particularly true when an individual has a long-term condition, such as diabetes or asthma. When they become experts in their own problems they know how to look after themselves and when to seek help, including directly from their hospital specialists. The NHS needs to promote and support self-care and provide readily accessible, reliable advice to help people take responsibility for their own health.

- Hospitals are a source of valuable expertise, but community healthcare staff and patients with long-term conditions who are under specialist care shouldn't always have to travel to a hospital to access this expertise. Improved communication between the hospital and community will allow GPs and patients to obtain specialist advice in a more timely way, or directly access a clinic or similar service when required. This approach has been shown to improve health outcomes and patient satisfaction, and should be more widely adopted. By removing the barriers between hospital and community it is possible to build a network of care in which information and expertise flows to where it is needed when it is needed, allowing urgent care to be provided closer to home.

A&E - same name, very different services

Although the section above clearly highlights the potential to meet the urgent care needs of millions of patients outside of hospital and closer to home, there will always be patients who require hospital based services for more serious problems.

The A&E "brand" is particularly trusted, but it is under serious threat from the relentless advance of medical science and steadily increasing demand. In the 1970s most A&Es and their hospitals could offer most people the best treatment of the day for most conditions. This is no longer the case.

Take heart attacks for example. In the 1970s heart attacks were treated with bed rest. The hospital mortality rate was about 25 per cent. Then coronary care units emerged so that similar patients were admitted to the same place and could be looked after by experts. The mortality fell to about 15 per cent. Then clot busting drugs came along. The mortality fell to 10 per cent. Then in the 1990s it became clear that the best treatment was to mechanically unblock the culprit coronary artery which was causing the heart attack. Evidence showed

that this reduced mortality to around 5 per cent, saved dying heart muscle, reduced the risk of a recurrent heart attack and prevented heart failure later. This was clearly the best treatment; but it required very expensive diagnostic equipment and cardiologists with special skills, and needed to be done quickly to be effective.

This combination meant that modern treatment of serious heart attacks was outside the realm of many hospitals. This treatment of heart attacks is now done by about half the hospitals in England, with about a third offering a comprehensive 24/7 service. We have good results by international standards because the diagnosis can be made in the ambulance and the right patients are taken to the right hospitals for the most advanced treatment. This means that for paramedics to get patients to the best and most appropriate services, they will sometimes drive past the nearest A&E to get the patient to the right place.

Similarly the treatment of those strokes which occur when the blood supply to part of the brain is blocked, has evolved. Effective treatment requires rapid transfer to a highly specialised unit with expensive diagnostic scanners and clinical expertise so that drugs can be given to minimise the extent of brain damage. Stroke services in London have been reorganised to offer this high level treatment, but this required redirecting patients with suspected strokes from 32 admitting hospitals to only 8. The end result is that London has the best stroke services of any capital city in the world, saving more lives and returning more patients back to independent living. The bald fact is that many hospitals should not be offering to treat acute strokes.

We have made good progress on treating heart attacks and strokes. Advancing science has directed the way we deliver services to achieve the best results, but this has also exposed the illusion and perpetuates the misconception that all A&Es are equally able to deal with anything that comes through their doors. We now find ourselves in a place where, unwittingly, patients have gained false assurance that all A&E's are equally effective. This is simply not the case. We also know that the likelihood of recovering from a particular illness or injury varies considerably between hospitals. Despite the best efforts of the staff who work there, many hospitals and their A&E departments do not have consistent consultant presence overnight or at weekends, and the support services available vary considerably. About 1 in 7 do not have on-site services such as critical care, acute medicine, acute surgery or trauma and orthopaedics.

So, A&E departments up and down the country offer very different types and levels of service and staffing, yet they all carry the same name. We need to ensure that there is absolute clarity and transparency about what services different facilities offer and direct or convey patients to the service that can best treat their problem. Most importantly, we need to ensure that anywhere that displays a red and white sign is a place that will provide access to the very best care to the most seriously ill and injured patients, 24 hours a day and 7 days a week. A place that can resuscitate, make a diagnosis, start treatment and ensure rapid transfer to the right place if it can't offer the very best care. This is what this review is about; building a responsive network of services across the system to better meet the needs of patients in the 21st century.

Chapter 3: Proposal for improving urgent and emergency care services in England

This chapter sets out our proposals for improving urgent and emergency care services in England. It has been informed by what we have learnt from building a research evidence base of facts and figures, and from our public engagement with clinicians, commissioners and patients.

Our vision is simple:

Firstly, for those people with urgent care needs we should provide a highly responsive service that delivers care as close to home as possible, minimising disruption and inconvenience for patients and their families.

Secondly, for those people with more serious or life threatening emergency care needs, we should ensure they are treated in centres with the very best expertise and facilities in order to maximise the chances of survival and a good recovery.

Figure 2 and the supporting commentary below sets out what we think needs to happen to deliver this vision.

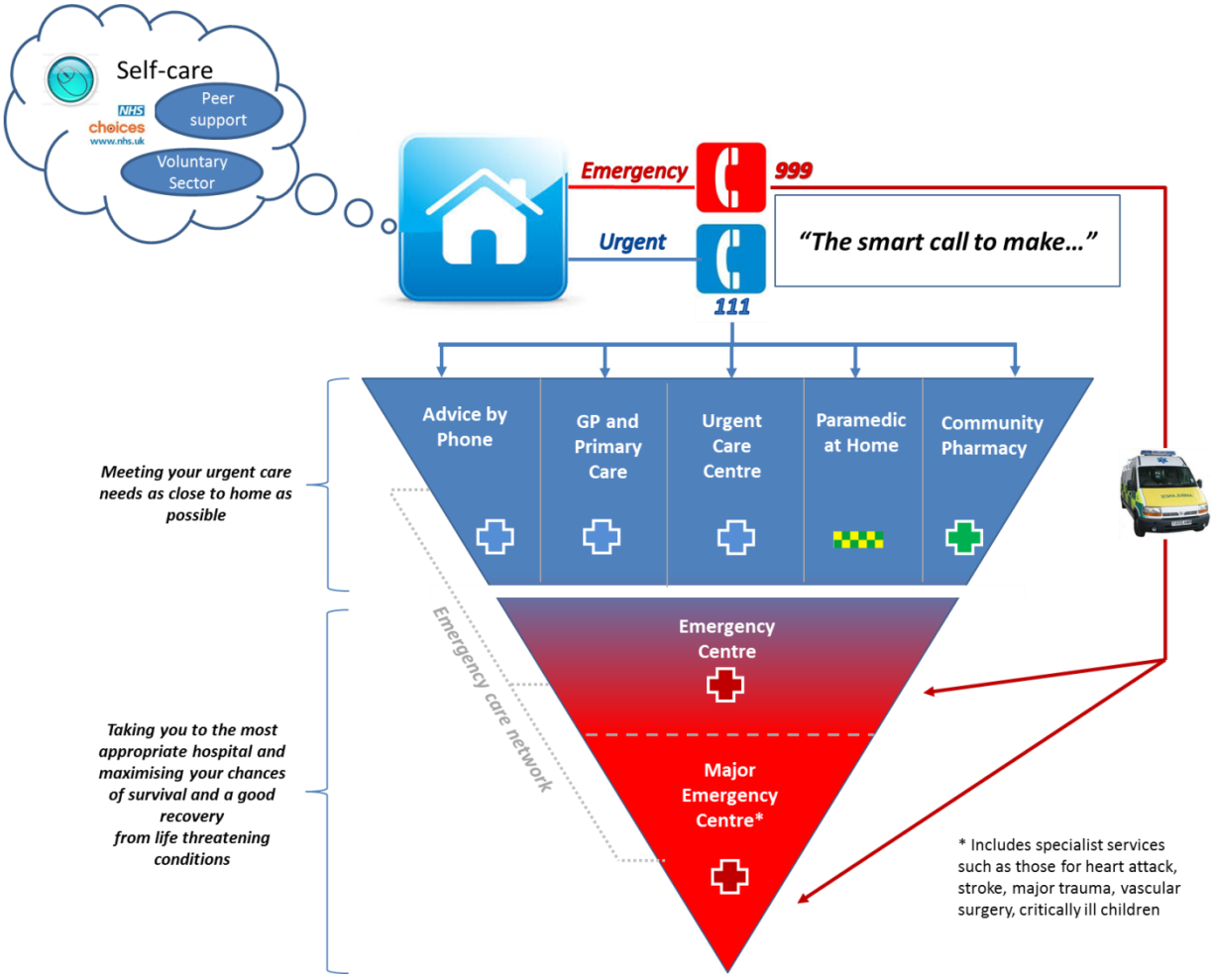
A. Supporting self-care.

Our starting point must be to equip as many people as we can with the skills, knowledge and support needed to self-care. This is by far the most responsive way of meeting people's urgent but non-life threatening care needs. Millions of people already do this, but millions more could be better supported to take control of their own health. To achieve this, we will need to:

- **Provide much better and more easily accessible information about self-treatment options so that people who prefer to can avoid the need to see a healthcare professional.** This will be developed with patient groups, NHS clinicians, charities, NHS Choices and other expert groups to maximise the opportunities offered by symptom-check technologies, health advice media, expert patients and peer support.

- **Accelerate the development of comprehensive and standardised care planning**, so that important information about a patient's condition, along with their values and future wishes, are known to all relevant healthcare professionals. This way, patients will be better supported to deal with their own condition before it deteriorates or additional help is required.

Figure 2: The proposed look and design of the new system.



B. Helping people with urgent care needs to get the right advice or treatment in the right place, first time.

Where people feel they need clinical advice or treatment for an urgent care need they must be rapidly supported in accessing the right advice or service first time and as close to home (or where they are) as possible. To achieve this, we will need to:

- **Significantly enhance NHS 111 so that it becomes the smart call to make, creating a 24-hour, personalised priority contact service. This enhanced service will:**

- **Have knowledge about you and your medical problems, so the staff advising you can help you make the best decisions.** Clinicians in the new NHS 111 service will have access to relevant aspects of your medical and care information, if you consent to this being available. This is particularly advantageous for people with long-term conditions or rare disorders, and those who are receiving end of life care.

- **Allow you to speak directly to a wider range of professionals (e.g. a nurse, doctor, paramedic, member of the mental health team, pharmacist or other healthcare professional)** if this is the most appropriate way to give you the help you need.

- If needed, **directly book you an appointment at whichever urgent or emergency care service can deal with your problem, as close to home as possible**. That could include a booked call back from a GP, a pharmacist review at a local chemist open for extended hours, an appointment at an urgent care centre, or a home visit by a community or psychiatric nurse.

- **Still provide you with an immediate emergency response if your problem is more serious, with direct links to the 999 ambulance service,** and the enhanced ability to book appointments at Emergency Centres.

C. Providing a highly responsive urgent care service outside of hospital so people no longer choose to queue in A&E.

To avoid people choosing to queue in A&E, or being taken to hospital unnecessarily to receive the treatment they need, the service outside hospital must be improved and enhanced. To achieve this, we will need to:

- Provide **faster and consistent same day, every day access to primary care and community services for people with urgent care needs.** This is likely to mean general practice, out-of-hours services, community health teams and the NHS 111 service working together, and differently, to ensure that patients with urgent care needs can receive prompt advice and care 24 hours a day, seven days a week. There are many innovative options to explore. The evidence for prompt telephone consultations is compelling, and can free up appointments to spend with those patients who would benefit from face to face care. GPs could lead integrated multi-disciplinary teams to manage whole pathways of care including the exacerbations of those patients with long term conditions, whilst improving assessment and treatment opportunities for the frail and elderly. We also need to ensure that GPs are better supported by hospital specialists so that they have access to a rapid, specialist clinical opinion, thus potentially avoiding the need to admit a patient in an emergency.

- **Harness the skills, experience and accessibility of community pharmacists** up and down the country. Pharmacists, with 4 years of training, have a wealth of knowledge and experience. They can advise on minor ailments, medication and prescription concerns and many have consultation rooms. We intend to ensure that these are utilised more effectively.

- **Develop 999 ambulances so they become mobile urgent treatment services, not just urgent transport services**. We know that paramedics can now deliver treatments that would only have been done by doctors 10 years ago, whilst with the support of improved community services they can safely manage many more people at scene. This gives us both more options to treat people at home, and to travel further to reach specialist care. There are opportunities for extending paramedic training to better assess, prescribe for and manage patients with exacerbations of chronic illnesses and work more closely with GPs and community teams.

- **Support the co-location of community-based urgent care services in coordinated Urgent Care Centres.** These will be locally specified to meet local need, but should consistently use the "Urgent Care Centre" name, to replace the multitude of confusing terms that are available at present. Urgent Care Centres may provide access to walk-in minor illness and minor injury services, and will be part of the wider community primary care service including out-of–hours GP services. Considering all local facilities in this way will mean that networks will need to examine the extent of duplication or gaps in service offered by all of these facilities currently. Urgent Care Centres may also be advantaged by co-location with hospital services, particularly in urban areas. Urgent Care Centres would not carry the emergency red sign, nor be considered the right place to go in a medical emergency, but would have protocols in place with the ambulance service if such events occurred.

D. Ensuring that people with more serious or life threatening emergency needs receive treatment in centres with the right facilities and expertise to maximise chances of survival and a good recovery.

Where people have more serious or life threatening emergency care needs then they must receive treatment at centres with the necessary facilities and expertise, 24/7, to maximise their chances of survival and a good recovery. To achieve this, we intend to:

- Introduce **two levels of hospital based emergency centre.** For the purposes of this report we have called these "Emergency Centres" and "Major Emergency Centres", but the final names will be determined in consultation with NHS staff and

patients to ensure maximum clarity. These two levels will only be introduced once access to urgent care services outside of hospital have been sufficiently improved and enhanced, and in time will replace the inconsistent levels of service currently provided by A&E departments:

  - **Emergency Centres will be capable of assessing and initiating treatment for all patients**. We anticipate that Emergency Centres in remote and rural communities, distant from more specialist services, will expect almost all patients to be directed or taken to them for initial assessment. Suitable patients will be managed by the local hospital services on the same site as the Emergency Centre. Those needing specialist treatments after assessment will be transferred; indeed critical care transfers will be a core part of the new system. In more urban areas, where specialist services are much closer, the assessment and commencement of treatment will often be undertaken by paramedics, followed by direct transfer to the specialist centre best suited to the patient's needs. This will, in turn, reduce demand at urban Emergency Centres.

  - **Major Emergency Centres will be larger units, capable of assessing and initiating treatment for all patients and providing a range of specialist services.** Major emergency centres will have consistent levels of senior staffing and access to specialist equipment and expertise. Transfer from a Major Emergency Centre will be rare, with the exception of patients returning to community settings closer to home when they are well on the road to recovery from major illness and injury.

- **Implement the findings of the NHS Services, Seven Days a Week Forum**, which will be published before the end of the year. This report will focus on improving urgent care services at the weekend and will include proposals to adopt of a set of clinical standards that should be delivered seven days a week. The presence of senior clinicians is important for ensuring the best decisions are taken, reassuring patients and families and making best use of NHS resources.

These proposals are **not** about cutting existing urgent and emergency care services. Indeed, we expect the overall number of Emergency Centres (including Major Emergency Centres) to be broadly the same as the current number of A&E departments. Our intention is to achieve a substantial shift of care out of hospitals and into community settings in order to create a comprehensive system of care across a network that will deliver good outcomes for all patients in a safe and effective way. As local communities achieve this, by re-designing their systems, some new services will be created and some old services will no longer be required. However, these decisions must be made in the context of local need and resources, and with the overall aim of improving the urgent and emergency care system.

E. Connecting the whole urgent and emergency care system together through networks.

To make the whole urgent and emergency care system operate as effectively and efficiently as possible, and become more than just the sum of its parts, a networked approach must be introduced in which patients, along with all relevant information, flow smoothly between the different components. To achieve this, we intend to:

- **Develop emergency care networks.** The recent introduction of major trauma networks has been a huge success story that has saved the lives of hundreds of patients. These principles will be extended to the whole emergency care system, ensuring a consistent approach to the delivery of services and formally linking the community and hospital components of the urgent and emergency care system. Major Emergency Centres will have a lead responsibility for the quality of care and operational performance of service across the network they support, including linked Emergency Centres. Furthermore, ensuring that there is senior clinical support available throughout this structure will improve outcomes and ensure the best use of resources.

- **Support the introduction of an efficient critical care transfer and retrieval system.** To ensure that patients with specialist needs reach the best possible care in a timely fashion we will support the introduction of formal transfer and retrieval systems in remote and rural areas. These will be modelled on the best existing services for critically ill and injured children and adults, and will be key to achieving the best possible outcomes for all patients.

- **Ensure that the networks extend to community services, with free flow of information and expertise between the hospital and community.** We will use the emergency care networks as a means to challenge and dissolve traditional boundaries between hospital and community based services, to facilitate a dialogue between primary and secondary care staff and to ensure the timely flow of information relevant to a patient's care. This will ensure that important clinical decisions are not made in isolation, but with the full support of the expertise and experience of the supporting network.

Chapter 4: Next Steps

The system-wide transformation of urgent and emergency care services, as described in the previous chapter, is a major undertaking. There will be many challenges along the way. Traditional barriers and vested interests will need to be broken down.

But the truth is that if we don't change the whole urgent and emergency care pathway, from start to finish, we will simply repeat the mistakes of the past: timid, limited or disjointed initiatives will be insufficient. All NHS staff and the public in England have an important part to play in implementing and supporting the changes that lie ahead.

With this in mind, we have already begun the work needed to deliver this change. We are working closely with our patients, partners and stakeholders in the NHS and local government, to make this happen. Throughout this review, we have committed ourselves to being open and transparent – developing and delivering this work in public on NHS Choices (www.nhs.uk). We will continue to do so and we will act on the feedback we receive.

We know people will want to see change as soon as possible, but we need to ensure that there are no risky, ill considered "big bangs", and that there is a managed transition to the future system. We anticipate that it will take 3-5 years to enact the major transformational change set out within this report. However, we expect to make significant progress over the next 6 months on the following areas:

- Working closely with local commissioners as they develop their 5 year strategic and 2 year operational plans;

- Identifying and initiating transformational demonstrator sites to trial new models of delivery for urgent and emergency care and 7 day services, supported by NHS Improving Quality;

- Developing new payment mechanisms for urgent and emergency care services, in partnership with Monitor;

- The completion of the new NHS 111 service specification so that the new service (which will go live during 2015/16) can meet the aspirations of this review; and

- Working through the NHS Commissioning Assembly to develop and co-produce with clinical commissioning groups the necessary commissioning guidance and specifications for new ways of delivering urgent and emergency care (with this process continuing over the remainder of 2014/15).

Some issues will take longer to resolve than others, and longer term streams of work are required to:

- Develop, cost and assess some of the clinical models described in this report, including those for primary care, Emergency Centres and the ambulance service;

- Carefully consider and develop the clinical standards, metrics and outcome measures which will enable us to monitor and measure the success of the new system;

- Develop models and tools to improve the monitoring and management of capacity within the system all year round;

- Amend contracts and make changes to their respective incentives to ensure that organisations can deliver the proposed changes; and

- Develop a programme with Health Education England to ensure that the correct workforce structure is in place to support the future changes.

We are particularly conscious that any new system must be responsive to the needs of the most vulnerable people in society who rely on the urgent and emergency care system: people at the extremes of age, people with troublesome long-term health problems, people from deprived communities and people suffering mental health crises. Unless we serve our most vulnerable and disadvantaged as well as our most affluent, we will be failing the values of our society and the values of the NHS.

Only by building the right system, and better supporting patients and the public to use it effectively, will we achieve improved outcomes for urgent and emergency care in the NHS and truly deliver high quality care for all, and ensure the same for future generations. We will report on progress in Spring 2014.

Appendices (published separately)

Appendix 1: **The Evidence Base from the Urgent and Emergency Care Review**

Appendix 2: **Revised principles and design objectives for a new system of urgent and emergency care**

Appendix 3: **Summary of Engagement Responses**

Major Trauma Centres

April 2012

Adult and Children's Major Trauma Centres

1. Addenbrooke's Hospital Cambridge
2. Frenchay Hospital Bristol
3. James Cook University Hospital Middlesborough
4. John Radcliffe Hospital Oxford
5. King's College Hospital London
6. Leeds General Infirmary
7. Queen's Medical Centre Nottingham
8. Royal London Hospital
9. Royal Victoria Infirmary Newcastle
10. St Mary's Hospital London
11. St George's Hospital London
12. Southampton General Hospital

Adult Major Trauma Centres

13. Derriford Hospital Plymouth
14. Hull Royal Infirmary
15. Northern General Hospital Sheffield
16. Queen Elizabeth Hospital Birmingham
17. Royal Preston Hospital
18. Royal Sussex County Hospital Brighton
19. University Hospital Coventry
20. University Hospital of North Staffordshire Stoke on Trent

Children's MTCs

21. Alder Hey Children's Hospital Liverpool
22. Birmingham Children's Hospital
23. Royal Manchester Children's Hospital
24. Sheffield Children's Hospital

Collaborative

25. Manchester Collaborative MTC
    a) Salford Royal NHS Trust
    b) Manchester Royal Infirmary
    c) University Hospital South Manchester
26. Liverpool Collaborative MTC
    a) Aintree University Hospital
    b) Walton Centre
    c) Royal Liverpool University Hospital

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Better Health Regional Joint Scrutiny Committee

Public concerns as provided by N.E.E.D Group, Hartlepool

Members of North East Empowerment and Diversity Group in Hartlepool (incorporating Save Hartlepool Hospital) have read with interest all the papers from Better Health Programme, attended their "public consultations" and also attended the BH Regional Joint Scrutiny Committee meetings.

We respectfully request that the following concerns be given to the members of the Scrutiny Board so that they might be better informed as to the aims and ultimate goals of the BHP and CCG.

In Hartlepool we have had our Hospital services systematically stripped, closure of A & E has basically just been the tip of the iceberg. We feel this is the plan for other areas and the Board can look at us as a prime example of what the intentions are and what will happen to hospitals in Darlington, North Tees, Durham, etc. For instance we were told that a service was failing, unsustainable, lack of staff, etc to be followed by that service being moved to North Tees. This happened time and again using the same "excuses". This now is beginning to be used about certain services at North Tees, in the hope of closing them and moving them to James Cook (eg Neo-natal and Maternity).

The majority of GPs have not come from a hospital background so how can the CCG / Better Health (which is made up primarily now of GPs) dictate what should go on in the hospitals and what standards should be met?

GPs have not got the training or speciality to be able to run an Urgent Care centre safely. It was stated previously this year that IF services were moved from the OneLife Centre in Hartlepool over to the Hospital site it would be Consultant-Led. This might not be 24/7 but would be for the best part of the day and possibly 5 days a week. Instead CCG have now announced it to be only GP-led and that it is being put in place in Hartlepool and then "will be rolled out to other areas". It is believed that this is pre-planning of A & E closures.

We are constantly being told that there is a huge deficit of GP's in the area so how is this new Urgent Care GP-led facility to be manned? Will this be to the detriment of other GP practices in the area? (ie closing down practices)

The installation of an Urgent Care centre at Hartlepool Hospital is actually a step DOWN from the OneLife centre but a lot of people will not realise this. In actual fact it will just be a sign-posting service to send people to Trauma Centre, GP, Pharmacy, A & E (where these still exist), etc. This could be a way of "weeding out" people who turn up with a very minor problem, but for others will be a significant delay in getting more urgent treatment.

Will this contract then be also given to Virgin Care? If so, when the OneLife Centre in Hartlepool has failed so spectacularly, then this is nothing short of abominable.

In summary of public consultation events in February the subject of A & E comes far down list of priorities discussed. In Hartlepool it was the one topic on everyone's lips and as they had the highest number of attendees (assuming that other areas especially Darlington talked about it too) how was it placed so low? The attached sheet (1) shows a triangle of supposed results from the consultation exercise. A & E is rated at the very bottom – ask any person in the street, especially around Hartlepool, Peterlee, Darlington, etc and they will say that is the highest priority.

A great number of people after attending the BHP consultation events have stated they felt the public were not being listened to, this ties in with the above point about Sheet (1).

Supposedly everything discussed in the consultation events was taken down by a scribe on each table. Just as an example there were 12 events yet only 7 are reported upon in the papers (Stanley, Chester-le-Street, Darlington, Barnard Castle and Spennymoor are missing). The absent ones appear to be where the circles were not used. So what happened to all the information the scribes wrote down? Is it possible to see this data? Surely these results are not acceptable if proof cannot be shown?

Feedback sheets – is it possible to see response sheets as it is stated a total of 160 people attended the events and it is claimed 124 responses were received? (In Hartlepool very few, if any, forms were filled in)

It seems that more concentration is being put on the results of phase 2 as it fits in better with the BHP criteria than phase 1 did – ie Hartlepool meeting must have skewed their results considerably. Dr. Posmyk's own admission is that A & E has nothing to do with Better Health.

In the results for the Eston event (which had only 4 attendees) it seems a very large list of things they covered with only 4 people. Suggest that those 4 people all must have had doctorates to come up with that comprehensive list in the time specified.

Hartlepool – nothing on the list was covered in the event = the results are totally skewed. (see attached Sheet 2)

In phase 1 event (and presumably phase 2) – A & E and maternity are the subjects most on people's minds so not to even mention these is a farce. Could it be that scribes did NOT put down what people really said, and once again attendees were "shepherded" by CCG representatives into the answers they wanted.

=========

Re: Poster of "Phase 2 issues critical to success"

When has a member of the public ever been heard to say "patient centric thinking", "stakeholder confidence in new systems" OR "quality assurance of new system". Clearly all clinician-speak.

"win hearts and minds of the public" Not sure how BHP intend to manage this.

=====

Several times throughout the documents Darlington is mentioned as having to plan for new houses, growing population, etc – this surely covers every area but it is only Darlington that keeps being referred to – is this because the decision has already been made to keep that hospital and so the other areas can be overlooked?

How have they drawn the working assumptions up? (Sheet 3)

1. For example the statement "balancing clinical standards, better outcomes and workforce requirements means emergency care for adults and children should be provided from fewer sites" – How was this conclusion reached and where is the proof?

2. "Bishop Auckland and Hartlepool hospitals will CONTINUE to be centres for planned surgery" (Hartlepool only has orthopaedics).

Who decided status quos – possible solutions long list – there are FOUR (Sheet 4)

BHP claim they looked at 133 possible combinations of services, yet they've only given a LONG list of 4, so how big is the short list? And why can this committee not see the full 133 to make a more informed decision? (Sheet 5)

Areas of Hartlepool and Billingham the big plans are to make people be at home for the main part of their recuperation – lack of social care and specialism in place at present so when is this to be begun? Things are not in place now so how can they add more to it and expect it to be delivered?

How can they justify taking the care further away and yet expect services not to suffer?

There has got to be trust in the people making these decisions and trust that they are doing these things for the right reasons. How on earth can these people be trusted when they keep things covered up?

At the meeting of Better Health Joint Regional Scrutiny Committee in Durham one of the BHP spokespersons stated "this is not a consultation but a conversation". So will the input of the Regional Committee members actually be taken on board?

Impact forecast of some sort is surely needed? – ie how these changes will affect people.

CCG have now transferred all this over to the BHP so they can say "ah it's the BHP not us".

**168 attended BH events earlier this year. How can this low number be taken as indicative of local health services when it's such a tiny proportion of the population?

It was stated BHP is NOT about money but then at Hartlepool Joint meeting Mr Cruickshank stated (re Heart ops) "lack of consultants so need to centralise services as its VERY expensive" !!!

Also in Hartlepool meeting of Joint Committee it was mentioned that already NEAS under severe pressure. So to then send people further to specialist care centres, taking even longer to get patients to hospital, even after ambulance eventually turns up.

700 standards queries

When will a complete list of these standards be available? And if not, why not?

The attached list which is available on the BHP website is far from complete, with only just over 200 standards visible.

Some of the standards, indeed, are not going to be achievable. Is this just another way of then telling the public "the service isn't meeting the standards set down by the BHP so it needs to close, or more importantly "Privatise"?

Sound management states that standards should be Smart, Specific, Measurable, Achievable, Relevant and Timely. If standards are set too high the business will fail and have to close, or be sold off.

The 700 standards are ones that have been "chosen" = BHP state they won't be able to fulfil all of them so why choose them in the first place? It has been stated that only 2/3 of them will be met.

Urgent care and trauma standards not included on list – not available to view so how can an informed choice be made when a lot of the information is missing like this.

Will these be used as a tool to remove services from hospitals? ie removal of A & E then leads to removal of service (a) because there is no A& E to back it up. This in turn leads to removal of service (b) as that needs service (a) for it to continue to exist at that location.

Specific questions on points on the Standards List

Page 4 – Item 1 – All emergency admissions to be seen and assessed by the responsible consultant within 12 hours of admission, or 14 hours of arrival at the hospital.

Page 4 – Item 6 – All hospitals dealing with acutely unwell children to be able to provide stabilisation with short term level 2 HDU (this means without an HDU that hospital cannot admit acutely unwell children)

Page 5 – Item 10 – All hospitals admitting medical and surgical paediatric emergencies to have access to all key diagnostic services in a timely manner 24 hours a day, 7 days a week to support critical decision making (ie without 24/7 imaging a hospital cannot take paediatric emergencies)

Page 10 – Item 12 – All admitted patients to have discharge planning and an estimated discharge date as part of their management plan asap and no later than 24 hours post admission – How can it be known in a lot of cases when discharge will be? If a decision is made then and something goes wrong will the initial decision be adhered to no matter what?

Page 10 – Item 13 – All hospital admitting emergency general surgery patients to have access t a fully staffed emergency theatre immediately available and a consultant on site within 30 minutes at any time of the day or night. (what about the claim that has been reiterated that the BHP is working to a standard of consultants on wards 24/7?) This was given as a reason why the likes of Hartlepool hospital couldn't have more services returned to it as "we can't attract consultants there".

Page 12 – Item 2 – A paediatric consultant is present in the hospital during times of peak activity. 7 day service (what on earth is peak activity?)

Page 12 – Item 3 – Every child or young person who is admitted to a paediatric dept with an acute medical problem is seen by a paediatrician on the middle grade (or consultant) within four hours of admission. (why would they need to wait four hours?)

Page 12 – Item 4 – every child or young person admitted to paediatric dept with acute medical problem to see a paediatric consultant competent in acute paediatric care within 14 hours of admission. (this gets scary)

Page 17 – Item 8 – All obstetric units should have direct access to special care baby unit facilities to manage babies requiring ventilation and have a defined rapid access route to neonatal intensive care. (If North Tees lose neonatal then it would follow on that they will then lose obstetrics)

Page 17 – Item 10 – No less than 2500 births per year for a consultant led unit (N.Tees had 3078 in 2014)

Page 17 – Item 12 – Access to second theatre must be available within 20 minutes 24/7.

Page 17 – Item 14 – Free-standing Midwifery Units must have robust admission criteria and transfer protocols, obstetric units should have Alongside Midwifery Units co-located with them. (Mohamed?)

Page 17 – Item 15 – Rather confusing so ask Mohamed if this seems reasonable?

Page 18 – Item 21 – Admittance to the labour ward should be limited to woman who are in established labour (Where do they go before this? And who decides?)

Page 19 – Item 28 – Labour wards whould be able to care for Critical care Level 2 (non-ventilated) patients. (this means if no A & E then no labour ward)

Page 19 – Item 35 – Women should have the choice of delivery location offered in an unbiased manner to include where appropriate home birth, MLU (stand alone and co-located) or consultant-led care. (Currently women are being warned that if something goes wrong in a MLU they will need to be blue-lighted to N.Tees, for instance, so are opting for consultant-led unit – as would any sane person)

Page 25 – Item 9 – Each admission to critical care should be reviewed by a consultant within 12 hours of admission (should this not happen to anyone, but why take so long on a critical care case?)

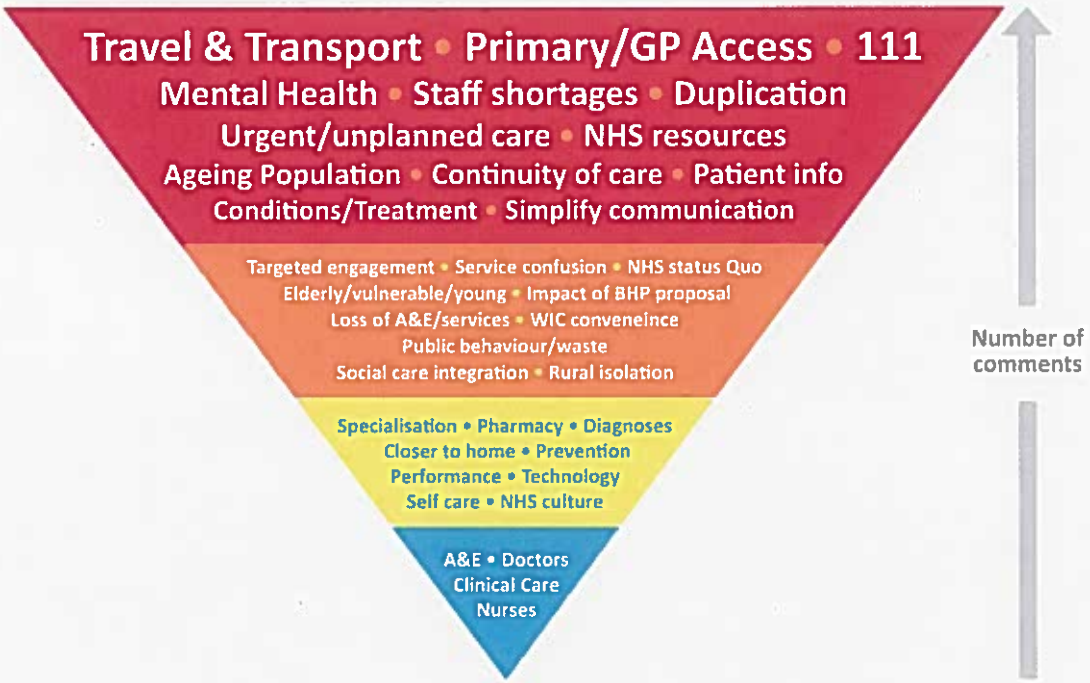
Page 27 – Item 28 – All sites admitting emergencies should have the ability to increase their Level 2 and Level 3 capacity to accommodate periods of exceptional need dependant upon local and regional ACCEP levels (J.Cook constantly at capacity as is N.Tees so how will this be achieved?)

9

SHEET 1

3.0 What Patients Care About - Key Themes from feedback

Comments captured from the scribe notes from each of the 12 events were allocated to subject matters or 'themes'. The key themes were those matters that raised the most comments consistently throughout the events.



The above diagram summarises the key themes raised in the engagement feedback. The feedback was prompted by specific 'Let's discuss' questions in the presentation.

The main themes over the 12 events that attracted the most concern and comments (represented below by the red band) were as follows:

- TRAVEL & TRANSPORT
- ACCESS TO GP
- NHS RESOURCES
- POPULATION CHANGES
- NHS 111
- MENTAL HEALTH CARE
- STAFF SHORTAGES
- EMERGENCY SERVICES/AMBULANCE RESPONSE
- COMMUNICATION AND ENGAGEMENT

Other themes that attracted some concern and comments (represented below by the orange band) were as follows:

- Loss of hospital services (particularly A+E in Hartlepool)
- Integration between health and social care and the voluntary networks
- Confusion over service provision and location
- The cost of some public behavior (inappropriate use of A+E, missing GP appointments)

Where should these services be? Hartlepool (38 attendees)

In your home	In your GP practice	Near your home - Not in hospital	Your local hospital	Your regional specialist centre	Outside circles
District community nursing	Better access for deaf patients i.e. 1) sms text appointment booking service 2) visual system for calling patients when it's their turn 3) flagging up when patient is deaf to ensure BSL interpreter is booked	Revolving door	Squeeze on social care (whole package)	Specific conditions which are uncommon or require specialist treatment	Travel and transport
GP practice	A&E	Social care provision and funding integration	Stroke unit	Public to be told what services are available where and when	Better home care will keep people out of hospital
Some minor ops	Senior Doctors	Join up GP and Out of Hours access to records	Maternity services	Don't make appointments for Hartlepool residents at North Tees before 9.30am to allow patients to get there via public transport	Cost effectiveness of transport
Home care		Modern 'step down' beds	A&E	Improve emergency access to services – 111, ambulance	Nurse training 'hands on'
Prevention		Community Nurses	Joined up IT		
Qualified nurses					

Working assumptions – current thinking

- Balancing clinical standards, better outcomes and workforce requirements means emergency care for adults and children should be provided from fewer sites.
- James Cook to remain the designated major trauma centre for Darlington, Durham and Tees.
- Key clinical services provided alongside each other to provide a comprehensive emergency service for adults and children.
- Consultant led maternity based in the emergency hospitals, to manage high risk deliveries. Midwife led care for low risk deliveries provided at other hospitals.
- Bishop Auckland and Hartlepool Hospitals continue to be centres for planned surgery.

Sheet 3

Better health programme

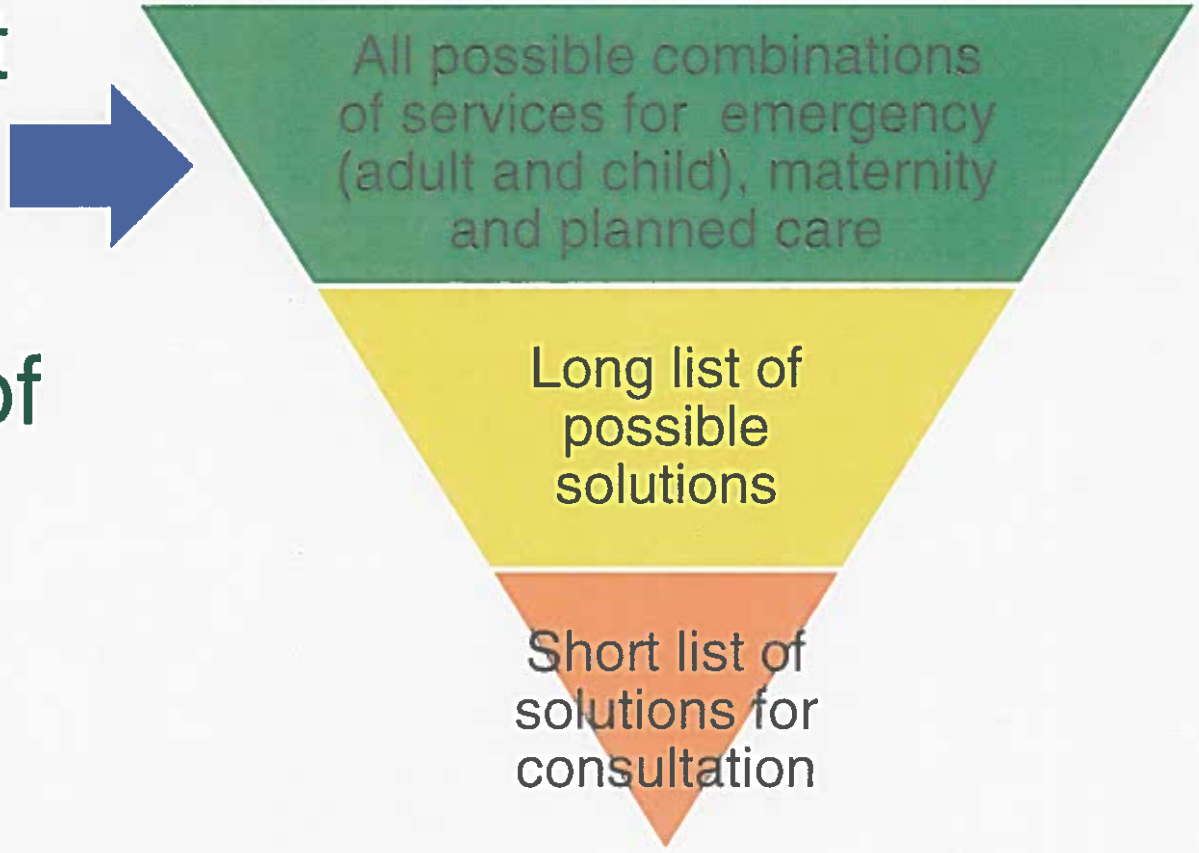
NHS
The NHS in Darlington, Durham and Tees

Possible solutions: long list

- ***Status quo*** *– James Cook as major trauma and heart attack centre and three other specialist emergency hospitals: Darlington Memorial, North Tees, University Hospital of North Durham (UHND)*
- **JCUH and two out of Darlington Memorial, North Tees and UHND** as emergency hospitals
- **JCUH and one of Darlington Memorial, North Tees and UHND** as emergency hospitals
- **Bishop Auckland and Hartlepool** and one other hospital out of Darlington Memorial, North Tees and UHND as planned care centres. The additional planned care centre would be at a local hospital with an integrated urgent care service.

SHEET 4

We worked out over 133 possible combinations of services



SHEET 5.

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Better health programme

NHS
The NHS in Darlington, Durham and Tees

BHP Clinical care standards

Better health programme

BHP Clinical care standards - Urgent & Emergency Care

NHS
The NHS in Darlington, Durham and Tees

Ref	Indicator	
1	A trained and experienced doctor (ST4 and above or doctor of equivalent competencies) in emergency medicine to be present in the emergency department 24 hours a day, seven days a week.	CEM (2011) Emergency Medicine The Way Ahead
2	A consultant in emergency medicine to be scheduled to deliver clinical care in the emergency department for a minimum of 16 hours a day (matched to peak activity), seven days a week. Outside of these 16 hours, a consultant will be on-call and available to attend the hospital for the purposes of senior clinical decision making and patient safety within 30 minutes.	CEM (2011) Emergency Medicine The Way Ahead
3	24/7 access to the minimum key diagnostics: - X-ray: immediate access with formal report received by the ED within 24 hours of examination - CT: immediate access with formal report received by the ED within one hour of examination - Ultrasound: immediate access within agreed indications/ 12 hours with definitive report received by the ED within one hour of examination - Lab sciences: immediate access with formal report received by the ED within one hour of the sample being taken - Microscopy: immediate access with formal result received by the ED within one hour of the sample being taken When hot reporting of imaging is not available, all abnormal reports are to be reviewed within 24 hours by an appropriate clinician and acted upon within 48 hours. **NICE Guidelines on Trauma Care – x-ray to report back to the patient before discharge.**	CEM (2011) Emergency Medicine The Way Ahead RCR (2009) Standards for providing a 24-hour diagnostic radiology service
4	Emergency department patients who have undergone an initial assessment and management by a clinician in the emergency department and who are referred to another team, to have a management plan (including the decision to admit or discharge) within one hour from referral to that team. When the decision is taken to admit a patient to a ward/ unit, actual admission to a ward/ unit to take place within one hour of the decision to admit. If admission is to an alternative facility the decision maker is to ensure the transfer takes place within timeframes specified.	CEM (2011) Emergency Medicine The Way Ahead London standards for inter-hospital transfers
5	An area for mental health assessments, where continuous observation is possible, should be in place in every emergency department. This are should reflect the needs of people experiencing a mental health crisis and be compliant with Royal College of Psychiatry standards.	Royal College of Psychiatry standards
6	A designated nursing shift leader (Band 7) to be present in the emergency department 24 hours a day, seven days a week with provision of nursing and clinical support staff in emergency departments to be based on emergency department-specific skill mix tool and mapped to clinical activity.	CEM (2011) Emergency Medicine The Way Ahead Emergency Nurse Consultant Association (2009) Royal College of Nursing & Faculty of Emergency Nursing

BHP care standards - Urgent & Emergency Care

Better health programme

The NHS in Darlington, Durham and Tees

Ref	Indicator	
8	Triage to be provided by a qualified healthcare and registration is not to delay triage.	LQS Clinical expert panel consensus
9	Emergency departments to have a policy in place to access support services seven days a week including: - Alcohol liaison - Mental health - Older people's care - Safeguarding - Social services	HM Government (2012) Alcohol Strategy LQS Clinical expert panel consensus
10	Timely access seven days a week to, and support from, onward referral clinics and efficient procedures for discharge from hospital.	CEM (2011) Emergency Medicine The Way Ahead
11	Timely access seven days a week to, and support from, Social Services/Social Worker, physiotherapy and occupational therapy teams to support discharge from hospital.	
12	Emergency departments to have an IT system for tracking patients, integrated with order communications. A reception facility with trained administrative capability to accurately record patients into the emergency department to be available 24 hours a day, seven days a week. Patient emergency department attendance record and discharge summaries to be immediately available in case of re-attendance and monitored for data quality.	CEM (2011) Emergency Medicine The Way Ahead
13	All emergency departments should have access to on-site liaison psychiatry within 1 hour of referral, 24 hours a day, seven days a week	
14	All those involved in the delivery of acute care must participate in the review of patient outcomes to drive care quality improvement. The duties, working hours and supervision of trainees in all healthcare professions must be consistent with the delivery of high- quality, safe patient care, seven days a week.	CEM (2011) Emergency Medicine The Way Ahead
15	Patients, and where appropriate families and carers, must be actively involved in shared decision making and supported by clear consultant-led communication and information including the provision of patient information leaflets to make fully informed choices about investigations, treatment and on-going care that reflect what is important to them.	London Health Programmes (2011) Adult emergency services standards
16	Patient experience data to be captured, recorded and routinely analysed and acted on. Review of data is a permanent item on the trust board agenda and findings are disseminated.	London Health Programmes (2011) Adult emergency services standards
17	Facilities allow audio-visual separation of children from adults	RCPCH (2012) Standards for Children and Young People in Emergency Care Settings [supersedes Services for Children in Emergency departments 2007]
18	Recommendations for number of nursing staff on duty as a whole and specific paediatric emergency nursing staff which is currently work in progress for NHS England	Evidence available from NHS England

BHP care standards - Urgent & Emergency Care

Better health programme

The NHS in Darlington, Durham and Tees

Ref	Indicator	
	Urgent Care Centre Standards – to be checked	
	Trauma Standards - to be checked	
	Paediatric emergency services	
P1	All emergency admissions to be seen and assessed by the responsible consultant within 12 hours of admission or within 14 hours of the time of arrival at the hospital. Where children are admitted with surgical problems they should be jointly managed by teams with competencies in both surgical and paediatric care.	NCEPOD (2007) Emergency admissions: A journey in the right direction? RCP (2007) The right person in the right setting – first time RCS (2011) Emergency Surgery Standards for unscheduled care RCPCH (2011) Facing the future
P2	All emergency departments which see children to have a named paediatric consultant with designated responsibility for paediatric care in the emergency department. All emergency departments are to appoint a consultant with sub-specialty training in paediatric emergency medicine. Emergency departments to have in place clear protocols for the involvement of an on-site paediatric team.	Intercollegiate Committee (2012) Services for children in emergency departments
P3	All children admitted as an emergency to be seen and reviewed by a consultant during twice daily ward rounds.	RCPCH (2011) Facing the future
P4	A consultant paediatrician is to be present and readily available in the hospital during times of peak emergency attendance and activity. Consultant decision making and leadership to be available to cover extended day working (up until 10pm), seven days a week.	RCPCH (2011) Facing the future
P6	All hospital based settings seeing paediatric emergencies including emergency departments and short-stay paediatric units to have a policy to identify and manage an acutely unwell child. Trusts are to have local policies for recognition and escalation of the critical child and to be supported by a resuscitation team. All hospitals dealing with acutely unwell children to be able to provide stabilisation for acutely unwell children with short term level 2 HDU.	DH (2006) The acutely or critically sick or injured child in the DGH NHSLA
P7	When functioning as the admitting consultant for emergency admissions, a consultant and their team are to be completely free from any other clinical duties or elective commitments.	NCEPOD (2007) Emergency admissions: A journey in the right direction? RCP (2007) The right person in the right setting – first time RCS (2011) Emergency Surgery Standards for unscheduled care

BHP care standards - Urgent & Emergency Care

Better health programme

The NHS in Darlington, Durham and Tees

Ref	Indicator	
P8	Hospital based settings seeing paediatric emergencies, emergency departments and short stay units to have a minimum of two paediatric trained nurses on duty at all times, (at least one of whom should be band 6 or above) with appropriate skills and competencies for the emergency area.	Intercollegiate Committee (2012) Services for children in emergency departments RCN (2010) Maximising nursing skills in caring for children in emergency departments HMSO (1994) Report of the Independent Inquiry relating to deaths and injuries on the children's ward at Grantham and Kesteven Hospital during the period February to April 1991
P10	All hospitals admitting medical and surgical paediatric emergencies to have access to all key diagnostic services in a timely manner 24 hours a day, seven days a week to support clinical decision making: · Critical – imaging and reporting within 1 hour · Urgent – imaging and reporting within 12 hours · All non-urgent – within 24 hours	RCP (2007) The right person in the right setting – first time RCS (2011) Emergency Surgery Standards for unscheduled care NICE (2008) Metastatic spinal cord compression
P11	Hospitals providing paediatric emergency surgery services to be effectively co-ordinated within a formal network arrangement, with shared protocols and workforce planning.	DH (2006) The acutely or critically sick or injured child in the DGH Healthcare Commission (2007), Improving services for children in hospital RCS (2010) Ensuring the provision of general paediatrics surgery in the DGH NCEPOD (2011) Are we there yet?

BHP care standards – Acute Medicine

The NHS in Darlington, Durham and Tees

Ref	Indicator
1	**All emergency admissions to be seen and assessed by a relevant consultant** (those who are designated by the organisation and capable of making an appropriate decision) within: **in hours:** 4 hours of the decision to admit within the Trust **out of hours:** 12 hours of the decision to admit within the Trust, or within 14 hours of the time of arrival at hospital.
2	A clear **multi-disciplinary assessment** (required composition to be defined in local protocols) to be undertaken and a **clear case management plan** (to include differential diagnosis, investigations, escalation of care, treatment and expected date of discharge) to be in place within **4 hours in hours** and within **12 out of hours**, or within **14 hours of the time of arrival at hospital out of hours**.
3	All patients admitted acutely are to be assessed using a validated early warning system (National Early Warning Score (RCP 2012)), with clear escalation processes followed for patients who reach trigger criteria as defined in local protocols. Consultant involvement for patients considered 'high risk' is to be within one hour.
4	When on-take, a consultant and their team are to be completely freed from any other clinical duties or elective commitments.
5	In order to meet the demands for consultant delivered care, senior decision making and leadership on the acute medical/surgical unit to cover extended day working, seven days a week. **CAG amended to:** In order to meet the demands for consultant delivered care, senior decision making and leadership on the acute medical unit to cover extended day working, for a minimum of 12 hours (e.g. 8am-8pm), seven days a week.
6	All patients on acute medical units to be seen by a consultant **on a morning ward round followed by relevant and targeted patient reviews.**
7	All hospitals admitting medical emergencies to have access to all key diagnostic services (CT, MRI, Ultrasound and Plain Radiology) in a timely manner 24 hours a day, seven days a week to support clinical decision making: · **Critical – imaging and reporting within 1 hour of request** · **Non-critical - imaging and reporting within 12hours of request**
8	All hospitals admitting medical and surgical emergencies to have access to interventional radiology 24 hours a day, seven days a week: · Critical patients – 1 hour · Non-critical patients – 12 hours

BHP care standards – Acute Medicine

Ref	Indicator
9	Rotas to be constructed, with adequate time for hand over to ensure that all relevant clinical information is transferred between individuals and teams, to maximise continuity of care for all patients in an acute medical and surgical environment. A single consultant is to retain responsibility for a single patient on the acute medical/surgical unit. Subsequent transfer or discharge must be based on clinical need.
10	A unitary document to be in place, issued at the point of entry (including A&E), which is used by all healthcare professionals and all specialties throughout the emergency pathway.
11	Patients admitted for unscheduled care to be nursed and managed in an acute medical unit, **specialty areas which are relevant to the patients' needs,** critical care environment.
12	Patients to be discharged to their named GP with a complete discharge summary sent within 24 hours.
13	All referrals to intensive care to be made with the involvement of a consultant both in the referring and receiving teams.
14	Responsibility is with individuals to ensure that there is a handover of patient information to each successive carer within every team structure - a structured process is to be in place for any such handover. Changes in treatment plans are to be communicated to nursing and therapy staff as soon as possible if they are not involved in the handover discussions.
15	Consultant-led communication and information to be provided to patients and to include the provision of patient information leaflets.
16	Patient experience data to be captured, recorded and routinely analysed and acted on. Review of data is a permanent item on board agenda and findings are disseminated.

BHP care standards – Acute Medicine

Ref	Indicator
17	Patients should always be admitted or transferred to the most appropriate ward for their clinical needs.
18	All acute medical units to have provision for ambulatory emergency care, seven days a week and have access to therapy services within a similar timeframe. Patients treated in these facilities must receive care which is compliant with standards 1 (on admission consultant assessments), 2 (multi-disciplinary assessment and management plans) and 3 (Early warning system).
19	Prompt screening of all complex needs inpatients to take place by a multi- professional team which has same-day access to pharmacy and therapy services, including physiotherapy and occupational therapy, seven days a week with an overnight rota for respiratory physiotherapy.
20	Single call access for mental health referrals to be available 24 hours a day, seven days a week with a maximum adequate clinical response time of 30 minutes.
21	Hospitals admitting emergency patients to have access to comprehensive 24 hour **upper GI** services that has a formal consultant rota 24 hours a day, seven days a week.
22	All hospitals dealing with complex acute medicine to have onsite access level 1, 2 and 3 critical care services.
23	Training to be delivered in a supportive environment with appropriate consultant supervision

BHP care standards – Acute general surgery

Ref	Indicator
1	All emergency surgical admissions to be seen and assessed by a relevant consultant with 12 hours of admission to a ward or assessment unit under a surgical team. Suggested reliability target of 90% .
2	A clear multi-disciplinary assessment to be undertaken within 12 hours and a treatment or management plan to be in place within 24 hours (for complex needs patients see 23 and 24).For the majority of surgical patients, a surgical and nursing assessment is sufficient to satisfy this requirement.
3	All patients admitted acutely to be continually assessed using a validated early warning system (EWS). Consultant involvement is required for patients who reach trigger criteria, with 'consultant involvement' to be clearly defined in Trust protocols. consultant involvement for patients considered 'high risk' to be within one hour.
4	When on-take, a consultant and their team are to be completely freed from any other clinical duties or elective commitments.
5	In order to meet the demands for consultant delivered care, senior decision making and leadership on the acute surgical unit to cover extended day working, seven days a week, amounting to a minimum of 70 hours per week.
6	All patients on acute medical and surgical units to be seen and reviewed by a consultant during twice daily ward rounds, including all acutely ill patients directly transferred, or others who deteriorate.
7	All hospitals admitting medical and surgical emergencies to have access to all key diagnostic services in a timely manner 24 hours a day, seven days a week to support clinical decision making: · Critical – imaging and reporting within 1 hour · Urgent – imaging and reporting within 12 hours · All non-urgent – within 24 hours
8	All hospitals admitting medical and surgical emergencies to have access to interventional radiology 24 hours a day, seven days a week: · Critical patients – 1 hour · Non-critical patients – 12 hours
9	Rotas to be constructed to maximise continuity of care for all patients in an acute medical and surgical environment. A single consultant is to retain responsibility for a single patient on the acute medical/surgical unit. Subsequent transfer or discharge must be based on clinical need.

Better health programme

BHP care standards – Acute general surgery

NHS
The NHS in Darlington, Durham and Tees

Ref	Indicator
10	A unitary document to be in place, issued at the point of entry, which is used by all healthcare professionals and all specialties throughout the emergency pathway.
11	Patients admitted for unscheduled care to be nursed and managed in an acute medical/surgical unit, a specialty ward relevant to the patient's clinical need, or critical care environment.
12	All admitted patients to have discharge planning and an estimated discharge date as part of their management plan as soon as possible and no later than 24 hours post-admission. A policy is to be in place to access social services seven days per week. Patients to be discharged to their named GP.
13	All hospitals admitting emergency general surgery patients to have access to a fully staffed emergency theatre immediately available and a consultant on site within 30 minutes at any time of the day or night.
14	All patients admitted as emergencies are discussed with the responsible consultant if immediate surgery is being considered. For each surgical patient, a consultant takes an active decision in delegating responsibility for an emergency surgical procedure to appropriately trained junior or speciality surgeons. This decision is recorded in the notes and available for audit.
15	All patients considered as 'high risk' to have their operation carried out under the direct supervision of a consultant surgeon and consultant anaesthetist; early referral for anaesthetic assessment is made to optimise peri-operative care. High risk is defined as where the risk of mortality is greater than 10%.
16	All patients undergoing emergency surgery to be discussed with consultant anaesthetist. Where the severity assessment score is ASA3 and above, anaesthesia is to be provided by a consultant anaesthetist.
17	The majority of emergency general surgery to be done on planned emergency lists on the day that the surgery was originally planned. The date, time and decision maker should be documented clearly in the patient's notes and any delays to emergency surgery and the reasons why recorded. Any operations that are carried out at night are to meet NCEPOD classifications and be under the direct supervision of a consultant surgeon.
18	All referrals to intensive care to be made from a consultant to consultant.

BHP care standards – Acute general surgery

Ref	Indicator
19	A structured process to be in place for the medical handover of patients twice a day. These arrangements to also be in place for the handover of patients at each change of responsible consultant/medical team. Changes in treatment plans are to be communicated to nursing and therapy staff as soon as possible if they are not involved in the handover discussions.
20	Consultant-led communication and information to be provided to patients and to include the provision of patient information leaflets.
21	Patient experience data to be captured, recorded and routinely analysed and acted on. Review of data is a permanent item on board agenda and findings are disseminated.
22	All acute medical and surgical units to have provision for ambulatory emergency care.
23	Prompt screening of all complex needs inpatients to take place by a multi- professional team which has access to pharmacy and therapy services, including physiotherapy and occupational therapy, seven days a week within an overnight rota for respiratory physiotherapy.
24	Single call access for mental health referrals to be available 24 hours a day, seven days a week with a maximum response time of 30 minutes.
25	Hospitals admitting emergency patients to have access to comprehensive 24 hour endoscopy services that has a formal consultant rota 24 hours a day, seven days a week.
26	Training to be delivered in a supportive environment with appropriate, graded consultant supervision,
27	There should be a minimum 8 person rota for all acute sites.

BHP care standards - Acute Paediatrics

Better health programme

The NHS in Darlington, Durham and Tees

Ref	Indicator
1	All SSPAUs (Short Stay Paediatric Assessment Units) have access to a paediatric consultant (or equivalent) opinion throughout all the hours they are open, 7 day service.
2	A paediatric consultant (or equivalent) is present in the hospital during times of peak activity. 7 day service
3	Every child or young person who is admitted to a paediatric department with an acute medical problem is seen by a paediatrician on the middle grade or consultant rota within **four hours** of admission.
4	Every child or young person who is admitted to a paediatric department with an acute medical problem is seen by a consultant paediatrician (or equivalent staff, speciality and associate specialist grade doctor who is trained and assessed as competent in acute paediatric care) within the first 14 hours of admission
5	All general paediatric inpatient units adopt an attending consultant (or equivalent) system, most often in the form of the 'consultant of the week' system.
6	All general acute paediatric rotas are made up of at least ten WTEs, all of whom are WTD compliant.
7	At least -two medical handover in every 24 hours is led by a paediatric consultant (or equivalent).
8	Specialist paediatricians are available for immediate telephone advice for acute problems for all specialties, and for all paediatricians.

BHP care standards - Acute Paediatrics

Ref	Indicator
9	All children and young people, children's social care, police and health teams have access to a paediatrician with child protection experience and skills (of at least Level 3 safeguarding competencies) available to provide immediate advice and subsequent assessment, if necessary, for children and young people under 18 years of age where there are child protection concerns. The requirement is for advice, clinical assessment and the timely provision of an appropriate medical opinion, supported with a written report.
10	PICU should have dedicated 24-hr cover by a consultant paediatric intensivist with appropriate training, and additional 24-hr consultant paediatric anaesthetist cover if the intensivist is not an anaesthetist.
11	Consultants should not be rostered for any other clinical commitment when covering the PICU during daytime hours. During daytime hours the consultant in charge of the PICU should spend the majority of his or her time on the PICU and must always be immediately available on the PICU.
12	No individual consultant paediatrician or anaesthetist practicing PIC should do so for less than 2 DCC PAs per week.
13	PICU should provide training for 1st year ICTPICM registrars, and the necessary requirements to equip nursing staff with specific training in paediatric intensive care.
14	All nurses who provide care to children and young people should have a specific qualification in the nursing of children and young people
15	A minimum of two qualified (registered) children's nurses should be on duty 24 hours-a-day in all children's wards and departments
16	Each children's ward/department nursing establishment should have a minimum of 1 WTE (whole time equivalent) Band 7 and 2 WTE Band 6 qualified children's nurses.

BHP care standards - Acute Paediatrics

Better health programme

The NHS in Darlington, Durham and Tees

Ref	Indicator
17	Paediatric short stay assessment units and inpatient units should apply a dependency model that is validated by commissioners. As a planning guide: - Short stay paediatric assessment units (SSPAUs) should plan on a nurse:patient ratio of 1:7. - Inpatient paediatric units should plan on a nurse:patient ratio of 1:4. However, this should not mean that high need patients such as those requiring a tracheostomy should have care provided on a 1: 3 ratio or if a unit is capable of providing CPAP a ratio of 1:2. **[clarification is required on the statement about the change or ratio of nurse to patient]** **Note**: Its expected that for the ratio to move to a 1:3 as common place community nurse teams would need to take on more complex cases, thus increasing the case-mix complexity of patients admitted to hospital.
18	A Band 7 nurse must be part of the total nursing establishment on every PICU shift. If the PICU has more than 12 beds, they should be supported by 2 Band 6 nurses per shift.
19	All senior PICU nurses (Band 6-8) should have a specific qualification in PIC nursing, with over 90% of PICU nurses being Children's Branch trained and at least 75% with a specific qualification in PIC nursing
20	PICU nurses should be trained in retrieval **[clarification training neonatal nurses to do transfers as well as PICU nurses?? – clarify with neonatal network plans for transport for transport system]**
21	General Paediatric Surgery in DGHs should be undertaken by surgeons who had undertaken a minimum duration of 6 months GPS training in a recognised post, at year 4 or higher of the then Higher Surgical Training programme in a centre undertaking at least 1 operating list exclusively for children once every two weeks. Exceptions to this are those individuals that have already been working but due to length of service won't meet this requirement.
22	Paediatric anaesthetist groups should undertake at least 100, ideally greater than 200, paediatric anaesthetic procedures per year.
23	On each hospital site there should be 24 hour cover by a consultant anaesthetist with paediatric interest who is able to attend within 30 minutes and does not have responsibilities to other hospital sites.
24	Anaesthetists with no regular paediatric commitment but who have to provide out-of-hours cover for emergency surgery or stabilisation of children prior to transfer should maintain skills in paediatric resuscitation and an appropriate level of CPD in paediatric anaesthesia to meet the requirements of the job.

BHP Clinical care standards - Acute Paediatrics

Better health programme

NHS
The NHS in Darlington, Durham and Tees

Ref	Indicator
25	Children should be anaesthetised by consultants who have regular and relevant paediatric practice sufficient to maintain core competencies. Children may also be anaesthetised by staff or Associate specialist (SAS) anaesthetists or specialty doctors (SDs), provided they fulfil the same criteria and there is a nominated supervising consultant anaesthetist. When trainees anaesthetise children, they should be supervised by a consultant with appropriate experience.
26	It was agreed that a minimum number of lists per week should be set for paediatric anaesthetists
27	It was agreed that a minimum number of cases per annum should be set for paediatric anaesthetists.
28	Anaesthetists should have a minimum of 6 months Paediatric anaesthesia in care of the poorly child and paediatric surgery, as part of their specialty training. Exceptions to this are those individuals that have already been working but due to length of service won't meet this requirement.
29	Every child or young person with an acute medical problem who is referred for a paediatric opinion is seen by, or has the case discussed with, a paediatrician on the consultant rota, a paediatrician on the middle grade rota or a registered children's nurse who has completed a recognised programme to be an advanced practitioner.
30	PICU must have access to the following paediatric subspecialties as per the critical interdependencies framework (see p.10): ENT (including airway management), specialised paediatric surgery, specialised paediatric anaesthesia, clinical haematology, respiratory medicine, cardiology, neurosurgery, metabolic medicine, neurology, major trauma, nephrology, immunological disorders, infectious diseases, urology, gastroenterology.
31	PICU must have 24-hr access to radiology, including CT and MRI scanners, with 24-hr reporting available by consultant radiologists and neuro-radiologists.
32	There should be technical staff available at all times (24-hr) to the PICU, to service and troubleshoot electronic equipment and other technical services.
33	All short stay paediatric assessment facilities to have access to a paediatric consultant throughout all the hours they are open, with on site consultant presence during times of peak attendance.

BHP Clinical care standards
Updated Maternity/Obstetrics standards

The NHS in Darlington, Durham and Tees

Ref	Indicator
1	Antenatal care should be provided in a variety of local settings and at times that take account of the demands of the woman's working life and family.
2	All women should be offered a comprehensive, high-quality antenatal screening and diagnostic service, based on the current recommendations of the National Screening Committee, and designed to detect maternal or fetal problems at an early stage.
3	All maternity care providers should ensure that each pregnant woman has two visits early in pregnancy with a midwife who can advise her on her options for care on the basis of an in-depth knowledge of local services.
4	For women with an uncomplicated pregnancy, the number of scheduled antenatal appointments should be planned in accordance NICE Guideline 62 (2008) – uncomplicated nulliparous women: 10 appts; uncomplicated parous women: 7 appts.
5	Women should be able to access promptly adequately equipped Early Pregnancy Assessment Units.
6	Larger obstetrics units (>3500) should provide 23hr EPAUs on weekdays and extended hours at weekends that provide scanning and assessment.
7	Commissioners and providers must develop maternity and neonatal care networks.
8	All obstetric units should have direct access to special care baby unit facilities to manage babies requiring ventilation and have a defined rapid access route to neonatal intensive care.

BHP Clinical care standards
Updated Maternity/Obstetrics standards

Ref	Indicator
9	All new-born infants should have a complete clinical examination within 72 hours of birth.
10	No less than 2500 births per year for a consultant led unit.
11	Every consultant led unit should have on site haematology, blood transfusion and ITU
12	Access to second theatre must be available within 20 minutes 24/7.
13	MLU's should maintain skills by rotating workforce via larger units.
14	Free-standing Midwifery Units must have robust admission criteria and transfer protocols; obstetric units should have Alongside Midwifery Units co-located with them.
15	Establish prospective consultant obstetrician presence on each labour ward: Units with between 2500-4000 births should have 98 hour consultant presence and units of 4000 births + should have 168 hour presence > In recognition of the differing needs of units with less than 4000 deliveries, not all units will require 168-hour presence to ensure the necessary quality and safety standards.

Better health programme

BHP Clinical care standards
Updated Maternity/Obstetrics standards

NHS
The NHS in Darlington, Durham and Tees

Ref	Indicator
17	A consultant obstetrician should be available within 30 minutes outside the hours of consultant presence.
18	Patients on the labour ward should have four board/team reviews between 8am and 10pm – amended to: Patients on the labour ward should have a minimum of four consultant board/team reviews every 24 hours. This was amended as 10pm to 8am was felt to be a long stretch of time without a board review
19	There should be a minimum of 10 WTE on medical staff rotas at each level.
20	There should be consultant attendance at vaginal breech, vaginal twins, C-section at fully dilated, trials, return to theatre, placenta previa, PdH ongoing of 1.5litres. There was debate around this list being longer.
21	Each woman should receive one-to-one midwifery care during the second stage of labour by a trained midwife or trainee midwife under supervision; the first stage of established labour should be overseen by an appropriately trained professional under the care of a midwife. Admission to the labour ward should be limited to women who are in established labour.
22	To deliver 1:1 care during established labour by an appropriately trained professional under the supervision of a midwife, staffing levels for all midwifery, nursing and support staff for each care setting should be calculated based upon the results of a Birth-rate Plus assessment which is not more than 3 years out of date; as a minimum, the CQC recommended ratio should be adhered to, changing from time to time as the CQC revises its position. Currently, the calculation should be based upon: > Home and birth centre: 1:28 Midwives:births , 6:1 midwife:MCA > Obstetrics units: 1:28 Midwives:births, 4:1 midwife:MCA The group discussed removing the ratios within this standard as there is a move towards staffing based on case mix. It was agreed to keep the ratios as a minimum standard with a view to revising this standard once further guidance is issued.
23	There should be an identified supernumery midwifery team leader on every shift located on the labour ward
24	Consultant obstetric units require a 24-hour anaesthesia and analgesia service with consultant supervision, including: • minimum 10 PA/40 hours consultant presence • specialist anaesthetic services (may require additional on-call consultant if no standalone obstetric anaesthetic rota) , • adult high-dependency and access to intensive care, haematology blood transfusion and other district general hospital support services and an integrated obstetric and neonatal care service.
25	A duty anaesthetist of appropriate competency and dedicated only to the labour ward must be immediately available, 24 hours a day, 7 days a week. This anaesthetist will normally have had more than 1 year of experience in anaesthesia and must have been assessed as being competent to undertake such duties. The duty anaesthetist must have access to prompt advice and assistance from a designated consultant anaesthetist whenever required.

BHP Clinical care standards
Updated Maternity/Obstetrics standards

Better health programme

The NHS in Darlington, Durham and Tees

Ref	Indicator
26	Extra anaesthetic cover during periods of heavy workload in addition to the supervising consultant anaesthetist and the duty anaesthetist is required in busier units (more than 5000 births/year, an epidural rate over 35% and a caesarean section rate over 25%, plus tertiary referral centres with a high proportion of high-risk cases).
27	For any obstetric unit there should be a separate consultant anaesthetist for each formal elective caesarean section list.
28	Labour wards should be able to care for Critical care Level 2 (non-ventilated) patients.
29	There must be 24-hour availability in obstetric units within 30 minutes of a consultant paediatrician (or equivalent staff and associate specialist grade) trained and assessed as competent in neonatal advanced life support.
30	24 hour paediatric middle grade cover should be available 24/7 to be present at vaginal breech, vaginal twins, C-section at fully dilated.
31	Foetal medicine review should happen within 72 hours from when indicated
32	Obs-med patients deemed to be of increased risk should be seen in a joint obs-med clinic with an appropriate physician
33	Pre term babies should be delivered in a unit with appropriate neonatal facilities
34	Women in pre term labour (less than 30 weeks should be offered magnesium sulphate and appropriate diagnostic testing
35	Women should have the choice of delivery location offered in an unbiased manner to include where appropriate home birth, MLU (stand alone and co-located) or consultant led care
36	All women should be offered the opportunity to develop with their midwife and if required obstetrician an individual care plan that takes into account their individual needs.

BHP Clinical care standards - Neonatology

Better health programme

The NHS in Darlington, Durham and Tees

Standard					Source
Medical staffing		**SCBU**	**NHDU / Local Neonatal Unit**	**NICU**	
Tier 1	**1**	At least 8 wte on rota	At least 8 wte on rota	At least 8 wte on rota	Toolkit for High Quality Nenonatal Services (2009)
ANNPs GP Trainees Foundation Year Doctors Trust doctors ST1-3 trainees**		24/7	24/7	24/7	
Source		General paediatrics rota	General paediatrics rota	Dedicated neonatal rota	
Note:		*When a NICU is co-located with a SCBU and NHDU, the NICU staff will also oversee the other units. Similarly when a NHDU is co-located with a SCBU, the NHDU staff will cover both units*			
Tier 2	**2**	At least 8 wte on rota	At least 8 wte on rota	At least 8 wte on rota	Toolkit for High Quality Nenonatal Services (2009)
ANNPs Trust doctors ST trainees - ST 3* and above SSASG Consultants		24/7	24/7	24/7	
Source		General paediatrics rota	General paediatrics rota and resident paediatric / neonatal consultants	Dedicated neonatal rota	
Note:		*When a NICU is co-located with a SCBU and NHDU, the NICU staff will also oversee the other units. Similarly when a NHDU is co-located with a SCBU, the NHDU staff will cover both units*			
Tier 3	**3**	At least 8 wte on rota	At least 8 wte on rota	At least 8 wte on rota	Toolkit for High Quality Nenonatal Services (2009)
Consultants		14-16/7	14-16/7	14-16/7	
Source		General paediatrics (on-call) rota.	General paediatrics (on-call rota) with a minimum of 1 consultant with a designated lead interest in neonatology plus neonatologists	Dedicated neonatal rota	
Note:		*When a NICU is co-located with a SCBU and NHDU, the NICU staff will also oversee the other units. Similarly when a NHDU is co-located with a SCBU, the NHDU staff will cover both units*			

BHP Clinical care standards –Acute Gynaecology standards

The NHS in Darlington, Durham and Tees

As Gynaecology standards were not agreed within phases 1 & 2 of BHP, the subgroup drafted the following new set of standards in December 2014:

Ref	Indicator
1	All inpatients should be reviewed by a consultant on a daily basis.
2	All inpatients should have a clearly documented management plan and a predicted date of discharge.
3	All patients admitted acutely to be continually assessed using a validated early warning system (EWS). Consultant involvement is required for patients who reach trigger criteria, with 'consultant involvement' to be clearly defined in Trust protocols.
4	There should be a clearly identified consultant on call for gynaecology, 24 hours a day.
5	All hospitals admitting medical and surgical emergencies to have access to all key diagnostic services in a timely manner seven days a week to support clinical decision making:
6	Rotas to be constructed to maximise continuity of care for all patients in an acute medical and surgical environment. A single consultant is to retain responsibility for a single patient on the acute medical/surgical unit. Subsequent transfer or discharge must be based on clinical need.
7	A unitary document to be in place, issued at the point of entry, which is used by all healthcare professionals and all specialties throughout the emergency pathway.
8	Patients admitted for unscheduled care to be nursed and managed in an acute medical/surgical unit, a specialty ward relevant to the patient's clinical need, or critical care environment.
Page 79	A policy is to be in place to access social services seven days per week.

BHP Clinical care standards –Acute Gynaecology standards

Better health programme

The NHS in Darlington, Durham and Tees

As Gynaecology standards were not agreed within phases 1 & 2 of SeQiHS, the subgroup drafted the following new set of standards in December 2014:

Ref	Indicator
10	All hospitals admitting emergency gynaecology patients to have access to a fully staffed emergency theatre immediately available and a consultant on site within 30 minutes at any time of the day or night.
11	All patients admitted as emergencies are discussed with the responsible consultant if immediate surgery is being considered. For each surgical patient, a consultant takes an active decision in delegating responsibility for an emergency surgical procedure to appropriately trained junior or speciality surgeons. This decision is recorded in the notes and available for audit.
12	All patients considered as 'high risk' to have their operation carried out under the direct supervision of a consultant surgeon and consultant anaesthetist; early referral for anaesthetic assessment is made to optimise peri-operative care.
13	The majority of emergency gynaecological surgery to be done on scheduled emergency lists on the day that the surgery was originally planned. The date, time and decision maker should be documented clearly in the patient's notes and any delays to emergency surgery and the reasons why recorded. Any operations that are carried out at night are to meet NCEPOD classifications. and the decision to operate made by the consultant Gynaecologist.
14	All referrals to intensive care to be made from a consultant to consultant..
15	A structured process to be in place for the medical handover of patients twice a day. These arrangements to also be in place for the handover of patients at each change of responsible consultant/medical team. Changes in treatment plans are to be communicated to nursing and therapy staff as soon as possible if they are not involved in the handover discussions.
16	Consultant-led communication and information to be provided to patients and to include the provision of patient information leaflets.
17	Patient experience data to be captured, recorded and routinely analysed and acted on. Review of data is a permanent item on board agenda and findings are disseminated.
18	All acute medical and surgical units to have provision for ambulatory emergency care.

BHP Clinical care standards –Acute Gynaecology standards

The NHS in Darlington, Durham and Tees

As Gynaecology standards were not agreed within phases 1 & 2 of SeQIHS, the subgroup drafted the following new set of standards in December 2014:

Ref	Indicator
19	Training to be delivered in a supportive environment with appropriate, graded consultant supervision.
20	There should be a minimum 8 person rota for all acute sites.
21	The principles of enhanced recovery should be adopted.
22	Recommendations from NICE should be implemented.

BHP Clinical care standards – Critical Care

The NHS in Darlington, Durham and Tees

Ref	Indicator
1	All Trusts must participate in ICNARC and achieve good clinical outcomes as compared to comparable units.
2	All Trusts must achieve the following minimum quality indicators targets: Unit acquired MRSA: <1% Unit acquired C.Diff: <2% Out of Hours ward discharges < 5% Early discharges <5% Delayed discharges (4 hour) <10% [For discussion is this achievable?] Early readmissions < 3% Post ITU deaths <10% [Keep this in?]
3	Non clinical transfers out of hospital should be a rare event and out of network an SUI.
4	All Critical Care services must have 24/7 access to an immediately available doctor @ ST3 or above with advanced airway skills (or equivalent, e.g. Advanced Critical Care Practitioners) with no other duties (theatre for example).
5	All consultants participating the Critical Care rota must do daytime sessions in Critical Care, 2 is considered minimum.
6	New consultant appointments to critical care rotas should have CCT in Critical Care and FFICM exam.
7	All critical care units should have consultant sessions and ward rounds in evenings and weekends. Standard 15 PAs for each 8 (or part) level 3 beds as national recommendation.
8	Each Critical Care Unit should have a named consultant 24 hours per day with no other clinical duties with 2 ward rounds as a minimum, 3 desirable, e.g.0900, 1600 and 2000.

BHP Clinical care standards – Critical Care

Ref	Indicator
9	Each admission to critical care should be reviewed by a consultant within 12 hours of admission.
10	Each Critical Care Unit should have a named Director with sufficient time for administration of the unit. A minimum of 1 session is recommended for each 8 level 3 beds and a whole time director whose job is directed to patient care and management is recommended for units with greater than 20 level 3 beds.
11	Each patient admitted to critical care should have a named parent specialty consultant whose team or nominated team visits daily until discharge from critical care .
12	All referrals to critical care should involve discussion with the referring and receiving parent consultant
13	Level 3 Units should deliver renal support in dialysis or CVVH.
14	Every patient in an Critical Care must have immediate access to a registered nurse with a post registration qualification in this specific speciality.
15	Level 3 (ventilated or CVVH) patients should have a minimum of one nurse to one patient.
16	Level 2 patients should have a minimum of one nurse to two patients.

BHP Clinical care standards – Critical Care

Ref	Indicator
17	Larger units (>6 beds) and/or geographically diverse units require a clinical co-ordinator who is a senior critical care qualified nurse who is not allocated a patient on the clinical shift.
18	Intensive Care Units should maintain mean occupancy levels of <70% for units of 8 beds or fewer and <80% for larger units.
19	A Level 3 bed should be available for a new admission requiring it within one hour of the need arising in 90% of cases.
20	There should be <10% delayed discharges to the wards, where delay is defined as delayed after **midday** on the day following them deemed suitable for ward transfer by the consultant.
21	Patient transfers between networked ICUs should be only undertaken on the basis of clinical need, and should be agreed between the referring and accepting intensive care consultant. Transfers outside the network should be avoided.
22	All Critical Care Units should perform a RCA on unplanned readmissions or early discharges from critical Care areas within a 48 hour period.
23	The National Early Warning Score (NEWS) should be a standard measured for patient safety for every patient. Clear pathways of referral must be in place (defined in local protocols) for patients who reach trigger criteria.

BHP Clinical care standards – Critical Care

Ref	Indicator
24	There should be an acute response team to call, in some smaller hospitals this may be an acute medical response team. In larger hospitals it is recommended that a form of Critical Care Outreach is adopted.
25	All Trusts should implement the NICE Rehabilitation after Critical Illness (NICE 2009) guidelines, including follow up clinics and 7 day rehab.
26	All Trusts must comply with the Network evidence based guidelines which should be in place in each unit for management of common critical care conditions e.g. sepsis management as per surviving sepsis guidelines and North East SHA sepsis standards.
27	The structure of Intensive Care Units should follow HBN 57 and CCUs V4 for all new builds or refurbishment.
28	All sites admitting emergencies should have the ability to increase their Level 2 and Level 3 capacity to accommodate periods of exceptional need dependant upon local and regional ACCEP levels.
29	All units should have a mandatory clinical educator
30	All larger centres should have a research nurse

Interventional Radiology Clinical Standards

Better health programme

NHS
The NHS in Darlington, Durham and Tees

Situations where urgent or emergency interventional radiology is indicated

- Stopping haemorrhage (eg, trauma, gastrointestinal (GI) bleeding, post-partum haemorrhage)
- Thoracic aortic aneurysm, traumatic dissection and the complications of Type B dissection, ruptured peripheral aneurysms
- Acute peripheral and visceral ischaemia
- Managing sepsis secondary to upper urinary tract and biliary obstruction (often urgent though rarely an emergency)
- Draining intra-abdominal and intra-thoracic abscess (often urgent, though rarely an emergency)
- Colonic stenting (often urgent, though rarely an emergency)
- Image-guided intervention in subarachnoid haemorrhage

Situations where emergency interventional radiology might be indicated in future

- Emergency management of abdominal aortic aneurysm
- Stroke

Ref	Indicator
	Recommendations for individual departments and trusts
1	Recognition that in the absence of provision of IR services patients will be placed at risk
2	There should be clarity within the trust and among referring clinicians and service commissioners about what interventional radiology services are available and when they are available
3	Clear pathways should be in place for treating patients appropriately when the interventional radiology service is not available
4	Out-of-hours service provision must be subject to a formal rota
5	There should be recognition of the resource implication of supporting a 24-hour interventional service in terms of diagnostic imaging and manpower
6	Onward referral pathways must be clear
	Recommendations for individual radiologists
7	All doctors are bound to adhere to General Medical Council (GMC) guidance and must comply with the principles and values set out in GMC Good Medical Practice
8	Radiologists should not normally carry out procedures with which they are unfamiliar
9	Radiologists should recognise that ad-hoc on call rotas are not in the best interest of patients
10	It is the duty of the radiologists to report any risk management concerns to the trust's clinical governance committee

Radiology Clinical Standards

Ref	Indicator
	Implementation of standards **Departmental leads should ensure the following:**
1	Local agreement is reached amongst radiologists in clinical departments about what services are provided on call. Discussion about maintenance of and definition of what constitutes "core" radiological skills among local radiologists and how these may be maintained should take place. Attendance at relevant continuing medical education (CME) courses such as those provided by the British Society of Interventional Radiology and the RCR is advisable and it may be necessary to update practical skills by spending time in larger departments
2	There is agreement with clinicians on treatment /alternative imaging pathways when a particular aspect of the imaging/interventional service is not available
3	There is mechanism for information to be available to clinicians on a daily/weekly basis about when services are/are not available
4	Formal contracts exist with other trusts to which patients are transferred for imaging or intervention
5	Locally agreed protocols and/or guidelines for referral for emergency imaging/intervention have the potential to reduce confusion and/or disagreement in individual cases. These protocols should be evidence-based and have been agreed with the local clinical governance committee and the relevant clinical teams
Page 87	Individual radiologists, in conjunction with clinical leads or their appraiser, should keep their range of skills and routine practice under review, with the aim of balancing subspecialty expertise with the maintenance of core skills needed to provide a trust-wide emergency radiology service (see 1 above)

Better health programme

NHS
The NHS in Darlington, Durham and Tees

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RICHMONDSHIRE DISTRICT COUNCIL

To:
Better Health Programme
Hambleton, Richmondshire & Whitby CCG
NHS Darlington CCG
South Tees Hospital NHS Foundation Trust
County Durham & Darlington NHS Foundation Trust
North Yorkshire Scrutiny of Health Committee
Darlington BC Health & Partnership Scrutiny Cttee
Better Health Programme Joint Health Scrutiny Cttee

Your Ref:
My Ref: CP/160719 Better Health
Dealt with by: Caroline Pounder
Democratic Services

Date: 4 August 2016

Dear Sir/Madam,

The Better Health Review of Critical Care Services

I write to advise you of a Notice of Motion relating to the Better Health review of Critical Care services at Darlington Memorial Hospital, considered at Richmondshire District Council's Council Meeting, held on Tuesday 19 July 2016.

Councillor John Blackie requested consideration of the following Notice of Motion:

"The Better Health review of Critical Care services, including Accident & Emergency and Consultant-led maternity and paediatrics services at the Darlington Memorial Hospital is causing Richmondshire District Council great concern as any reduction or cut in these services would have a hugely detrimental impact on the health, well-being, and peace of mind of all those who live in the District. It strongly supports the initiative launched at the May meeting of North Yorkshire County Council which has led to a high level alliance between the Leaders of the political administrations at Darlington Borough Council and North Yorkshire County Council and the establishment of a joint Scrutiny of Health Committee between the two Councils.

It instructs Officers at Richmondshire District Council:

1) to convey its deep concerns to the relevant NHS organisations, including the organisation conducting the Better Health Review itself and the Hambleton, Richmondshire and Whitby Clinical Commissioning Group.

2) to inform Darlington Borough Council and North Yorkshire County Council and their joint Scrutiny of Health Committee of its support, and to offer to join in these initiatives in any way it is considered appropriate.

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Richmondshire District Council considers the maintenance at their current level, or preferably with an embedded programme committed to their continuous improvement, of the Critical Care Services at the Darlington Memorial Hospital essential to guarantee their availability to deal with the immediate, urgent and unplanned healthcare needs of all residents in the District, and it resolves accordingly to adopt appropriate actions or measures to resist any attempt to downgrade them."

The Notice of Motion was seconded by Councillor Stuart Parsons and endorsed by all Members.

We would welcome your comments.

Yours sincerely,

pp. *Sarah Holbird*

Caroline Pounder
Senior Democratic Services Officer

01748 901014
caroline.pounder@richmondshire.gov.uk

cc. County Councillor Jim Clark
County Councillor Caroline Dickenson