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.

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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.

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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?

<u>How have they drawn the working assumptions up?</u> (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 <u>acute</u> 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)

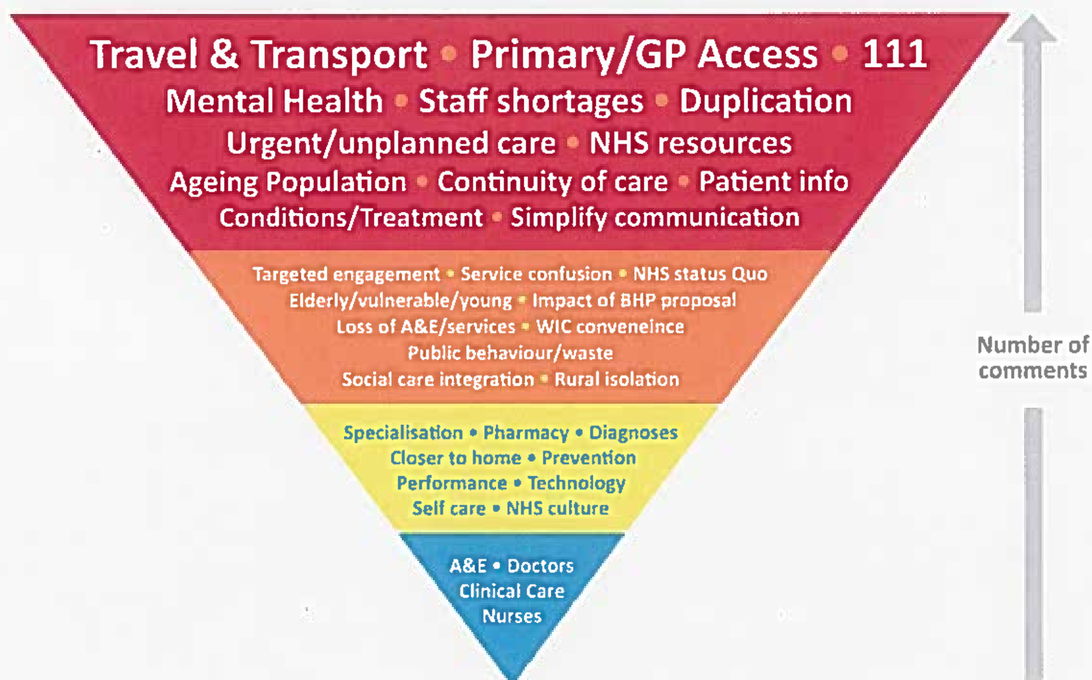
Page 19 – Item 35 – Women should have the choice of delivery location offered in an unbiased manner to include where appropriate home birth, MLU (stand alone and co-located) or consultant-led care. (Currently women are being warned that if something goes wrong in a MLU they will need to be blue-lighted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

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					

SHEET 3

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 4

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.

Better health programme

The NHS in Darlington, Durham and Tees

SHEET 5.

We worked out over 133 possible combinations of services