

AUDIT AND GOVERNANCE COMMITTEE AGENDA



31 May 2013

at 3.00 pm

**in Committee Room B,
Civic Centre, Hartlepool.**

MEMBERS: AUDIT AND GOVERNANCE COMMITTEE

Councillors Ainslie, S Akers-Belcher, Brash, Fisher, Loynes, Robinson and Shields.

1. APOLOGIES FOR ABSENCE

2. TO RECEIVE ANY DECLARATIONS OF INTEREST BY MEMBERS

3. MINUTES

No items.

4. AUDIT ITEMS

No items.

5. STATUTORY SCRUTINY ITEMS

5.1 Reconfiguration of Emergency Medical and Critical Care Services at North Tees and Hartlepool NHS Foundation Trust:-

- (a) Covering Report – *Scrutiny Support Officer*
- (b) Presentation – *Representatives from Hartlepool and Stockton-on-Tees Clinical Commissioning Group and North Tees and Hartlepool NHS Foundation Trust*



6. OTHER ITEMS

No items.

7. ANY OTHER BUSINESS WHICH THE CHAIR CONSIDERS URGENT

FOR INFORMATION:

Date of next meeting – 27 June 2013 at 9.30am.



AUDIT AND GOVERNANCE COMMITTEE

31 May 2013



Report of: Scrutiny Support Officer

Subject: Reconfiguration of Emergency Medical and Critical Care Services at North Tees and Hartlepool NHS Foundation Trust

1. PURPOSE OF REPORT

- 1.1 The purpose of this report is to inform Members that representatives from Hartlepool and Stockton-on-Tees Clinical Commissioning Group and North Tees and Hartlepool NHS Foundation Trust will be in attendance at today's meeting to discuss with Members the reconfiguration proposals for Emergency Medical and Critical Care Services at North Tees and Hartlepool NHS Foundation Trust.

2. BACKGROUND

- 2.1 The National Clinical Advisory Team (NCAT) visited North Tees and Hartlepool NHS Foundation Trust to clinically assure reconfiguration proposals for North Tees and Hartlepool NHS Foundation Trust. Following the visit the team produced a report which is attached at **Appendix A**. The report summarises views and provides recommendations for change.
- 2.2 The representatives in attendance today will provide information on the following areas:-
- (a) NCAT Report and Recommendations
 - (b) Reconfiguration proposals for Emergency Medical and Critical Care Services at North Tees and Hartlepool NHS Foundation Trust

3. PROPOSALS

- 3.1 The CCG have launched a public consultation to ask for views of the proposals and concerns about how the impact of the changes can be managed and implemented. The consultation document is attached as **Appendix B**.

4. RECOMMENDATION

- 4.1 That the Audit and Governance Committee consider the information and proposals provided and determine how and when to respond to the consultation.

5. REASONS FOR RECOMMENDATIONS

- 5.1 To ensure Members are aware of the reconfiguration proposals to enable a response to be formulated to the consultation.

6. BACKGROUND PAPERS

(a) National Clinical Advisory Team (NCAT) Review – *(available at <http://www.hartlepoolandstocktonccg.nhs.uk>)*

7. CONTACT OFFICER

Contact Officer:- Laura Stones – Scrutiny Support Officer
Chief Executive's Department - Corporate Strategy
Hartlepool Borough Council
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NCAT review

To: North East NHS

North Tees & Hartlepool NHS Foundation Trust

Date of Visit: 29 January 2013

Venue(s): Hartlepool and North Tees Hospitals

NCAT Visitors: Dr Chris Clough
Dr Mike Jones

King's College Hospital
Denmark Hill
London
SE5 9RS

Administrator – Judy Grimshaw
Tel: 020 3299 5172
Email: Judy.grimshaw@nhs.net

1. Introduction

- 1.1. NCAT was asked to clinically assure reconfiguration proposals for North Tees and Hartlepool NHS Foundation Trust (NTHFT) involving the University Hospital of Hartlepool (UHH) and University Hospital of North Tees (UHNT). The request for clinical assurance was initiated by Hartlepool and Stockton-on-Tees Clinical Commissioning Group as part of their service change assurance process as the Trust and Clinical Commissioning Group move towards public consultation.

- 1.2. Information reviewed - list of information received is shown in Appendix 1

- 1.3. Agenda and list of people met is shown in Appendix 2

2. Background

- 2.1. The background to this reconfiguration is lengthy and complex starting with the Tees Service Review in 2003, followed by the acute services review for Hartlepool and Teeside in 2005, the recommendations of the Independent Reconfiguration Panel 2006 and the development of the strategic plan Momentum – pathways to healthcare 2007. The details of these various recommendations and strategic plans will not be summarised here, but the conclusion of the most recent Independent Review Panel (IRP), the Momentum programme, is that there should be a single new hospital, built between Hartlepool and Stockton, to replace the current services provided at UHH and UHNT. Additionally there should be a number of other work-streams to ensure that health services were as near to patient homes as possible, with the development of community services.

- 2.2. As part of the health service reform/redesign in North of Tees and the shared vision originating from the recommendations of the IRP, the new hospital capital project was consulted on in late 2008, leading to a final draft of the outline business case. As part of the spending review undertaken by the new coalition government following the general election in May 2010, the approval for public dividend capital (£464m) was withdrawn in June 2010. The Trust, with support from the then PCT (NHS Tees) and now NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group, is exploring alternative options for securing the required finance and, by the end of 2013 hope to identify an appropriate financial partner. A new hospital at the Wynyard site is expected to be in service by 2017.
- 2.3. In advance of and as anticipated in the new NHS with a strive for greater quality and safety standards that move to the new hospital the Trust is experiencing clinical problems of sustainability to keep abreast of escalating standards with the continued provision of two site acute medical and critical care services. It is the case for change for these services that NCAT has examined, but we have also reviewed the overall strategic direction of the Trust plans. Within the accompanying paperwork, plans to close the stand alone midwife led birthing unit (MLBU) at UHH were advanced, but we understand these are being reconsidered in an overall assessment of the provision of midwife-led services that exist within the community, or are hospital based. Whilst NCAT can understand that there may be concerns about the affordability and sustainability of a small stand-alone MLBU (approximately 300 births per year) we have not addressed the issue of maternity services directly, and these are not further discussed within the following report.

3. Case for change

- 3.1. Presently acute medicine and critical care (intensive care and high dependency care) are provided on the two sites of UHH and UHNT. Whilst UHNT is the major provider of acute medical services and critical care, UHH continues to admit acutely ill medical patients. Patients suffering from a possible stroke are already taken to UHNT (patients identified by the FAST test are transferred by the ambulance services to UNHT, other patients can self-present or be referred by GPs), and secondly patients

with acute coronary syndromes (ie those so-called STEMI patients) are taken directly or transferred to James Cook University Hospital for percutaneous coronary intervention. About 30 patients a day present to the acute medical unit (emergency medical unit) at UHH and a significant proportion of these will be ambulatory.

- 3.2. UHH is supported by a small critical care service with two ITU beds and two high dependency beds. Over recent years the bed occupancy has been 50% on average. Most of the activity using this service is referred on by the acute medical team. It is supported by anaesthetists with intensive care skills who are able to do a once daily ward round but are not able to offer the full panoply of intensive care support such as haemofiltration and routine tracheostomy can only be performed on mornings when the consultant is there. Such services are available routinely on the UNHT site. Patients for surgical tracheostomy need to be transferred to UNHT. It has been difficult to recruit and retain anaesthetists and medical staff to the UHH. In addition the nurses feel isolated within the unit and insecure about the level of care they are practicing.
- 3.3. The acute medical unit does run well and there are plenty of beds to which patients may be admitted , but again is not supported by the full panoply of services one would expect in a modern AMU. Patients need to be transferred to UNHT for endoscopy or other specialist opinion or interventions.
- 3.4. Thus the case for change here is predominantly clinically based, driven by the need to close the critical care unit at UHH which may potentially be unsafe, and secondly to provide modern fully supported acute medical care which certainly could not function without on-site critical care facilities. In the present situation patients may be left at UHH following their admission when it would have been better to transfer them in the first place to UNHT.
- 3.5. The proposal is to create a larger acute medical unit at UHNT, which would then be supported by a larger group of medical staff and other clinicians with specialist skills. The intensive care/critical care unit at UHH would

close and the capacity at UHNT would be expanded to accommodate the increased activity. Again there are likely to be efficiencies of scale and quality dividends by bringing all the individuals with intensivists skills onto one site.

- 3.6. The proposal will mean that the number of beds at UHNT will need to be expanded, and the figure given was of 100 extra beds committed to acute medicine. Within this present move there would also be some movement of plain X ray and diagnostic services to support acute medicine and critical care but these services would also remain on the UHH site to support outpatient services. Patients requiring elective surgery on the UHH site would undergo appropriate assessment to ascertain their ASA grade. Low grade patients (ASA 1 and 2) would be deemed fit enough to undergo surgery at the elective care centre. Those with higher ASA grades would be treated at UNHT in case of the need for critical care.

4. Views expressed on the day

- 4.1. The Trust and the CCG both have clear and creditable plans to develop high quality care for the people of Stockton and Hartlepool. It is important that the plans that emerge are evidence based and can be supported by our clinicians.
- 4.2. The Trust took on community services some time ago and would like to deliver integrated care, but there has been less investment in the community services at the Stockton side to enable us to do this.
- 4.3. There are now three short-listed bidders which have emerged to compete for the development/funding of the new hospital, and we would expect a recommendation by the end of the year
- 4.4. There has been a renaissance in community services. The single point of access has been a great success with signposting of appropriate services for the first time. However staff working at the SPA centre can feel stressed when attempting to make a decision about what is the appropriate patient pathway to recommend, and the default position may well be to admit.

- 4.5. We need to plan for the future, particularly the management of the frail elderly. It will be important to have integrated services with social services. A large proportion of these patients will have dementia who require appropriate care.
- 4.6. These plans will mean that 97% of the healthcare contacts that occur presently will remain in Hartlepool. We recognise that transport needs to be a key project. We are suggesting there needs to be a shuttle bus between the two hospitals. We know the public is worried about transport and it will be important to enhance both public transport and ensure that the ambulance service has sufficient capacity to make swift transfers if need be.
- 4.7. We are an upper decile performer with regard to average length of stay (3.6 days) for the acute medical service. We are trying to run an 85% bed occupancy, but often the occupancy is over 90%, particularly at the Stockton end (UHNT). Surgery runs at much lower occupancy rates (77-78%). Overall there will be 100 extra beds at North Tees to accommodate the increase in medical activity and this can be provided by refurbishing wards as at present. Additionally it would be relatively easy to reprovide the intensive care beds by some creative utilisation of space within the present ITU.
- 4.8. We must try to concentrate our elective surgical activity on the UHH site. Out of hours there will be a resident medical officer supported by advanced care nurse practitioners.
- 4.9. There are problems treating patients safely in the present UHH ITU. The number of beds is small, with low bed occupancy, and the medical cover relies on general anaesthetists some with intensivist skills. There is no dedicated intensivist presence on the ITU.
- 4.10. There is a growing disparity between the two sites because of the increasing isolation of the acute medical service and supportive critical

care. This can lead to an unwillingness to transfer patients from UHH which may not be in the patients' best interests. It is difficult to get specialist advice re haemofiltration and other specialist interventions for the patients in ITU. We have difficulty recruiting anaesthetists because of the low ITU throughput and facilities at UHH.

- 4.11. It would be difficult to justify training of junior anaesthetists in the ITU, and it is unlikely that the Deanery would support this at the UHH site. Increasingly we rely on locums which are difficult to find, and locum behaviour is worrying. Whilst what we are doing is adequate, this is not the model of care we want to see in the future.
- 4.12. One of the biggest challenges we have is working with the social services. However we do think we can preserve the relationships that have developed at UHH with community and social services if the acute services were to transfer to UHNT.
- 4.13. We want to develop consultant-led surgical care and this plan would assist that direction of travel. In the main UHH, as a surgical elective centre, would be dealing with orthopaedics (lower limb arthroplasty, spinal anaesthesia), breast surgery and paediatric day case surgery. There have been rare occasions when it has been necessary to open up the theatre out of hours for a deteriorating surgical patient using the UHH team. In future this occurrence must be kept to a minimum but in an extreme case it may be necessary to stabilise patients on the UHH site before transfer to UHNT.
We must utilise the capacity at UHH because without those 3 operating theatres we would not have the capacity to deliver all the surgical activity at UHNT.
- 4.14. There are concerns about equipment transfer between the two sites, and this needs to be clarified. We also need to do further work about understanding what competencies the out of hours team must have to support the level of elective care we would predict.

- 4.15. The acute medical team is comfortable with the assumptions about the rising level of admissions. We would expect this to be no more than 1% per year if integrated care and management of the vulnerable patients is developed within the community. We have work streams in mental health, substance misuse which aim to look at those care pathways carefully to identify patients at risk and prevent them being admitted unless absolutely necessary.
- 4.16. The local GPs are happy with the quality of care presently delivered at the two hospitals. We recognise the challenges faced by the Trust and support the movement of acute care to one site at UHNT.
- 4.17. We are not happy with the numbers of patients presently attending the ambulatory care unit at the Trust, and think these numbers need to be reduced over time by better provision of primary and community care. We recognise that GP services need to be more accessible, with 7 day working and extended hours. Presently there are a lot of zero day admissions; these need to be prevented wherever possible.
- 4.18. We are not happy with the paediatric assessment unit at UHH. We expect our children who are identified as being sick to be assessed by a paediatrician, at best a consultant, and presently this is mainly being performed by a nurse practitioner. Hence many of us are diverting children to UHNT anyway.
- 4.19. Whilst we recognise that community care needs to be developed, we must accept there has never been sufficient investment in the community services. It is worrying that the Trust re-admission rate is high, better community provision would help improve that.
- 4.20. Transport issues are key factors for patients.
- 4.21. The local Hartlepool Council has passed a vote of no confidence in the Trust management. Many people in Hartlepool do not support the building of a new hospital at Wynyard.

- 4.22. We would like to challenge the logic of the Momentum proposals. Why it is necessarily Stockton is the acute site rather than Hartlepool?
- 4.23. Patients do have concerns about the interim plans. Many of us took some convincing about the Momentum plans but have come to the view that the plans are acceptable as long as we develop community plans, and we would strongly support all attempts to keep care close to home.
- 4.24. We think the staff on both sites are good, and when we access care it is generally of a good quality. There are problems with access to some of the GPs locally, with up to 48 hours wait for an urgent appointment.

5. Discussion

- 5.1. Prior to the NCAT visit, both visitors were provided with a good deal of information about the background to the reconfiguration and the considerable political and other difficulties that the Trust and Commissioners have had over the past few years in making change happen with the North East. Thus it wasn't always clear from the paperwork what the substance of the proposal was, and what operational steps had been taken to achieve that. We fully understand the political difficulties in making change happen. Nevertheless we think the supportive paperwork could be considerably simplified, and certainly this would be necessary for public consumption, so that everybody is clear exactly what the proposal is about, the clinical case for change and what are the objectives and hoped-for outcomes to be achieved.
- 5.2. The core of this reconfiguration proposal is relatively straight-forward and that is the consolidation of the acute medical service on one site at Stockton and the transfer of the critical care services (ITU and HDU) to the Stockton site. This is the proposal we have clinically assured. As above, we have not reviewed plans for any changes in maternity services but did express our concerns about the viability of small standalone midwife led birthing units. We have not clinically assured any plans for a single site for all services, as envisaged with the new hospital build. Nevertheless we would like to make some broad strategic comments about the movement to

a possible new hospital at Wynyard, as this needs to be seen in the context of a national movement to create hospitals able to deliver care 24/7 with round the clock working for the acute team and supportive diagnostics.

- 5.3. We recognise that the public see a linkage between the interim plans and the final plans, but we think there is a pressing need to do something about what is happening to the acute services presently, no matter what the plans are for the future. Thus we see no need to link our decision with the decision making processes required for the acute hospital.
- 5.4. The clinical case for change can be strongly supported. What we witnessed today was dedicated and hard-working clinical teams at both sites, endeavouring to create a first class service but hampered by the present configuration. The key to what must happen is the provision of critical care. The present critical care service at UHH is inadequate, poorly staffed and does not meet the standards required for a modern intensive care unit. Its size and level of use mean that it will never be able to achieve these standards, thus it is not surprising that anaesthetists feel uncomfortable about working there, and there are problems with recruitment of anaesthetists and support staff. We heard that at times the nursing staff, particularly at night, feel unsupported and concerned in case a clinical error occurs. Certain practices are unacceptable, for instance the level of support for tracheostomy, the lack of haemofiltration and the ability to call on other specialist services. It is difficult to envisage how these deficits may be corrected. Massive investment in the service is not justified on the level of patient use, and it would be unlikely to be supported by the local education and training board (previously deanery). Thus we can see no alternative other than to transfer this service to UNHT. We believe there is capacity at that site to accommodate the increasing activity, and there will be the opportunity to bring together all the available staff and develop a dedicated intensivist workforce at UNHT.
- 5.5. The inevitable consequence of decommissioning critical care at UHH is that acute medical care can no longer be provided. Acutely sick patients need the availability of on-site resuscitation and critical care facilities. This must trigger the movement of acute medical care to UNHT. Not only that,

the present service is relatively small and does not have the full panoply of acute specialist care that is required to deliver high quality acute medicine. The bringing together of the two units under a single roof will undoubtedly enhance the level of support required for acute medicine and ensure there are viable specialist rotas, for instance in gastroenterology, respiratory medicine etc. It should also enhance the ability of elderly medicine to play an important part in identifying the frail elderly who require a comprehensive geriatric assessment and subsequent multi-disciplinary management.

- 5.6. When we spoke to the public and to the Overview & Scrutiny Committee members there was a significant majority in favour of the clinical argument for reconfiguration of the service. Not surprisingly the strongest support did come from those members of the public residing within the Stockton end of the patch. Nevertheless there were others from Hartlepool who also supported the plans. Understandably there are great concerns from the Hartlepool population about any changes to the services at UHH. They had two main concerns; firstly, whilst recognising that only a small part of the hospital services were being transferred to UNHT, and that the majority of services were remaining, it was felt that this could be the beginning of the end for UHH. Secondly, there are considerable concerns about transport – this has two components, firstly the extra travelling that relatives and carers would have to make in order to see their loved ones at UNHT when they were admitted acutely, and secondly was there sufficient capacity within the ambulance services to absorb the increased activity that inevitably would result from this transfer. From a clinical standpoint, the potential for small increases in travel times does not pose a significant clinical risk.
- 5.7. The Trust and its partners need to explain clearly the clinical case for change here, which is strong and can be strongly supported, but also reassure the Hartlepool public in particular that there is a continuing future for their hospital as a centre for elective care and other cold site services such as diagnostics and outpatients. Indeed there is a potential within the plans to develop intermediate care at UHH which would improve the care pathway for patients and ensure that once Hartlepool patients in particular had been treated at UNHT, they would be rapidly stepped down to

appropriate intermediate care facilities at UHH. The development of intermediate care at UHH will be an important component in managing the throughput of patients at the acute end.

- 5.8. Not enough has been done to describe patient narratives which I tell the story of what happens now and what will happen in the future. Overall we would expect these changes to deliver better patient outcomes, and all the OSC representatives and members of the public we spoke to agreed that some increased travel times was a necessary price to pay for better quality of care.
- 5.9. We were concerned about the lack of clarity about capacity planning for the enlarged Stockton unit. The assumptions used to model the bed numbers need to be robustly challenged and risk-assessed. Whilst it is very commendable that the CCG is emphasising the importance of providing adequate community services, and are putting plans in place to enhance admissions avoidance, it would be unwise to make any great assumptions that this necessarily will result in lowering the rise in hospital admissions. The Trust does need to plan for worse-case scenarios and risk-assess appropriately. It is possible that levels of admissions continue to rise and the planned achievements or reduction in average length of stay are not realised. We think the public need to be reassured that capacity planning has been carried out rigorously and the new service will be able to run efficiently and provide beds when they are needed. It would be best practice for the acute medical unit to assume a bed occupancy of 75% rather than the higher levels it has been achieving presently. The proposed bed/ambulatory care spaces in the acute medical unit on the UHNT site must be carefully modelled on present numbers and the time of day when patients present to ensure that the high quality care provided at the moment will not be compromised by the introduction of patients queues
- 5.10. There is much to be gained by developing primary care services and utilising community care. A community approach that utilises case registers for elderly patients with multiple morbidities, who are then appropriately risk stratified, would hopefully identify those patients in danger of needing admission so that they can receive targeted care within the community. Whilst we cannot guarantee that this would drive down

hospital admissions, the health economy can only thrive in the future if it reduces the reliance on hospital services, where the majority of costs are; the approach must be to concentrate on provision of high value interventions and decommission those healthcare interventions that have low value.

- 5.11. Removal of the acute services and critical care services from UHH will mean the Trust is able to focus on the provision of elective care on the UHH site. This can have considerable advantages in improving efficiency , patient flows and lowering rates of hospital acquired infection. Elective sites should be run to maximally utilise those resources, ensuring high levels of bed occupancy and theatre utilisation with low rates of cancellation and short waiting times. Patients will need to be appropriately risk-stratified, we were pleased to hear that the surgeons and anaesthetists fully recognise this. Consideration should be given to all the specialties that could potentially provide services on the UHH site as part of an elective care centre to ensure maximal utility of this site.
- 5.12. So far there has been very little debate about what the clinical support will be like following reconfiguration, and the key clinical competencies that must be provided in and out of hours within the on-site clinical team. This will be an important issue to resolve in advance of the transfer, and will determine exactly what the case-mix of patients who will be treated at UHH should be. There are a number of modern practices which can significantly enhance post-operative care of patients within daytime and early evening hours to ensure safe post-operative recovery and identify those patients who need further care (ie if they deteriorate surgically or have medical complications). This will require that appropriate protocols are put in place with physiological tracking schemes which provide an early warning of those patients who might need further care or indeed transfer to UHNT.
- 5.13. We would suggest that the clinicians, i.e. the surgeons and anaesthetists, get together very quickly to discuss these issues and agree on what the protocols of care should be, and what this might mean for the design of the clinical services. A lot can be safely done out of hours with the provision of a clinical team consisting of advanced care nurse practitioners with

resuscitation skills (ALS) but we suspect, following the discussion of the proposed case-mix of patients, there will need to be a medical presence on site overnight. This was described as a resident medical officer, or alternatively as a surgical trainee. The key to unlocking this problem is to look at the competency base of the whole team required to be on site in and out of hours. This will identify the skills and competencies of the individuals required. For instance we have seen similar plans where it was thought the most appropriate individual was an anaesthetist in training. Senior level support can be via telephone, presumably the on-call team at UHNT. Further thought should be given to whether telemedicine connections have anything to offer; for instance a video link might enable a consultant at distance to see and evaluate a patient, and watch a clinical exam. Digital imaging information can be easily transferred between the two hospitals. Our conclusion was that more work needs to be done to define the level of clinical support which would reside in and out of hours at UHH.

- 5.14. Turning to the more strategic issue of the long-term future of acute hospital services within the North East. This is of course a very large question, but it is one we feel we must raise. Whilst we wouldn't want to hold up the planning that is moving at a pace for the new acute hospital at Wynyard, we would point out that, within the North East, there are probably too many small DGH style hospitals. It would be appropriate to consider the consequences of planning a new hospital as above, but also to recognise that there may be an opportunity to configure services advantageously for the North East which in this case we would define roughly as that area between the Tyne and the Tees. It is clear that the two fixed points for acute hospital services are the Royal Victoria Infirmary at Newcastle and the James Cook University Hospital Middlesbrough. These are both large tertiary and, secondary care style hospitals which provide most services. What then is the requirement for other acute care providers? Whilst we recognise that the Healthcare Act provides for more qualified providers coming into the marketplace, acute care is extremely complex and costly and requires a strategic plan with partnership working between commissioners and providers.
- 5.15. The challenges ahead are a health economy which will not be growing as in previous years, and a requirement for year on year significant efficiency

savings. The major brunt of this inevitably will fall on the acute services, especially as there is a drive to improve primary and community services and deliver more care closer to patients' homes. The inevitable result of this is that there will be a requirement for fewer acute hospitals, and that these will cater for larger populations. The other side of the coin is that clinical care is becoming increasingly specialised within the acute sector, and needs to be provided by larger teams of clinicians who are available around the clock to ensure that patients' conditions are diagnosed speedily, and that there is immediate access to diagnostics and treatment in order to improve clinical outcome and produce shorter stays in hospital. Other drivers to change include a coming together of more specific services, for instance paediatrics, with the drop in the need to admit children and a requirement to provide 24/7 high quality inpatient care from dedicated paediatricians. This inevitably means there will be fewer paediatric inpatient units in the North East. We are aware that there are discussions within the North East to determine where these may be placed. The inevitable consequence of fewer paediatric units is fewer neonatal intensive care units and that will define where obstetric units will be placed (unless the size of the maternity unit justifies having its own standalone NICU).

- 5.16. We raise these issues because we think that there needs to be a broader strategic assessment of the requirement for acute hospital services within this geographical area and that CCGs need to come together to future-proof any plans they may have for new capital investment in acute hospital services. In the case of the proposed new hospital at Wynyard for instance, there may be a critical cut-off level for the population catchment area which will mean that the business case is challenged. If for instance this geographic site means that more patients from Hartlepool, through choice, are drifting down to the James Cook University Hospital, that could reduce the patient catchment to about 300,000, which will lead to a potential fall in income to fund the complex acute hospital care we would envisage as above. We would estimate (and here the evidence base can be challenged) that a larger population base of 500,000 and above, would lead to a more sustainable and affordable model. Nevertheless there are many other factors to consider including geographical variation, population clusters, travel times and political factors. Despite this, we think that this issue must

be raised with the commissioners and addressed speedily prior to proceeding with the new hospital build.

6. Conclusions

- 6.1. The clinical case for change is accepted. NCAT can support the move of the acute medical services and critical care services to UHNT. The timescale, whilst challenging, is supported and necessary in view of the potential for clinical risk at the UHH site
- 6.2. Capacity modelling needs to be robust and ensure that the reconfigured acute medical service aims to operate with an average bed occupancy of 75%.
- 6.3. The Trust needs to describe clearly what these changes will mean for the public and what services can be expected on both sites. A number of clinical narratives describing patient journeys need to be put forward to explain the change.
- 6.4. The public needs to see action taken about their concerns regarding transport and availability of appropriate public services between the two sites. Additionally the North East ambulance service needs to ensure they have sufficient capacity to deliver the increased numbers of transfers that might arise.
- 6.5. The residual clinical support (including medical on call) needs to be described on the UHH site. The approach should be one whereby the clinical competencies for the out of hours and in hours teams are defined to support the acutely ill patient.
- 6.6. The CCG and Trust need to work together to define patient pathways which ensure the right patient is treated in the right place first time, the aim being to reduce the number of patients who are admitted to secondary care and to improve overall quality of care delivered to patients, particularly those with multiple morbidity and long-term care needs.

- 6.7. The bigger questions of acute hospital strategy for the North East need to be addressed (see above).

7. Recommendations

- 7.1. The Trust proceeds to public consultation regarding the changes described above as soon as possible.
- 7.2. The CCG and Trust working together to respond to the conclusions as above and gives a written response to NCAT and NHS North of England within 3 weeks.
- 7.3. The CCG and Trust consider the need for external clinical review of the plans for the new hospital beyond the element of review built into the next steps of commissioning the new hospital to ensure that the model of care and facilities proposed will meet the needs of the local population and wider strategic direction of healthcare in the North East.

Appendix 1 Documentation Received

1 Covering Letter

2 Strategic Options

2.1 Strategic Options – 4 May 2012

Previous versions available if required

2.2 Presentation Transition Plan Summary of Options 12 June 2012

3 Cases for Change

3.1 Transition Plan 17 October 2011

3.2 Transition Workshop outcomes

4 Project Management of Service Reconfiguration

4.1 Presentation Strategic Options for Future Configuration of Services – 24 April 2012

- Transition Board Agenda – 17 January 2012
- Transition Board Agenda – 17 October 2011
- Service Transformation Project Group – Agenda of 7 December 2012

4.2 Service Transformation Project Group – Terms of Reference

4.3 Service Transformation Project Group – Project Initiation Document

4.4 Service Transformation Project Plan

5 North of Tees Partnership Board Agenda 20 December 2012

4.5 North of Tees Partnership Board Terms of Reference

5 North of Tees Partnership Board Agenda 21 June 2012

4.6 Minutes of the North of Tees Partnership Board – 21 June 2012

4.7 Service Transformation Presentation to North of Tees Partnership Board – 21 June 2012

5 Communication and Stakeholder Engagement

5.1 Communications Strategy and Implementation Plan

5.2 £40 m Challenge / Transition Plan – Engagement Schedule

5.3 Report to Executive Team: future service model 28 August 2012

5.4 Report to Trust Board: future service model 13 September 2012

5.5 Presentation to Trust Directors Group 19 October 2012

Report to Trust Executive Team 27 November 2012

Audit Trail of Current Engagement relating to Service Transformation.

6 Overview and Scrutiny Committee

6.1` Presentation to demonstrate the Trusts' commitment to developing services in Hartlepool – February 2012

6,2 Presentation by NHS Hartlepool on the proposal to transfer Outpatient Services to One Life

Hartlepool – 23 August 2012

6.3 (a & b) Presentation by NHS Hartlepool and Stockton and Tees Clinical Commissioning

Group and North Tees & Hartlepool NHS Foundation Trust – October 2012

6.4 Report to outline the potential impact of Outpatient moves into Community settings –

December 2012

6.5 The Positive Moves discussed with Hartlepool OSC on 15 December 2011

7 Clinical Evidence

- Links to Clinical Evidence documents

8 Guidance and Service Reviews

8.1 Guide to Service Change – Incorporating the NHS Yorkshire and the Humber Service Change Assurance Process

8.2 Reconfiguration Proposals That Have Passed The Lansley Criteria (HSJ Online (19/11/10))

8.3 Tees Review Acute Services – Report by Professor Sir Ara Darzi 2005

8.4 Independent Reconfiguration Panel Report (IRP) – Advice of Proposals for changes to Maternity and Paediatric Services in North Tees and Hartlepool 2006

9 Clear and Credible Plans

9.1 NHS Hartlepool and Stockton-on-Tees CCG

9.2 NHS Durham Dales, Easington and Sedgefield CCG

10 Activity and Performance and Additional Information

10.1 Annual Report

10.2 Annual Plan

10.3 Operational Efficiencies Report 2011/12

10.4 Operational Efficiencies Report 2012/13 to date

10.5 Board of Directors Report – Operational Efficiencies – November 2012

10.6 Board of Directors - Winter Resilience Report – October 2012

Appendix 2

PROGRAMME FOR VISIT

Time	Subject	Venue
9.15 am	Introduction to NCAT by Dr Chris Clough	Board Room University Hospital of Hartlepool
9.20 am	Expectations of the Visit and NHS Hartlepool and Stockton-on-Tees Clear and Credible Plan – led by Dr Boleslaw Posmyk and Mrs Alison Wilson.	
9.35 am	Case for Change and the bigger picture – led by Trust Executive Team.	
9.50 am	Discussion	
10 am	Tour of facilities at the University Hospital of Hartlepool including ITU, Ward 7, EAU and Ambulatory Care	Visit General Medicine and Critical Care
11.45 am	Clinical Case for Change	Board Room University Hospital of Hartlepool
12.15 am	Discussion	
12.30 pm	WORKING NETWORKING LUNCH Trust consultants drop in	
1 pm	Meet with Local GPs and CCG Representatives	Board Room, University Hospital of Hartlepool
2pm	Meet with Representatives from Hartlepool, Durham and Stockton Overview and Scrutiny Committee	Board Room, University Hospital of Hartlepool
2.45pm	Meet with Representatives from Patient Carer Groups (LINKs, Hospital User Group)	Board Room, University Hospital of Hartlepool
3.15 pm	TRAVEL TO UNIVERSITY HOSPITAL OF NORTH TEES	
3.50 pm	Tour of facilities on the University Hospital of North Tees including EAU, Ambulatory Care, Short Stay Unit and Critical Care Unit.	Visit General Medicine and Critical Care
4.45 pm	Closing Session	Board Room, University Hospital of North Tees
5 pm	Depart the University Hospital of North Tees	

National Clinical Advisory Team - NCAT

People Met

Julie Gillon	Chief Operation Officer/Deputy Chief Executive
David Emerton	Medical Director
Lynne Hodgson	Director of Finance & Information Management
Alan Foster	Chief Executive
Sue Smith	Director of Nursing and Patient Safety
Farooq Brohi	Consultant Anaesthetist & Critical Care
Kevin Oxley	Commercial Director
Narayanan Suresh	Clinical Director Anaesthetics
Cameron Ward	Acting CE NHS Tees
	Director (Durham, Darlington & Tees) Area Team of NHS
	Commissioning Board
Ben Clark	Assistant Director (Durham, Darlington & Tees) Area Team of NHS
	Commissioning Board
Katie Dixon	Strategic Planning Manager
Nick Roper	Clinical Lead, Acute Medicine and New Hospital
Jean Macleod	Clinical Director Medicine
Linda Watson	Clinical Director of Community Services
Peter Tindall	AD Strategic Planning & Development
Boleslaw Posmyk	Chair NHS Hartlepool and Stockton-on-Tees CCG
Ali Wilson	Chief Officer NHS Hartlepool and Stockton-on-Tees CCG
Paul Williams	Locality Lead (Stockton) NHS Hartlepool and Stockton-on-Tees CCG
Mike Smith	Locality Lead (Hartlepool) NHS Hartlepool and Stockton-on-Tees CCG
Paul Pagni	GP
Nick Timlin	GP
Paddy O'Neill	GP
S Findlay	GP, CCO DDES CCG
Graeme Niven	Chief Finance Officer, NHS Hartlepool and Stockton-on-Tees CCG
Jed Hall	Vice Chair, Hartlepool Health Scrutiny Forum
Louise Wallace	Director of Public Health, Hartlepool Borough Council/PCT
Keith Fisher	HBC – Member of Health Scrutiny Forum

National Clinical Advisory Team - NCAT

G Lilley	HBC – Member of Health Scrutiny Forum
J Beall	Deputy Leader, Chair HWB Stockton Borough Council
M Javed	Chairman Health Committee Stockton Borough Council
Peter Kelly	Director of Public Health, Stockton Borough Council
Peter Meenear	Scrutiny Officer, Stockton Borough Council
Cllr Robin Todd	Chair, PWH OSC Durham County Council
Feizel Jassat	OSC Manager, Durham County Council
Chris Greaves	General Manager, Anaesthetics & Critical Care
Sue Piggott	General Manager Medicine & Emergency Care
Chris Tulloch	CD Trauma/orthopaedics
Pud Bhaskar	CD Surgery/urology

Reconfiguration proposals for emergency medical and critical care services in Hartlepool and North Tees

Draft Consultation Plan – 20th May 2013 v4

‘Providing safe and high quality emergency medical and critical care.’

Introduction

This document outlines the plan for a consultation by NHS Hartlepool and Stockton on Tees (HAST) Clinical Commissioning Group (CCG), Durham Dales, Easington and Sedgefield (DDES) CCG (the commissioners) and North Tees and Hartlepool NHS Foundation Trust on how best to ensure people have access to the safe, high quality emergency medical and critical care they need.

Emergency medical services and critical care services work together closely to support patients who become critically ill.

The consultation will ask for views on our proposal to move emergency medical and critical care services from the University Hospital of Hartlepool to the University Hospital of North Tees and seek to understand concerns about the proposed changes so as to inform next steps.

Durham Dales, Easington and Sedgefield (DDES) CCG will be involved as a partner commissioner as their population will also be affected by these proposals.

This plan follows good communications and engagement practice and focuses on what will be meaningful to stakeholders. High quality communications and engagement must underpin any formal consultation to ensure it is as fair, robust and inclusive as possible. Adherence to Public Sector Equality Duties must also be demonstrated.

The approach will take into account the need for reconfiguration proposals to meet the four Tests for reconfiguration proposals to demonstrate:

- support from commissioners;
- strengthened public and patient engagement;
- clarity on the clinical evidence base; and
- consistency with current and prospective patient choice.

Section 244 of the consolidated NHS Act 2006 (which replaced Section 7 of the Health and Social Care Act 2001) requires NHS organisations to consult relevant Overview and Scrutiny Committees on any proposals for a substantial development of the health service in the area of the local authority, or a substantial variation in the provision of services.

A substantial variation is not defined in Regulations – Section 244 applies to any proposal where there is a major change to services experienced by patients.

It is important to understand the new legal framework for making service changes and the obligations both in statute and guidance over consultation. That is because the previous statutory obligations under s.242 of the Act will continue to apply to FTs and other NHS bodies, even though for commissioners they have changed to some degree, see below.

Obligations under the NHS Act 2006 (as amended) for CCGs and FTs

The duty placed on CCGs to promote public involvement and consultation is set out in section 14Z2, which states:

14Z2 Public involvement and consultation by clinical commissioning groups

- (1) This section applies in relation to any health services which are, or are to be, provided pursuant to arrangements made by a clinical commissioning group in the exercise of its functions (“commissioning arrangements”).
- (2) The clinical commissioning group must make arrangements to secure that individuals to whom the services are being or may be provided are involved (whether by being consulted or provided with information or in other ways)—
 - (a) in the planning of the commissioning arrangements by the group,
 - (b) in the development and consideration of proposals by the group for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them, and
 - (c) in decisions of the group affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.
- (3) The clinical commissioning group must include in its constitution—
 - (a) a description of the arrangements made by it under subsection (2), and
 - (b) a statement of the principles which it will follow in implementing those arrangements.
- (4) The Board may publish guidance for clinical commissioning groups on the discharge of their functions under this section.
- (5) A clinical commissioning group must have regard to any guidance published by the Board under subsection (4).
- (6) The reference in subsection (2)(b) to the delivery of services is a reference to their delivery at the point when they are received by users.

Context

North Tees and Hartlepool NHS Foundation Trust raised concerns with NHS HAST CCG that they could not sustain required quality and safety standards of emergency medical and critical care services at the University Hospital of Hartlepool, in either the medium or long

term. The trust put forward proposals to move emergency medical and critical care services from the University Hospital of Hartlepool to the University Hospital of North Tees.

NHS HAST CCG requested a review from the National Clinical Advisory Team (NCAT) in order to test the case for change and to provide clinical assurance for proposals. A review visit was undertaken on 29th January 2013 and the formal report launched on 15th May 2013.

The independent report from NCAT supported the trust's proposals and agreed with their concerns regarding sustainability and safety. Whilst NCAT are not recommending an emergency closure in their report, they acknowledge that the changes should be made as quickly as possible to ensure that local services are safe and of the required standard.

North Tees and Hartlepool NHS Foundation Trust have appraised potential options and concluded that the proposals to move these services to the North Tees site are the only viable option. The safety issues include isolation of working and access to appropriately trained staff, and therefore cannot be resolved through a financial solution.

Therefore, the scope of the formal consultation will ask for views and concerns about the proposal and how the impact of the proposed changes could be managed and implemented. It will be critical to explain the reasons for this option, and to make available supporting information which outlines how all options were appraised and evaluated. It will also be important to explain that the point of access for patients would not change as a result of these changes.

It should be noted that that approach and methodology for the consultation is proportionate to this scope. (See Appendix 1 – Communications and Engagement Implementation Plan.)

This proposal is set against the backdrop of the momentum: pathways to healthcare programme which was established in 2008 by North Tees and Hartlepool NHS Foundation Trust and the former PCT commissioners to transform the local healthcare system. (See Appendix 3)

A significant element of this programme is the capital project to build a new hospital to serve the people of Hartlepool, Stockton and parts of Easington and Sedgefield. Whilst some interim changes to services across the two existing sites are planned via the Momentum programme, this proposed change is not one of these as it has arisen due to concerns over quality and safety which are outwith the scope of Momentum.

Formal consultation

The formal consultation period will run for a 12 week period, beginning on Monday 20th May 2013.

In terms of governance and accountability, North of England Commissioning Support (NECS) will lead the formal consultation for the commissioners and North Tees and Hartlepool NHS Foundation Trust, and is therefore responsible for its successful delivery.

Support from the provider North Tees and Hartlepool NHS Foundation Trust will be essential in ensuring that the knowledgeable clinicians on the subject are able to both support and participate in the consultation process.

NHS Hartlepool and Stockton on Tees CCG and NHS Durham Dales, Easington and Sedgefield (DDES) CCG (the commissioners) and North Tees and Hartlepool NHS Foundation Trust (the provider) will jointly lead this plan.

Affected NHS provider organisations will take responsibility for consulting with their own staff.

A Task and Finish Group will be set up to plan and monitor the delivery of the consultation process.

The commissioners and Hartlepool NHS Foundation Trust will be accountable to Health Scrutiny Committees for Stockton-on-Tees, Hartlepool and County Durham on the consultation process. Local HealthWatch organisations will contribute to this consultation by representing the interests of patients and the public and will advise on consultation materials and contribute to discussion on the consultation proposals.

Key messages have been developed to communicate the scope of the consultation and case for change effectively to patients, the public, political and wider stakeholders and the media. A range of communications and consultation mechanisms will be utilised to ensure sufficient information and involvement opportunities are available to identified stakeholders.

Mapping of and planned engagement with hard to reach and protected groups is also underway as part of the commissioners' ongoing engagement plans.

NECS will commission independent specialist consultants to receive and independently analyse the responses. Respondents to the consultation will be able to feed back by email, freepost address, telephone or via the website.

NECS will produce a report on the consultation which will cover:

- stakeholders who have been consulted;
- what information was provided to those stakeholders;
- what matters those stakeholders were consulted about;
- the result of the consultation, including a summary of the differences expressed by those consulted; and
- details of the decisions or changes made following the consultation and the influence the results of the consultation had on that decision / change.

A Communications and Engagement Implementation Plan has been developed. (Appendix1).

Stakeholders

A list of stakeholders is attached at Appendix 2.

Objectives

A programme of activity will:

- Encourage responses to and involvement in the formal consultation
- Promote the consultation via all appropriate communications channels.
- Effectively manage and co-ordinate stakeholder engagement

Channels

The following communications channels will be utilised:

- A full consultation document which includes questions seeking views on the proposals to be distributed widely across the district, available online and on request.
- Public meetings in appropriate and accessible locations across the district and at a range of times to take account of the public's preferences.
- Presentations to a wide range of groups and audiences (pro-active and on request) including OSC, Healthwatch, patient groups, voluntary and community groups etc.
- Staff briefings and meetings as required.
- Information in prime community and health settings.
- The main website will be that of NHS Hartlepool and Stockton-on-Tees CCG. It will signpost people to online information/opportunities to comment, etc. There will be a link from NHS DDES CCG and North Tees and Hartlepool NHS Foundation Trust websites.
- Media – press release and paid-for advertorials and adverts.
- Posters in a range of community venues throughout the health economy including health settings, libraries etc.
- Information distributed and shared through public partners' publications and information points.
- Feedback forms and questionnaires.

- Local foundation trust members.
- Social media will be an important part of the process but there will need to be clear and robust mechanisms for monitoring, recording and responding to messages sent via social media.
- Appropriate commissioner and NTHFT representatives will meet with Overview and Scrutiny Committees, HealthWatch and any other appropriate groups identified to discuss the consultation document, respond to questions and facilitate consultation responses.
- Internal communications mechanisms such as staff newsletter and intranets will be used to ensure information is communicated to key staff groups.
- Opportunities for hard to reach, protected and under-represented groups, and all literature will be offered in alternative languages and formats.
- Third party distribution will be used where possible for economy, to encourage better dissemination and to demonstrate independent support e.g. articles for voluntary sector and local authority magazines.
- Consultations documents will meet accessibility guidelines.
- Web and online communication will provide access to all the information quickly and easily and enable people to have their say, and will meet accessibility guidelines.

Key messages

- Proposals to move emergency medical and critical care services from the University Hospital of Hartlepool to the University Hospital of North Tees have been validated for by national clinical advisors and are fully supported by the commissioners.
- The point of access for patients will not change i.e. people will not have to do anything different once the changes are put into place because the initial call will still be to 999 or the GP.
- The proposed changes are necessary and appropriate to support improvements in clinical quality and safety. An independent report has provided independent clinical assurance that these changes will result in better services for local people.
- Transferring services from the University Hospital of Hartlepool (UHH) to the University Hospital of North Tees (UHNT) is hoped to be an interim solution. In the longer term, both hospitals will close and until the new purpose-built hospital development receives final approvals.

- Investment has already been made in community services and intermediate care and towards reducing emergency admissions, and that this remains a priority.
- Commissioners and the trust are we are still all committed to moving to the new hospital because this will mean we can provide services in a more convenient geographical location. However, we need to take this interim step now to preserve and improve quality and safety.
- Acknowledging any short-term recommendations made and that proposals will be agreed across the health economy to address these and key stakeholders, including Overview and Scrutiny Committees, will be fully involved in this.
- As a result of the changes, 97 per cent of healthcare contacts will remain in Hartlepool. In the lead up to the opening of a new Hospital at Wynyard Business Park in 2017, the University Hospital of Hartlepool will become a centre for diagnostic tests, daycase and low risk operations. There will also be an increase in the number of medical rehabilitation beds at the hospital.

Managing issues and risks

A rolling handling plan will be established at the start of the consultation and maintained by the NECS Communications and Engagement Team. This will include key lines and actions, and provide a core script with key messages, process detail, organisations' corporate lines and rebuttal messages to support all actions outlined.

It is vital that all the major partners are highly visible through this process, including clinicians from the trust. It will be important to provide adequate notice of meetings for clinicians in particular.

Appendix 1

Communications and engagement Implementation Plan

Area	Task	Who's responsible	Timescale
Stage 1 - consultation planning			
Task and Finish Group	Establish membership, agree scope and schedule meetings	MB/CY	By 3 rd May
Finalise key messages and question areas	Develop: <ul style="list-style-type: none"> Briefing paper Presentation Key messages and question areas 		
Plan access to existing communications mechanisms	<ul style="list-style-type: none"> Ensure/schedule upload to CCG and FT websites Gather all supporting documentation e.g. <ul style="list-style-type: none"> ➤ Consultation document ➤ Relevant background information e.g. Momentum, Tees Review ➤ Options appraisal evidence Prepare briefing via My NHS Distribution of information to GPs, pharmacists Prepare information – based on above – for communications teams within neighbouring NHS Trusts, local authorities, key relevant charities and groups 	SJ/CY	By 10th May
Implement communications via mechanisms	<ul style="list-style-type: none"> All consultation materials and supporting information available on CCG and FT websites Briefings and distribution above 	SJ/CY	15th May
Brief FT PALS team	<ul style="list-style-type: none"> Provide information and timetable 	CY	By 17th May By 10th May
Communications with staff	<ul style="list-style-type: none"> FT mechanisms NHS HAST CCG bulletin NECS 	CY SJ MB	By 10th May
Plan attendance at existing meetings and events	Agree schedule and attendance	T&F Group	By 10th May

Consultation planning	<ul style="list-style-type: none"> • Agree consultation timelines for: <ul style="list-style-type: none"> - Planning - Response mechanisms and handling - Questionnaire and document design and print - Advertising - Full handling of consultation meetings - Response handling, analysis and reporting 	T&F Group	By 10th May
Prepare and finalise consultation document for agreement	<ul style="list-style-type: none"> • Ensure this meets four reconfiguration tests • Source case studies 	CY – lead T&F Group	By 17th May
Agree final consultation document	<ul style="list-style-type: none"> • Agree via extraordinary NHS HAST CCG Governing Body meeting 	AW	16th May
Further consultation materials	<ul style="list-style-type: none"> • Agree range of materials based on main consultation document • Draft and agree materials • Produce materials • Agree distribution 	T&F Group	By 17th May
Map/schedule all meetings with key stakeholders	<ul style="list-style-type: none"> • Health and Wellbeing Boards • Scrutiny meetings – formal and informal 		
Public meetings - preparation	<ul style="list-style-type: none"> • Set dates • Book venues • Confirm dates for attending representatives – well in advance for clinicians • Confirm lead/chair for each • Plan advertising • Plan media i.e. ongoing releases • Prepare presentation using available resources • Prepare facilitators' recording materials • Draft and issue press release with contact details 	T&F Group	By 17 th May

Prepare access and response mechanisms	<ul style="list-style-type: none"> Source supplier of analysis Freepost Addresses 	T&F Group	By 17th May
Liaison with Scrutiny	<ul style="list-style-type: none"> Informal discussion with officers to determine formal presentation of plans Determine presentation of Consultation Plan 	SJ/CY	By 17th May
Media	<ul style="list-style-type: none"> Arrange meetings with Hartlepool Mail and Evening Gazette (re NCAT report) Issue NCAT media release to include consultation dates Draft, agree and issue consultation launch release 	SJ/CY	For 15 th May 16 th May By 17 th May
Advertising	Schedule and organise paid advertisements in local print and broadcast media	SJ	By 17th May
Stage 2 - 12 week formal consultation – from Monday 20th May to Friday 16th August 2013			
Materials	<ul style="list-style-type: none"> Commissioning production of consultation materials in alternative formats as required 	T&F Group	Ongoing – as required
Consultation document available	<ul style="list-style-type: none"> Upload document to CCG and NTHFT websites 	SJ/CY	For 9am Monday 20 th May
Send out consultation document to key stakeholders	<ul style="list-style-type: none"> Prepare covering letter and response form Identify list of stakeholders as key consultees Indicate deadline for responses Provide full list of consultees, stakeholders and contacts 	T&F Group	By 24 th May
Distribution	<ul style="list-style-type: none"> Co-ordinate distribution of consultation materials e.g. to independent contractors and community based health locations 	T&F Group	From 20th May
Media handling	<ul style="list-style-type: none"> Production and distribution of press releases Set up and maintain media handling plan 	T&F Group	From 20 th May
Public meetings	<ul style="list-style-type: none"> Organise and manage consultation meetings, Commission recording and transcribing 	SJ T&F Group	By 17 th May in sufficient time

	<ul style="list-style-type: none"> • Arrange BSL interpreting services 		h sufficient time
Other meetings	<ul style="list-style-type: none"> • Manage and record outcomes from targeted meetings/focus groups with key stakeholder groups with a vested interest in consultation 	T&F Group	Ongoing
Analysis, response handling and reporting	<ul style="list-style-type: none"> • Arrange and manage ongoing handling of postal responses • Log, collect and collate responses from web, mail, email letter and meetings (meeting summaries and notes) including a breakdown to show organisational and public responses. • Summarise and provide analysis of all of the responses received • Prepare final report - presentations, printed report in hard copy 	T&F Group / external supplier	By 17 th May
Post consultation – from 16th August 2013			
Collation of responses	<ul style="list-style-type: none"> • Liaison with supplier re completion of report 	T&F Group	19th August
Reporting	<ul style="list-style-type: none"> • Make report available on CCG website • Identify stakeholders who should receive a copy of the report directly 	T&F Group	By 30 th August
Awareness-raising of the consultation outcomes through local media	<ul style="list-style-type: none"> • Issue press release reporting on outcomes and when final report will be available 	T&F Group	By 30 th August
Communications with staff	<ul style="list-style-type: none"> • NECS • CCG • NTHFT 	MB AW CY	By 30 th August
Feedback to stakeholders	<ul style="list-style-type: none"> • Provide feedback on outcomes of consultation and related involvement and how these have been used to inform the decision 	MB – lead T&F Group	By 30 th August
Decision making	<ul style="list-style-type: none"> • Prepare full paper (with report) for Board / Governing Body • Prepare messages re implementation 	AW/MB/CY	By 30 th August

Monitoring and evaluation

The evaluation process should ensure sufficient feedback is received to:

- Help steer the content of future communications by capturing the needs of the internal and external audiences
- Ensure that information being communicated is understood by the intended audience/s
- Gauge any misunderstanding or confusion about the project.

DRAFT

Appendix 2

Appendix A: Draft Stakeholder Map

Stakeholder Group	Stakeholder	Stakeholder Prioritisation Category	Communication Method(s)	Lead contact/spokes people
Internal	Boards – North Tees and Hartlepool NHS Foundation Trust, South Tees Acute NHS Foundation Trust	Key Player	Face to face meetings	
Internal	Heads of Clinical Service	Key Player	Face to face meetings and briefings	
Internal	Senior clinical staff	Key Player	Face to face meetings and briefings	
Internal	Staff-side representatives	Active Engagement and Consultation	Face to face meetings/briefings	
Internal	Medical Staffing Committee	Active Engagement and Consultation	Meetings/briefings	
Internal	Staff affected by changes	Active Engagement and Consultation	Team and individual briefings/meetings with line managers/ Q&As/ existing internal comms tools	
Internal	All staff (including hospital volunteers)	Active Engagement and Consultation	Open staff meetings/Q&As/ existing internal comms tools	
Internal	NTH Governors			

Patients & Public (charities)	Charitable organisations and highly interested groups	Active Engagement and Consultation	Face to face meetings and briefings/engagement events and activities	
Patients & Public	General Public	Keep Informed and Consult	Public Meetings/ Media Releases/ Website/information stands/ posters/info distributed at prime settings/consultation documents	
Patients & Public	Affected Service User Groups	Active Engagement and Consultation	Meetings with identified service user groups/ Engagement events/ Focus groups/ Consultation events	
Patients & Public	GP Patient Participation Groups	Keep Informed and engaged via practices	Meetings/briefings	
Patients & Public	Local Involvement Network /Health Watch	Active Engagement and Consultation	Meetings and presentations/ongoing briefings and updates/ Consultation documents	
Patients & Public	Protected groups, voluntary and community groups, third sector	Active Engagement and Consultation	Meetings with identified groups/ Engagement events/ Focus groups/ Consultation events	
Patients & Public	Foundation Trust members	Keep Informed and Consult	Briefings	

Patients & Public	MY NHS members	Keep Informed and Consult		
Political Audiences	Ministers	Keep Informed	Briefings through Ministerial Briefing Unit (via SHA)	SHA
Political Audiences	Local MPs	Key Player	Regular briefings/letters/ meetings / phone calls on urgent issues/ Consultation Documents	
Political Audiences	Area Committees	Active Engagement and Consultation	Meetings & presentations/ regular briefings	
Political Audiences	Local Councillors	Active Engagement and Consultation	Regular correspondence updating on progress /rep to attend meeting if necessary/ Consultation Documents	
Political Audiences	Overview and Scrutiny Panels and Joint Health Scrutiny Committee	Key Player	Meetings & presentations/ regular briefings	
Media	Local and regional media	Keep Informed	Pro-active and re-active press releases and statements/ interviews / briefings/ paid-for advertorials and supplements	
Partners	PCTs and Clinical Commissioning Groups	Key Player	Meetings/ Regular briefings/ Consultation Documents/ Website	

Partners	Local Medical Committee	Active Engagement and Consultation	Meetings & presentations/ regular briefings	
GPs	GPs	Active Engagement and Consultation	Meetings & presentations/ regular briefings	
Partners	Surrounding trusts -	Keep Informed/ Active engagement where necessary	Briefings as required/ Consultation Documents	
Partners	Deanery	Keep Informed and Consult	Briefing w hen required	
Partners	PFI partners	Keep Informed	Briefing w hen required/consultati on document	
Partners	LHWP Boards	Keep Informed		
Governance & regulators	Department of Health	Keep Informed	Briefings via SHA	
Governance & regulators	Strategic Health Authority	Key Player	Meeting	
Governance & regulators	Care Quality Commission	Keep Informed	Regular Briefings/ Consultation Documents	
Governance & regulators	NCAT	Key Player	Visit	
Governance & regulators	National Reconfiguration Team	Keep Informed	Briefings	
Governance & regulators	Health Gatew ay Team	Key Player	Meetings/briefings	
Governance & regulators	Local health and Wellbeing Boards	Key Player	Meetings/briefings	

Appendix 3

momentum: pathways to healthcare

The programme was established by North Tees and Hartlepool NHS Foundation Trust and the former commissioners Stockton Teaching Primary Care Trust and Hartlepool Primary Care Trust.

The *momentum* programme has three elements:

- | | |
|----------------------|---|
| <i>Element one</i> | Transforming services – came as a result of the White Paper <i>our health, our care, our say</i> |
| <i>Element two</i> | Primary and community care capital planning project designed to create a network of enhanced and improved community facilities to support the above changes |
| <i>Element three</i> | The hospital capital planning project – building a new hospital to serve the people of Hartlepool, Stockton and parts of Easington and Sedgefield. |

A condition of the outline planning permission granted by Hartlepool Borough Council was that the community facilities and services had to be in place by the time the new hospital opens. This is to ensure that all three elements of the programme fit together and are right for the future needs of the changing population while also allowing for advances in medical and surgical care. It follows that services would be moving and transforming into the lead up to the new hospital opening to enable this condition to be met.

The hospital programme is also supported by a £10.5m transport plan to ensure the hospital is accessible to patients, visitors and staff. An accessible transport system – a section 106 agreement – was also a condition of the outline planning permission for the new hospital.

However the hospital programme has been delayed until 2017 due to the withdrawal of capital project funding approval in 2010.

Providing safe and high quality care leading up to the opening of the new hospital



Providing safe and high quality care leading up to the opening of the new hospital

A consultation on how best to ensure people have access to the safest and best quality, acute medical and critical care they need, in the lead up to the opening of the new hospital by:

Hartlepool and Stockton-on-Tees Clinical Commissioning Group

Durham, Dales, Easington and Sedgefield Clinical Commissioning Group

North Tees and Hartlepool NHS Foundation Trust

Consultation begins 20 May and ends 11 August 2013

If you require this information in another language or format please contact us on [01642 666815](tel:01642 666815)

Arabic إذا احتجت لهذه المعلومات بلغة أخرى أو تنسيق آخر، فالرجاء الاتصال بنا على [01642 666815](tel:01642 666815)

যদি আপনি এই তথ্য যে কোনো ভাষাতে বা ফর্মেটে চান তাহলে, অনুগ্রহ করে [01642 666815](tel:01642 666815) নম্বরে আমাদের সাথে যোগাযোগ করুন। Bengali

若您需要本資料的其他語言版本或格式，請與我們聯絡，電話 [01642 666815](tel:01642 666815) Cantonese

यदि आपको यह जानकारी कि सी अन्य भाषा अथवा फॉर्मेट में चाहिए तो कृपया [01642 666815](tel:01642 666815) पर हमसे सम्पर्क करें। Hindi

ਜੇ ਤੁਹਾਨੂੰ ਇਹ ਜਾਣਕਾਰੀ ਕਿਸੇ ਹੋਰ ਭਾਸ਼ਾ ਜਾਂ ਫਾਰਮੈਟ ਵਿਚ ਚਾਹੀਦੀ ਹੋਵੇ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਸਾਡੇ ਨਾਲ [01642 666815](tel:01642 666815) 'ਤੇ ਸੰਪਰਕ ਕਰੋ। Punjabi

اگر آپ کو یہ معلومات کسی دیگر زبان یا شکل میں چاہئیں تو براۓ مہربانی ہم سے [01642 666815](tel:01642 666815) پر رابطہ قائم کریں۔ Urdu

Why are we carrying out this consultation?

The commissioners' view



Dr Boleslaw Posmyk
Chair, Hartlepool and Stockton-on-Tees Clinical Commissioning Group (CCG)



Dr Paul Williams
Stockton-on-Tees locality lead, Hartlepool and Stockton-on-Tees CCG and governing body member



Dr Mike Smith
Hartlepool locality lead, Hartlepool and Stockton-on-Tees CCG



Dr Stewart Findlay
Chief clinical officer, Durham, Dales, Easington and Sedgfield Clinical Commissioning Group

We are carrying out this consultation because the doctors who provide emergency medical and critical care services at North Tees and Hartlepool NHS Foundation Trust have told us they cannot carry on providing these services safely and to the expected quality standards on two sites until the new hospital opens in 2017.

We buy these services from the hospitals for local people and we are responsible for their safety and quality. As commissioners we cannot wait until a problem arises before acting. Our job is to look forward and try to prevent problems from happening because this is in the interest of patients and everyone we serve.

We asked the National Clinical Advisory Team to visit us to listen to the doctors, nurses and managers, patient representatives, politicians and other stakeholders so they could give us an independent view of the situation and what we should do about it.

The National Clinical Advisory Team provide independent clinical expertise to support and guide the local NHS on service reconfiguration proposals to ensure safe, effective and accessible services for patients. Our team was lead by Dr Chris Clough from Kings College Hospital, London.

We now have a copy of the National Clinical Advisory Team report and this is why we are now holding this consultation.

The report said we should:

- ‡ work with the trust to centralise emergency medical services and critical care to the University Hospital of North Tees as soon as possible
- ‡ explain to the public what this means for them, which is why we are including a number of examples later in this document
- ‡ ask their views about the things that they are concerned about, especially how they and their relatives get to hospital

The provider's view



Dr Suresh Narayanan
clinical director for
anaesthetics and
critical care

Dr Jean MacLeod
clinical director for
medicine

North Tees and Hartlepool NHS Foundation Trust

As the doctors who lead medicine and critical care in the trust, we are becoming increasingly concerned about our ability to provide safe services across our two hospital sites until the new hospital opens.

We are passionate about providing the safest, highest quality care possible and to meeting or exceeding the standards expected by the Department of Health, professional organisations, the deanery (which is responsible for organising the training of tomorrow's doctors) and most of all our patients.

While our services are safe and good quality today we want to ensure they will continue to be in the years to come. We want to ensure we can continue to provide excellent care for all our patients in the short, medium and long term – the type of care we would want for ourselves and our loved ones – but when our medical and nursing colleagues tell us they are concerned, then we have to act.

We raised these concerns at the highest level in the trust and, quite correctly, the trust raised these concerns with our commissioners who buy this care from our trust.

Together, as commissioners and provider, we are totally committed to ensuring that patients from the area we serve – Hartlepool, Stockton and parts of Easington and Sedgefield – can rely on the same standard of service regardless of where they live.

Had the new hospital opened its doors in 2014 as originally planned then we would have been bringing medical and nursing teams together now to be ready for the move to the new hospital. As things stand the new hospital is now expected to open in 2017 and we know things cannot stay as they are until then because:

- ‡ quite rightly, safety and quality standards continue to rise, but it is becoming increasingly difficult for us to keep pace with these requirements on two sites
- ‡ the way junior doctors are trained has changed and the deanery will not allow trainees to work in hospitals where they do not see enough patients to increase their learning and skills
- ‡ like the rest of the NHS we need to bring services together to ensure we can achieve the same standards of care for everyone living in the area served by our trust

Already, because of advances in medicine many patients from our area already go past their local hospital for their emergency medical care. For example:

- ‡ patients who have had a stroke are all taken to the University Hospital of North Tees where we can offer the latest treatments seven days a week, 365 days a year. We used to provide these services seven days a week at the University Hospital of North Tees but were only able to provide them Monday to Friday, 9am until 5pm, at the University Hospital of Hartlepool which was unfair on people from Hartlepool and Easington because strokes don't just happen in working hours. Because we have brought the skilled doctors who can carry out these treatments together we can now provide these services for everyone we serve.
- ‡ patients who have had certain types of heart attack are assessed at the scene and taken to The James Cook University Hospital in Middlesbrough to have the affected artery unblocked.

Both of these advances in medicine give patients a better chance of survival and recovery. As doctors we want local people to have access to the very best care available. This does mean this care cannot always be on the doorstep but in the modern NHS we have to accept that, while we can have most of our straightforward care provided locally, we have to travel for more specialist care.

It's also important to remember that most of the care provided by the health service is already provided in GP surgeries, local clinics and in people's homes and, under the *momentum: pathways to healthcare* programme, this will continue. We are beginning to take advantage of new technologies like telehealth where people can monitor their own health at home supported by a highly skilled team of community nurses. We already have many excellent examples of where this is working well and preventing people from having to be admitted to hospital. Medicine is advancing all of the time and we want to ensure we can offer the latest and best services and technologies to local people.

We are working closely with our commissioners because they, as the people who buy your care, and we, as the people who provide your care, have the same aim; that is to make sure your care is of the very best standard, wherever you live in the area we serve.

The important thing for you to know is, once the changes have been made, you do not need to do anything different. If you are unwell you will either contact your doctor or ring 999, just as you would today. Ambulance paramedics will assess you when they arrive and, if appropriate, begin treating you. They will make sure you get to the right place and to the right experts for any further treatment and care you need.

This is why we are joining Hartlepool and Stockton-on-Tees Clinical Commissioning Group and Durham, Dales, Easington and Sedgefield Clinical Commissioning Group to explain why things need to change but also to listen to any concerns you may have so we can address them.

How did we get to where we are now?

In 2008 what were then Hartlepool Primary Care Trust and North Tees Primary Care Trust and North Tees and Hartlepool NHS Foundation Trust began the *momentum: pathways to healthcare* programme.

The programme came about because the then Secretary of State for Health carried out a large national public consultation to ask people how they would like health care to be in the future. The results of this large national consultation became the White Paper *Our health, our care, our say*

People said they wanted:

- ‡ to be kept fit and healthy and for the health service to step in early if people start to become ill
- ‡ care given close to or in their own homes
- ‡ a health service that fits in with their lives, not the needs of the health service
- ‡ only to go to hospital if they couldn't be looked after nearer home or at home

There were other reasons too:

- ‡ people are, fortunately, living longer but they are often living with a number of health problems and the local health service has to change the way it works to ensure it can provide the type of care local people need
- ‡ the doctors, nurses and other health professionals want to continually improve care and that means they have to change the way they work to do this by:
 - making waiting times shorter
 - providing more services in GP practices and town centre clinics
 - making services safer
 - working in increasingly specialised teams to make the best use of their skills and resources
- ‡ the way doctors are trained has changed and the organisation responsible for training will only send their doctors to work and train in areas where they will get the right experience to improve their skills

The *momentum: pathways to healthcare* programme is made up of three things:

- ‡ changing and transforming the way the local health service works to provide better, safer care for patients
- ‡ providing a network of community and town centre facilities
- ‡ building a new hospital to replace the University Hospital of Hartlepool and the University Hospital of North Tees

The new hospital

The new hospital is the final piece of the *momentum* jigsaw



The government offered public funding for the new hospital in March 2010. However the new government withdrew this funding in June 2010. The government said it realised there was a need to build the new hospital but the organisations who buy services on behalf of local people and the trust needed to find a different way to pay for it.

This means that, instead of the new hospital being open in 2014 as planned, it is now expected to open in 2017.

Doctors providing emergency medical and critical care at North Tees and Hartlepool NHS Foundation Trust told the commissioners that, while they could have made arrangements to keep the two hospitals' emergency medical wards and critical care open until 2014, they simply cannot do this until 2017. They said they want to take the interim step of centralising emergency medical wards and critical care at the University Hospital of North Tees until the new hospital opens to keep services to the high standards we all want and expect.

As commissioners and providers of care our main concern is safety and quality and we are becoming increasingly uncomfortable with the current situation because we know the services in the two hospitals are increasingly unequal. This is making it impossible to provide the levels of safety and quality we would all want in the longer term

We are doing our very best to minimise these inequalities but, because of the increasingly high standards of care required, this is becoming a major challenge and we all know we cannot keep providing the type of care patients deserve with things the way they are.

This is because:

- ‡ it is becoming more and more difficult to staff medical rotas on two sites
- ‡ the standards of care required are, quite rightly, rising continuously



What we are proposing to do

After much discussion with health professionals, a review of alternative options and receiving the report from the independent National Clinical Advisory Team, which agreed with us that there are no viable safe alternatives, we are now proposing to centralise emergency medical and critical care services at the University Hospital of North Tees from October 2013.

Bringing these services together would affect some other services such as other parts of the medical directorate, pathology, radiology, pharmacy and other support services such as facilities and catering. It would mean that patients with lots of medical problems will not be able to have planned operations like hip replacements at the University Hospital of Hartlepool but we do not expect this would affect very many patients because modern anaesthetics are safer. We want to ensure that most health care in Hartlepool continues to take place locally so we will be looking at ways to provide more low-risk operations and other treatments in the University Hospital of Hartlepool for local people. However we always have to assess if this will be safe and it will be for that reason and that reason alone, that we would transfer high risk planned operations to the University Hospital of North Tees.

We know this proposal will worry and disappoint some people but as the organisations which are responsible for your services we cannot allow this situation to go on any longer and we know these changes should be made.

How it will work

Leading up to the proposed changes we would:

- ‡ open 120 beds at the University Hospital of North Tees to make sure we have enough beds and staff to look after patients from right across our area;
- ‡ make extra space in critical care so we can look after critically ill patients;
- ‡ we would then, gradually, close the beds in medicine and critical care at the University Hospital of Hartlepool and;
- ‡ transfer a number of staff from support services such as pharmacy, radiology and pharmacy and estates who need to come to the University Hospital of North Tees to support the new arrangements.

Patient stories

The National Clinical Advisory Team said we should set out how things would work in future if these proposals are implemented.

Here are some examples

Elsie's story

Elsie, 75, from Greatham is feeling unwell. She has had heart problems for a while but today she feels very short of breath, her daughter is worried about her and phones her GP. The GP calls at the house and decides Elsie needs to be in hospital. The GP tells the hospital he would like Elsie brought in during the next two hours. The ambulance arrives and takes Elsie to the emergency assessment unit at the University Hospital of North Tees where she is assessed by the doctor in charge. The doctors diagnosed an irregular heart beat and start Elsie on drugs to treat it. She is also put on a heart monitor and observed by nurses for the next 24 hours. The doctor says Elsie can go home and her daughter comes to collect her. The nurses make Elsie an appointment to see the heart specialist in outpatients at the University Hospital of Hartlepool the following week.

George's story

George, 80, from Hartlepool, has a painful swollen leg. He is worried about this and phones 999. The ambulance takes him to the ambulatory care unit which is part of the emergency assessment unit at the University Hospital of North Tees. He is diagnosed with a deep vein thrombosis. While in the ambulatory care unit he is started on blood thinning drugs. A specialist nurse explains to George that he will have to take the drugs for several weeks. The doctor says George can go home. A nurse arranges for George to be taken home by ambulance. The district nurse visits George at home to see how he is doing until he is fully recovered.

Jason's story

Jason, 45, from Easington, has diabetes and had a fluttering feeling in his chest and was dizzy. He thought he was going to faint so he called 999. The ambulance paramedic carried out an ECG (a heart test) at Jason's house. The ECG showed that Jason wasn't having a heart attack but he did need medical attention so the ambulance brought him to the emergency assessment unit at the University Hospital of North Tees. Jason was put on heart monitoring equipment and was given drugs to stabilise his abnormal heart beat. The doctor said Jason could go home once he was stabilised on the treatment but he needed to see a heart specialist to get to the bottom of the problem so an appointment was made for him to see a heart specialist at the University Hospital of Hartlepool the following week.

John's story

John, 75, has diabetes. He was feeling ill because his diabetes was out of control and he phoned 999. The ambulance paramedic assessed him at home and then he was brought to the University Hospital of North Tees. A doctor specialising in diabetes was able to see him straightaway and he was given the appropriate drugs to stabilise his diabetes. He stayed in overnight for observation and was allowed home the next day. He saw the diabetes specialist in outpatients the following week to ensure his diabetes was stable.

Mary's story

Mary, 70, is taken ill and her son phones 999. The ambulance takes Mary to the University Hospital of North Tees where she is diagnosed with pneumonia. Mary becomes worse and she has to be transferred to critical care for intensive medical support. After two days Mary is improving and she is transferred back to the ward. After three days Mary is allowed to go home with support from the community team who give her intravenous (a drip) antibiotics every day for the next 10 days until she has fully recovered.

Sharon's story

Sharon, 47, from the Fens, Hartlepool, noticed her leg was red and sore. She also felt feverish. She went to her GP who said she needed to be seen by a hospital doctor. Her husband took her to the ambulatory care unit at the University Hospital of North Tees, part of the emergency assessment unit. A doctor assessed Sharon's leg and the soft tissue infection was diagnosed as cellulitis. She was started off on a drip of antibiotics while in the ambulatory care unit and after further observations she was allowed home four hours later. The unit arranged for the rapid response nurses to go to Sharon's home to give her intravenous antibiotics each day. Three days later she came back to the ambulatory care unit to see the doctor who was happy with how the soft tissue infection was clearing up. He recommended intravenous antibiotics until the end of the week and the rapid response team came to Sharon's house daily to give the treatment until the infection cleared up. This saved Sharon and her husband several trips to hospital.

Betty's story

Betty, 90, from Easington, was confused and unable to get out of bed and her son called the GP. The GP thought Betty should be in hospital and asked for her to be admitted in the next two hours. The ambulance brought Betty to the emergency assessment unit at the University Hospital of North Tees where she was assessed by doctors. Betty had a urine infection which was making her confused so doctors started her on antibiotics. Doctors arranged for Betty to be transferred to the step down ward at the University Hospital of Hartlepool in a ward staffed by highly skilled nurses and therapists. It was becoming clear that Betty was having difficulty managing in her own home and discussions began so Betty could move to a home specially set up to meet her needs. Her family were pleased that they could visit her easily in the two weeks she stayed in hospital.

Transport

When the new hospital is built

Looking on a map, the new hospital (signified by the red dot) is centrally located in the area we serve. At the moment it is a green-field site on what we know is a very busy junction off the A19/A689. But the plans for the new hospital are supported by a comprehensive public and private transport plan and we are committed to ensure the new hospital is easily accessible for all.



As things are now

We know people may not find it easy to get to the University Hospital of North Tees for emergency care or to the University Hospital of Hartlepool for a planned operation. We know it can be difficult for people to visit their loved ones.

North Tees and Hartlepool NHS Foundation Trust's council of governors has a transport committee which is already working on improving transport for patients, visitors and staff.

So far the trust has:

- ‡ set up joint working with Hartlepool Borough Council to improve transport
- ‡ recruited a team of volunteer drivers to help people with transport problems to access hospital services
- ‡ ordered two 17-seater buses so it can increase the cross-site shuttle bus service

Please tell us about your concerns and if there's anything else we could be doing so we can try to address them.

Publishing the report

On 15 May we shared the report of the National Clinical Advisory Team with all the people the independent experts met when they visited the area in January.

At that meeting we listened to the questions and comments and we have added them to this document so we can ensure that we address all of these issues.

- ‡ People were disappointed that services could not stay in two separate sites and the doctors explained why this was the case. They also explained that they had done many things to try and preserve services on two sites but that was becoming increasingly difficult to do.
- ‡ The main concern was transport and people told us that it was very difficult for people to get to the University Hospital of Hartlepool from Stockton and to the University Hospital of North Tees from Hartlepool and Easington, especially by public transport. There were issues about the ambulance patient transport service which does not start until 8.30am. This is a problem for people who have early appointments and makes it impossible for people to get to hospital on time when they are already worried and distressed about their treatment. We promise we will look into this urgently.
- ‡ People wanted to know if we would scrap the plans if the public consultation resulted in local people being unhappy about the changes. We said we were going into the consultation with an open mind and we were not prepared to say what we would do until we had heard everyone's views at the end of the consultation.
- ‡ People thought we didn't try hard enough to put things right in Hartlepool. We explained that we had done as much as we possibly could to put things right and we were left with no option but to centralise services to keep them safe for the future.
- ‡ People thought the North Tees and Hartlepool NHS Foundation Trust paid different rates of pay and gave shorter contracts to doctors working at the University Hospital of Hartlepool. This is not true. All doctors working at the trust have a trust-wide contract and are expected to work at either hospital.
- ‡ People thought the people of Hartlepool were being let down. The doctors explained that they would be letting people down if they allowed the current situation to continue.
- ‡ People thought that no more joint replacements would be done at the University Hospital of Hartlepool. This is not correct. The trust's doctors explained that they intend to continue carrying out joint replacement at the University Hospital of Hartlepool with the only exception being where patients had many medical problems because those patients need the back up of critical care so the operation can be carried out safely.
- ‡ People thought that the people of Stockton might suffer if all of the services were brought together. The trust's doctors said things would actually improve for everyone if the services were brought together.
- ‡ People thought the consultation is a done deal. The clinical commissioning group explained that, while they believe the changes need to go ahead, they do want to listen to people's views.
- ‡ People thought the National Clinical Advisory Team were the hatchet men. The National Clinical Advisory Team is a team of independent medical experts who do not know the organisations and who come in, look at the evidence in front of them and speak to doctors, nurses, managers, patient representatives, politicians and other stakeholders. No health organisation can persuade the National Clinical Action Team to say anything it doesn't want to say.

What this consultation is about

We want to get your views on our proposals and understand your concerns about the proposed changes and we would particularly like you to answer the following questions for us:

1. What do you think are the advantages and the difficulties (or disadvantages) of the proposed changes?
2. If you still have concerns, what are you most concerned about and how could we help to reduce your concerns?
3. What do you think are the main things we need to consider in putting the proposed changes in place?
4. Is there anything else you think we need to think about?

We know for example that people could be concerned about how they get to the hospital to visit their loved ones. We promise we will listen to these concerns and we will work with the local authorities and others to do whatever we can to help.

Please use the time in the 12 weeks of the consultation to tell us your views. You can do this by:

Writing us an email and send it to: communications@tees.nhs.uk or,

Writing to:

Hartlepool and Stockton-on-Tees CCG
FREEPOST NEA9906
Middlesbrough
TS2 1BR

or by coming to one of the meetings we have organised, see the website at:

www.hartlepoolandstocktonccg.nhs.uk for more details

