IRP

Independent Reconfiguration Panel

ADVICE ON PROPOSALS FOR CHANGES TO THE CARDIAC MONITORING UNIT AND ACUTE MEDICAL SERVICES AT BRIDLINGTON & DISTRICT HOSPITAL

Submitted to the Secretary of State for Health

31 July 2008

IRP

Independent Reconfiguration Panel

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RECOMMENDATIONS

1. **All medical emergency admissions, including those to the Cardiac Monitoring Unit, should transfer from Bridlington to Scarborough Hospital as proposed by the Scarborough and North East Yorkshire Trust (SNEYHT). This transfer should take place as soon as the facilities and staff are in place to handle the extra inpatients at Scarborough.**

2. **The Urgent Access Clinics that have been developed at Bridlington must continue and the arrangements for a 24/7 combined Minor Injuries and Out-of-Hours Service must be agreed between the East Riding of Yorkshire Primary Care Trust (ERYPCT) and the SNEYHT without further delay.**

3. **A detailed implementation programme, including for transport, must be finalised and actioned by the Trust as soon as possible. It is essential that sufficient capacity is made available at Scarborough and that the ambulance service is ready to meet the extra demands which will be made on it. This includes sufficient staff to carry out thrombolysis whenever appropriate. In view of the extensive managerial changes which have taken place in the Trust over the last six months, the North Yorkshire and York Primary Care Trust (NYYPCT), ERYPCT and the Yorkshire and the Humber Strategic Health Authority (SHA) should closely monitor the programme.**

4. **SNEYHT must develop a clear communication plan and involve staff in both hospitals and the public fully in the changes.**

5. **Public confidence will only be rebuilt when it is clear that the PCTs and the SNEYHT are committed to ensuring maximum local access to services and delivering on their commitments. It is therefore essential that proposed new developments at Bridlington are confirmed and then quickly put in place. A decision is urgently needed about how diagnostic facilities at Bridlington can be strengthened.**

RECOMMENDATIONS

6. **The PCTs and the SNEYHT must move quickly to determine the future role of Bridlington & District Hospital as part of their service strategy for this part of Yorkshire. Staff and the local community need to be fully involved in this process.**

7. **SNEYHT must improve the clinical integration between Scarborough and Bridlington. It should also encourage and strengthen its clinical links with neighbouring larger acute Trusts.**

OUR REMIT

What was asked of us

1.1 The Independent Reconfiguration Panel's (IRP) general terms of reference are included in Appendix One.

1.2 On 15 April 2008, Sue Lockwood, Director of Corporate Resources at East Riding of Yorkshire County Council, wrote to the Secretary of State for Health, the Rt Hon Alan Johnson MP, on behalf of the Scrutiny of Health Committees of East Riding of Yorkshire Council and North Yorkshire County Council, using powers of referral under the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002. The referral was about proposed changes to the Cardiac Monitoring Unit (CMU) and Acute Medical Services at Bridlington & District Hospital. These proposals had been set out in a consultation document, *A Future Role for Bridlington Hospital,* by Scarborough and North East Yorkshire Hospitals NHS Trust in December 2006.

1.3 The Secretary of State for Health wrote to the IRP on 29 April 2008 asking for advice on the referral. The IRP undertook an initial assessment of the facts presented and replied on 20 May 2008 advising the Secretary of State that a full review was appropriate in this case. Terms of Reference for the review were set out in the Secretary of State's letter to Dr Peter Barrett, Chair of the IRP, on 22 May 2008. Copies of the correspondence are included at Appendices Two to Four.

1.4 The Panel was asked to advise:

a) Whether it is of the opinion that the proposals for the future role of Bridlington Hospital including acute medical and cardiac admissions will ensure the provision of safe, accessible and sustainable services for local people and, if not, why not;

b) On any other observations the Panel may wish to make in relation to the proposals;

c) On how to proceed in the interests of local people, in the light of a) and b) above and taking into account the issues raised by the Joint Scrutiny of Health

Committees of East Riding of Yorkshire Council and North Yorkshire County Council in their referral letter of 15 April 2008

It is understood that in formulating its advice the Panel will pay due regard to the principles set out in the IRP's general terms of reference.

OUR PROCESS

How we approached the task

2.1 The NHS Yorkshire and the Humber Strategic Health Authority (SHA) was asked to provide the Panel with relevant documentation and to arrange site visits, meetings and interviews with interested parties. The SHA, together with the relevant PCTs and NHS Trusts, completed the Panel's standard information template. This can be accessed through the IRP website (www.irpanel.org.uk).

2.2 The Joint Scrutiny of Health Committee of East Riding of Yorkshire Council and North Yorkshire County Council (Joint HOSC) was also invited to submit documentation and suggest other parties to be included in meetings and interviews.

2.3 The IRP Chair, Dr Peter Barrett, wrote an open letter to editors of local newspapers on 3 June 2008 informing them of the IRP's involvement (see Appendix Five). The letter invited people, particularly those who had new evidence to offer or who felt that their views had not been heard adequately during the formal consultation process, to contact the Panel.

2.4 A sub group of the full IRP carried out the review. It consisted of four Panel members - Gina Tiller, who chaired the group, Brenda Howard, Nick Naftalin and Linda Pepper. They made four visits to Bridlington, reviewing the medical facilities and Cardiac Monitoring Unit at the Hospital and taking oral evidence. Panel Secretariat staff accompanied members on visits. Details of the people seen on these visits are included in Appendix Six.

2.5 Dr Peter Barrett visited Bridlington & District Hospital on 11 June 2008 and joined the formal evidence sessions.

2.6 Greg Knight MP (East Yorkshire) gave written evidence to the Panel.

2.7 A list of all the written evidence received – from the SHA, PCTs, NHS Trusts, Joint HOSC, individual scrutiny committees, MPs and all other interested parties is contained in Appendix Seven. The Panel considers that the documentation received, together with the information obtained in evidence sessions, provides a fair representation of the views from all perspectives.

2.8 Throughout our consideration of these proposals, the IRP's aim has been to consider the needs of patients, public and staff taking into account the issues of safety, sustainability and accessibility as set out in our terms of reference.

2.9 The Panel wishes to record its thanks to all those who contributed to this process. We also wish to thank all those who gave up their valuable time to present evidence to the Panel and to everyone who contacted us offering views.

2.10 The advice contained in this report represents the unanimous views of the Chair and members of the IRP.

THE CONTEXT

A brief overview

The locality

3.1 Scarborough and North East Yorkshire Hospitals NHS Trust (SNEYHT) provides acute healthcare to a community of 220,000 people across an area of about 1,600 square miles.

3.2 The Trust serves one of the largest geographical areas of all acute Trusts in England. The overall population density is about one fifth of the national average. However, in the summer months visitors greatly increase - we were told perhaps as much as double - the population.

3.3 The main towns in the area are Scarborough (population around 50,000), Bridlington (32,000) and Whitby (13,500), all on the coast; but much of the population lives in smaller towns or in rural communities. Bridlington together with its hinterland has a population of about 60,000.

3.4 Bridlington is 19 miles from Scarborough to the north and 32 miles from Hull to the south, the two nearest places with district general hospitals. It is directly linked to both by rail - about 40 minutes travel time to either, with trains every 40 minutes to Hull but only every 80 minutes to Scarborough. Otherwise, the area is dependent on buses, taxis and private cars for transport. Roads are relatively slow - there are no motorway links and few dual carriageways and many routes wind through uplands. Journey times may be lengthened by holiday traffic in summer and poor weather in winter. The map on the next page shows the local geography.

3.5 The socio-economic profile of the district is mixed but Bridlington suffers some notable deprivation, especially in the south of the town. Average household income is well below the average for east Yorkshire and for England generally, and unemployment is well above average. Tourism dominates the local economy and is estimated to provide one third of all jobs, more than 50 per cent of which are part-time (Great Britain: 32 per cent); many are seasonal. About 35 per cent of people

over retirement age in Bridlington receive pension credit compared with 23 per cent nationally.

3.6 Bridlington is popular as a retirement destination with more than a quarter of residents over 60 (and almost 40 per cent in the north of the town) compared with about 21 per cent nationally; by contrast the number of adults under 40 is well below average.

3.7 Health indicators are generally poor - smoking and obesity are well above the national and East Riding averages, teenage pregnancies rates are high (in the second quintile nationally) and 12 per cent of people of working age receive incapacity benefit.

Service provision

3.8 The SNEYHT provides services from two principal hospital sites:

- Scarborough Hospital, a 350-bed district general hospital with a 24-hour A&E, supported by ITU/CCU facilities, a full range of diagnostic services and 24-hour surgical and anaesthetic cover
- Bridlington & District Hospital, which provides inpatient cardiac monitoring and acute medical care, some day surgery, a midwife-led maternity unit and a range of out patient services, including a minor injuries unit

3.9 The Trust also provides outpatient services, some minor day case surgery and maternity services at Malton and Whitby community hospitals.

3.10 The SNEYHT was formed in 2002 and has had to overcome a range of financial and performance challenges. It is a relatively small Trust (income £108m for 2008/09) serving a widely dispersed population. In 2006/7, the Trust handled about 68,000 A&E attendances, 17,500 non-elective episodes and 19,000 elective episodes. The Trust broke even in 2007/8, following a deficit of £7.2m the previous year; it had an accumulated deficit of £20.7m in March 2007 which is expected to be resolved in the next few years.

3.11 Bridlington is in the area covered by East Riding of Yorkshire PCT and about 80 per cent of the activity of the Hospital relates to east Yorkshire residents. However, only a quarter of SNEYHT income comes from ERYPCT. Its principal commissioner, North Yorkshire & York PCT (NYYPCT), was created in 2006 (amalgamating Craven, Harrogate and Rural District PCT; Scarborough, Whitby and Ryedale PCT; Selby and York PCT; and Hambleton and Richmondshire PCT). Both PCTs have also faced financial difficulties.

3.12 The SNEYHT's 2006/7 Healthcare Commission assessment was:

- Use of Resources: weak
- Quality of Services: weak.

The Trust's acute services have NHS Litigation Authority (NHSLA) Level 1 accreditation.

INFORMATION

What we found

4.1 A large amount of written and oral evidence was submitted to the Panel. We are grateful to all those who took the time to offer their views and information. The evidence put to us is summarised below - firstly general background information followed by an outline of the proposals, the reasons for referral by the East Riding and North Yorkshire Joint HOSC, issues raised by others and finally other evidence gathered.

Bridlington & District Hospital

4.2 Bridlington & District Hospital (BDH) is about 20 years old and was built as part of a rationalisation of small hospital units in Bridlington itself and other local centres such as Driffield, 11 miles to the south west. The building itself is in good condition, indeed much better than some of the facilities at Scarborough Hospital. BDH is not a district general hospital and does not have an A&E department and associated critical care services.

4.3 The Hospital has 79 beds across consultant-led wards for acute medicine, a nurse-led intermediate care ward, a day case/short stay ward, a cardiac monitoring unit (CMU) and a maternity unit. A further 29-bed medical ward has recently been closed but is expected to reopen shortly. There are two theatres for day case surgery with associated recovery facilities, used for a range of procedures in orthopaedics, gynaecology, urology, maxillo-facial and general surgery. Outpatient clinics are held for many specialties. A nurse-led Minor Injuries Unit (MIU) operates from 9am to 9pm each day. (Following a separate consultation, the Secretary of State for Health decided on 21 July 2008 that intrapartum care at BDH, Malton and Whitby should be discontinued once the new MLU at Scarborough is fully operational.)

4.4 Currently there are about 3,150 medical admissions each year. The number has fallen by 10 per cent over the last five years. About half are new acute admissions, the rest ‘step down’ admissions, mostly from Scarborough. Admissions increase slightly (7 per cent in 2007) at the height of the holiday season.

4.5 The Hospital has ultrasound and x-ray and some blood testing facilities (available during the day, Monday to Friday) and is equipped for cardiac monitoring; endoscopy is conducted in the day case unit. There is no pathology laboratory or CT scanner.

4.6 Some acute services have been withdrawn over the years. Until 2001 a range of general surgery was carried out at the Hospital, supported by 24-hour anaesthetic cover. More recently, tighter protocols have also reduced urgent medical admissions, so that patients with suspected acute strokes or with gastro-intestinal bleeding are now taken to Scarborough or Hull; so generally are severe diabetes cases, though there is currently no formal protocol covering this.

4.7 Four consultants are based at BDH - permanent appointees in cardiology and respiratory medicine together with two locums. There are currently seven fixed term special training appointment (FTSTA) and foundation year 2 (FY2) junior doctor posts, though these are being withdrawn by the medical schools from August 2008. Recruitment is taking place for middle-grade doctors to replace these training posts.

4.8 Urgent admissions to the Hospital may come from GP referral, the ambulance service or very occasionally the MIU. A consultant-led Urgent Access Clinic (UAC) has recently been established as a reference point for referrals.

Proposals and Consultation

4.9 In November 2006, the SNEYHT published a '*Discussion Document on a future role for Bridlington Hospital'*. This acknowledged that *'A number of clinical reviews of local hospitals have been undertaken over the last five years. The conclusions of those reviews have either not been implemented, or the conclusion was that there was no single action or simple fix; the issues were too complex'*. It then set out the intention of the Trust to proceed with a formal public consultation on specific proposals for future services at Bridlington.

4.10 The Discussion Document, which had been preceded by informal work with staff and some external stakeholders, described a range of factors which were determining the need for change. These included:

- The government White Paper *Our health, our care, our say*, published in January 2006, which emphasised the opportunity and need for health care to be provided at home and at places in local communities wherever possible.
- The development by East Riding of Yorkshire PCT of ideas for developing community-based services which would directly involve the catchment area of, and services at, the Hospital. The ERYPCT published its own discussion document, *A new start for community health services*, in November 2006. Two of the options this described involved developing Bridlington as a 'level 2' community hospital - a major focal point for a wide range of non-acute services.
- Changes in clinical practice which had greatly reduced the length of hospital stay (and in many cases made it unnecessary).
- Changing demands on health services, especially from the ageing of the population, which increased the incidence of chronic conditions and the number of dependent older people for whom effective support required integrated intermediate health and social care services.

4.11 The discussion document outlined a number of possible developments in services at BDH but was less specific about acute services, proposing to "*Review the range of acute medical services provided . . . to ensure services are safe, sustainable and affordable . . . It is envisaged that there will be a broad range of acute medical services provided on the Bridlington hospital site. In common with almost every hospital in England, the number of beds on the site may reduce. The number of hospital beds does not equate to the quality of care patients receive"*.

4.12 In December 2006, SNEYHT published its formal consultation document *A future role for Bridlington Hospital* and launched a three-month public consultation from 21 December 2006 to 18 March 2007. This confirmed the background issues set out in the discussion document but also emphasised:

- The impact of changes in **clinical staffing requirements**, including both greater specialisation (which increases the numbers of doctors needed for 24-hour cover and relies on a greater throughput of patients in each specialty to maintain skills and experience) and the need to implement the European Working Time Directive from 2009.
- The implications of the **report of the Royal College of Physicians** on *Isolated Acute Medical Service* (July 2002). This recommended that hospitals like Bridlington without acute general surgery, A&E, resident anaesthetic cover, and an intensive care unit should take only 'step down' patients - those whose diagnosis has been confirmed in a district general hospital, whose condition has been stabilised, and for whom a medical care plan has been made.
- The importance of obtaining **value for money**, especially where services were duplicated on two or more sites.

4.13 The Trust proposed, and invited comments on, four options for acute medical services at Bridlington:

1. No change
2. Transfer all acute medical wards (including the Cardiac Monitoring Unit) away from the Hospital (to Scarborough Hospital)
3. Restrict acute medical admissions to 9am to 9pm
4. Restrict acute medical admissions to 9am to 9pm but without the Cardiac Monitoring Unit.

4.14 The Consultation Document outlined the objectives of the ERYPCT, set out in a parallel consultation, to enhance the range of diagnostic facilities, community-based health services and home based treatment and support to improve care for chronic conditions (accounting for 80 per cent of GP appointments). These developments were expected to reduce the need for some hospital admissions and move many hospital outpatient consultations from major hospitals to other locations. Possible additions to services at Bridlington included: integrating the MIU with the out-of-hours GP service to provide effective 24-hour cover; extended diagnostic services and consultant sessions for more specialties; more day-case surgery; and specialist day treatments, for example chemotherapy and kidney dialysis.

4.15 The SNEYHT Board discussed the proposals for Bridlington on 3 April 2007 and agreed to postpone a decision on acute medical care and the cardiac monitoring unit until June 2007. This in part recognised that there had been inadequate time to prepare a full assessment of the public consultation (which ended two weeks before the Board meeting) but was also to allow opportunity for the Trust to commission an external clinical review of these services. However, the Board did approve:

- The development of an integrated minor injuries service (bringing together the Hospital MIU and the GPs' Out of Hours arrangements). This would take two to three years to put in place but as a first step the MIU would restore 24 hour cover.
- Increasing the range of day case surgery; laparoscopy was specifically identified.

4.16 On 16 May 2007 Sir George Alberti, the National Director for Emergency Access, visited the Hospital and met the Trust management team and then separately with the consultants. His report concluded that: *"It is obvious that changes in acute medical services at Bridlington are vital on the grounds of safety and quality. The current physicians have done an excellent job but the position is not sustainable"*. He recommended that acute admissions should end, that all coronary care should be based in Scarborough, that a consultant-led urgent access clinic for medical patients should be held at Bridlington & District Hospital every morning for at least six days each week and the establishment of a multi-disciplinary older people's assessment unit.

4.17 At the Trust Board meeting on 26 June 2007 Professor Alberti's recommendations were reported together with the concern of the Yorkshire School of Postgraduate Medicine (the 'Deanery') about the acceptability of continuing the training of junior doctors at Bridlington. The Deanery suggested that they could be willing to support continued training experience there for posts based in Scarborough if Professor Alberti's recommendations were adopted.

4.18 At this meeting, the Trust Board also received a summary of the responses to the consultation. During the three months there had been four meetings with Scrutiny of Health Committees, one with the PPI Forum and two open public meetings. There were just under 100 replies to the consultation questionnaire. More than three quarters preferred the Trust's Option 1 (no change), but half agreed that there might be variations on the four options which should be considered. The consultation identified particularly strong feeling from the local community and Bridlington clinicians that the CMU should stay in Bridlington; concern that transport must be improved if more patients and their visitors had to go to Scarborough; and general anxiety that Bridlington Hospital was gradually being run down and might eventually close altogether.

4.19 A principal concern for the Joint HOSC was that the Yorkshire Ambulance Service (YAS) had neither the vehicles nor enough appropriately trained staff to provide a fast and reliable service for the greater number of patients who would need urgent transfer to Scarborough if acute medical admissions and the CMU were moved from Bridlington.

4.20 The Board agreed that further work should be done on the best configuration of services and on implementation planning, including costings.

4.21 At the Trust Board meeting on 11 September 2007 the Chief Executive reported that Professor Alberti had met representatives of the Health Scrutiny Committees and the Pensioners Action Group for the East Riding (PAGER) and held discussions with Professor Boyle (the National Director for Heart Disease and Stroke). Agreement had been reached with clinicians to increase day case surgery at Bridlington. The Board agreed in principle to develop the urgent access clinics and the older people's assessment service.

4.22 In October and November 2007 there were detailed discussions with NYYPCT, ERYPCT, and YAS about the resources needed to develop the ambulance service and the timescale for implementing expansion. A request was made to the SHA to help fund initial recruitment and training.

4.23 On 20 December 2007, the Trust Board discussed a paper which summarised the background to proposals for changes at Bridlington, reviewed again the advantages and drawbacks of each of the Options 1 to 4 presented in the public consultation and outlined a new approach:

"*Recent discussions have led us to believe that there is a potential fifth option. Option 5 comprises of the following:*

- *Medical Emergencies to Scarborough General Hospital*
- *Provision of Urgent Access Clinics for GP Selected Patients at BDH*
- *Older People's Assessment Unit (similar to urgent access for medicine but with Multi-disciplinary Assessment Including Social Worker Professions Allied to Medicine)*
- *Expansion of the Existing Rapid Access Chest Pain Clinics".*

This Option formalised ideas for service developments which had been put forward by Professor Alberti and in other assessments since April 2007.

4.24 Outline capital and revenue costs were given for all five options. It was also reported to the Board that: plans were being made for a pilot shuttle bus service between Scarborough Hospital and Bridlington & District Hospital; detailed negotiations were taking place with ERYPCT, NYYPCT and YAS about developments to the ambulance service in the Bridlington area; and pilot an integrated 24-hour minor injuries service (bringing together the hospital MIU and the GPs out-of-hours (OOH) service) would be starting in January 2008.

4.25 The Board endorsed Option 5 in principle, enabling *". . .significant work . . to commence to validate the indicative costs and secure the agreement of both PCTs"* with the objective of developing *"a phased approach to implementation"* once funding had been secured.

4.26 On 1 April 2008 the Trust Board considered more detailed implementation proposals and capital and revenue costs for Option 5 and agreed that the planning should continue along with programme elements which were common to other options,

while recognising that funding had still not been confirmed and that the Joint HOSC was expected to refer the proposals to the Secretary of State.

4.27 The Joint HOSC referred the proposals on 15 April on the general grounds that they were "*not in the interest of the health of the population in the area"* and specifically because:

- The proposals " . . . *did not resolve the concerns regarding the impact on YAS both in terms of patient transport, possible delayed access to appropriate treatment and the need to train ambulance staff in thrombolysis"*
- The SNEYHT had ". . *failed to address the broader strategic issue of joint working with other organisations and the need to invest in Bridlington due to its high levels of deprivation and health inequalities"*
- The SNEYHT had not responded effectively to public desire to retain the CMU at Bridlington, to concern about transport and the perception that the Hospital was being 'run down'

Evidence provided to the Panel

4.28 The Panel held a total of 31 face-to-face meetings and two telephone discussions with a wide range of stakeholders in the acute medical services including hospital clinicians from both Scarborough and Bridlington, nurses, GPs, patient and community representatives, the Joint HOSC, management and Board members of the SNEYHT, senior staff from the two PCTs, the SHA and the Deanery. Appendix Six lists the people who gave formal evidence. We visited the wards and other facilities at Bridlington and met informally with some patients. The IRP also received during the review, and took into account, 24 letters and emails and 10 phone calls about the proposals.

4.29 Some of those who gave evidence to us supported the Trust's proposals to move acute medical services and the CMU from Bridlington to Scarborough and others opposed them. Contributors variously confirmed and added to the case made in the consultation document and to the criticisms made of the proposals during the consultation. The views expressed and the information provided were considered by

the Panel in relation to safety, accessibility and sustainability, the key criteria against which the IRP assesses proposals.

Clinical quality and safety

4.30 SNEYHT Board papers and presentations made to the Panel by senior clinicians propose the withdrawal of acute medical services from BDH because consistently timely and high standards of diagnosis and treatment for seriously ill people can no longer be provided in small, isolated acute medical units. The main reason given for this is that medicine has become more specialised; this means that, in general, outcomes for patients will be best if they can be seen by the clinician(s) most knowledgeable about their own particular problems. It is not possible to have a wide range of specialists available throughout the week, or to provide a full range of diagnostic services to support them, in a small hospital. This is partly because the cost would be very high. But it is also for an important clinical reason - specialists would not see enough patients to enable them to develop and maintain their experience and expertise.

4.31 This approach to reconfiguring small hospitals is supported by national guidance. When the consultation on acute services at Bridlington began, the reference work was the Royal College of Physicians working party report *Isolated Acute Medical Services* (July 2002). This recommended that: *"Hospitals which do not have critical care facilities and adequate diagnostic services are not appropriate sites for the admission of acutely ill medical patients, who should be admitted to district general hospitals for prompt assessment, diagnosis and management"*.

4.32 During 2007, further guidance has repeated, developed and reinforced the conclusions of this report. The Panel was referred in particular to: *Acute Health Care Services* (Academy of Medical Royal Colleges, September 2007); *Acute Medical Care* (Royal College of Physicians, October 2007); and *Emergency Admissions: A journey in the right direction?* (National Confidential Enquiry into Patient Outcomes and Death - NCEPOD, October 2007).

4.33 In summary, these reports suggest that:

- Acutely ill patients should go to a facility able to provide, 24 hours a day, seven days a week, initial assessment, stabilisation and treatment of most serious conditions
- This hospital should have as a minimum a full A&E service, acute medical beds, elderly care, an intensive care unit (ICU), and imaging (including CT) and laboratory services. Full anaesthetic cover is needed.
- Intensive care is difficult to maintain unless there is also on-site general surgery.

4.34 Over the last five years, as described above (para 4.6), the Panel was told that the range of inpatients treated at BDH has changed, in part because of the limited range of support services. Recently, the number of admissions per day has gone down (on average, nine in 2006, seven in 2007), and the average length of stay has increased (six days in 2006, nine days in 2007) reflecting a continuing shift to 'step down' services.

4.35 A different view was put forward by consultants from Bridlington and a number of GPs. They suggested that the clinical case based on national guidance for moving acute medical services and the CMU did not sufficiently take into account the specific circumstances of BDH. They noted in particular that there was no history of patient safety problems at BDH; isolated cases had raised questions about the lack of particular facilities - such as a CT scanner - but the clinical staff had long argued that this should be available to support the current range of clinical services anyway. They indicated that clinical outcomes for coronary care were in the past (when comparative audits were carried out) better at Bridlington than at Scarborough, and that recent data on chronic obstructive pulmonary disease (COPD) showed Bridlington's record both for death rates and length of stay to be slightly better than national averages.

4.36 A summary of serious untoward incidents (SUI) reported within the Trust over the last four years does not suggest any obvious cause for concern. The Trust agrees that the proposed changes are not a response to specific recent safety incidents.

4.37 Those who were concerned about the move also argued that, even with a reliable and effective ambulance service, some seriously ill patients (especially those with chest pains or with breathing problems) who would currently be admitted directly into BDH would be put at greater risk by the longer transport times needed to take them to Scarborough. They referred in particular to two studies, from Tayside and Sheffield, showing an association between distance to hospital and mortality, especially for COPD, but also for acute myocardial infarction (MI), and another study suggesting that early death is not reduced by taking patients to hospitals with catheterisation facilities. This latter supported a policy of directing patients with suspected acute coronary syndrome to the nearest hospital with acute facilities.

4.38 However, others said in their evidence that these studies were based on travel to a district general hospital (which BDH is not). The consensus of advice on emergency treatment is that the most effective approach is rapid attention from well-trained paramedic staff, who are able to carry out procedures such as thrombolysis (intravenous administration of 'clot busting' drugs to stabilise myocardial infarction) and immediate transfer to a hospital with a full range of specialist facilities and staff.

Other views

4.39 At the end of 2002, the Royal Colleges of Surgeons, Physicians and General Practitioners carried out a Tripartite Review of BDH at the invitation of the Trust, making their report in February 2003. Local clinicians, trade union and community group representatives emphasised that this report considered a number of options and recommended as the best building up BDH as *'an enhanced Diagnosis and Treatment Centre'*. This would have increased the clinical staffing for acute medicine and expanded the volume and range of surgery carried out, making use of the second operating theatre (at that time closed) and carrying out orthopaedic, general and urological surgery as well as the existing day surgery. The Report suggested that most of the extra staff required were needed by the Trust in any case to respond to demand for its services but that a specific addition would be needed to the number of anaesthetists. "*Careful pre-operative assessment of surgical patients would be needed by the anaesthetic department to exclude patients likely to need ITU facilities post-operatively. However, the availability of the acute medical team on site would enhance the care of post-operative surgical patients . .*".

4.40 Trust clinicians told the Panel that this approach, similar in some ways to Option 3 of the 2006 consultation proposals, would in their view no longer meet the guidance issued by the Royal Colleges and that the volume of work available for the Trust as a whole could not justify the extra staffing required to carry out elective inpatient surgery on two sites. They also noted that national action had greatly reduced surgical waiting times since the Report was published.

4.41 Other groups who gave evidence were broadly in favour of maintaining existing services and simply wanted to see provided whatever additional staffing might be necessary to enable the CMU to be retained and acute medical admissions continued. Some argued that reinforcing staffing at BDH was a better use of any additional resources than investment in the ambulance service or refurbishing facilities at Scarborough Hospital since it would keep the services more accessible to the Bridlington community.

4.42 Some GPs, clinicians from Bridlington and community groups put their support for continuing acute services at BDH in the context of reservations about the quality and reliability of the facilities and quality of care at Scarborough Hospital. They suggested that:

- The range of therapies provided by the CCU at Scarborough was very similar to those available at the CMU in BDH. In particular primary angioplasty, increasingly regarded as the therapy of choice for serious MI, was not available in either hospital - patients were transferred to Hull for this. In addition, cardiology consultant cover was not available at all times in Scarborough - showing that a full 24-hour service was not necessarily essential.
- The acute medical wards at Scarborough were already heavily used; admissions were sometimes suspended and the hospital did not always manage frail elderly patients with appropriate respect - for example, moving them from ward to ward too often in order to manage bed shortages.
- The Trust's proposals for additional ward capacity to manage acute patients currently admitted to BDH were unsatisfactory. In particular, Haldane Ward, which was expected to provide 20 beds, was a 'Nightingale' facility which

would not provide the same quality of in-patient environment as the much newer wards currently used at Bridlington.

4.43 Some of those who spoke to the Panel also expressed doubts about the attention which Scarborough-based consultants would in future give to intermediate and rehabilitation patients at Bridlington.

Clinical sustainability

4.44 The Trust and others drew attention to the low levels of acute activity currently taking place at BDH, and therefore the limited effect of ending acute admissions. The newly established Urgent Access Clinic (see para 4.53) was expected to reduce acute medical admissions by about one quarter, providing alternative support to perhaps two of the seven or eight referrals each day. ERYPCT said that it expected about half of the acute medical admissions - perhaps three of the remaining six per day (which were likely to include one or two myocardial infarctions seen each week) - would in future go to Scarborough; while up to half would still be admitted to BDH. The Trust similarly estimate that 60 per cent of BDH's current patients are in hospital for active rehabilitation or intermediate care, and would therefore continue to be admitted there.

4.45 At the time the consultation began, there had long been concern in the Deanery about the training of postgraduate students at BDH. The 2003 Tripartite Report noted that in the mid 1990s the Royal College of Physicians had highlighted professional isolation at Bridlington and that its pressure led to the appointment of staff grade doctors to provide support for Senior House Officers (SHOs). At the time of the Colleges' visit the hospital was under direct threat of losing its SHO training posts and uncertainty has continued since. Early in 2008 the Deanery informed the Trust that it would no longer support training posts at BDH beyond 1 August 2008 and recruitment for seven staff grade doctors is currently taking place to enable services to continue.

4.46 The Panel was told that the training posts had been withdrawn principally because the range of cases going through BDH is too small to give trainees a good range of experience and clinical challenge. The number of admissions is perhaps one quarter

of that in a district general hospital and feedback from doctors in training noted that the protocols used meant that more serious (for them, necessary for their training) cases went directly to other hospitals. The implementation of the Working Time Directive, which reduces the duty hours of junior doctors, thus places a higher premium on seeing a wide range of patients in a shorter time. Students had also reported dissatisfaction with working in an environment with very limited diagnostic resources.

4.47 It is unlikely that direct trainee rotations into BDH will be offered again in the immediate future, but the Deanery has proposed that daytime placements at BDH could be a useful component of training based in Scarborough and that this might start in 2009.

4.48 The Panel was also told of plans to manage the additional acute patients at Scarborough and to expand non-acute services at Bridlington, consistent with the clinical manpower available and the anticipated numbers of patients on both sites.

4.49 The Trust described the implementation plans for the transfer. At Scarborough, the CCU would move into new accommodation with 10 beds and incorporate the patients from the existing six CMU beds at Bridlington. The Trust's development plan includes a new ward unit, for which capital is available, to be completed in about two years and it recognises that reopening a 20-bed open ward for acute inpatients is not a satisfactory long-term solution.

4.50 At Bridlington, a new renal dialysis unit has been built and will open in 2008. The PCT explained that it was investing heavily in community services and is setting up a Neighbourhood Team in Bridlington; this will have 13 staff across a range of therapeutic and support disciplines; some appointments have been made and the Team will be fully operational in six to nine months time. The objective is to provide services which will enable many, particularly older, patients both to be treated at, and be able to have as much as possible of their care at home.

4.51 The Panel heard that other proposals for extended services at Bridlington included a wider range of short stay (day case) surgery (laparoscopy, gynaecology,

orthopaedics, ophthalmology), a chemotherapy clinic and a pharmacy. All these are being discussed with consultants but there are as yet no specific plans in place.

4.52 The Trust's plans include maintaining three inpatient wards, one specifically for active rehabilitation, the other two for rehabilitation and step-down intermediate care as required. Rehabilitation patients may come from a wider area than the immediate Bridlington catchment, including from Scarborough. However, the Panel was told that rehabilitation services would continue at Malton and Whitby community hospitals (where there are some inpatient beds) as well as at Scarborough, so that Bridlington would not become the only location whatever the inconvenience for family and other visitors.

4.53 One of key developments planned by the Trust, following the visit of Sir George Alberti, is the introduction of a consultant-led UAC, which reviews referrals made by GPs and the ambulance service. A UAC has been in operation in Scarborough for two years; a trial in BDH, supported by consultants based in Scarborough and one of those based in BDH itself, has been running for three months. We were told that early results from this trial were similar to those observed in Scarborough, with about 25 per cent of referrals not needing admission but requiring home treatment and/or other care or support services, with the others about equally divided between acute admission (in future, Scarborough) and intermediate admission (remaining in Bridlington). This experience is broadly in line with the assessment of the range of cases described by staff from their own informal assessments (above), and anticipates that the total number of admissions will be reduced significantly from current levels. Currently, some patients are admitted and then assessed but this would no longer happen.

4.54 The BDH Urgent Access Clinic is operating from 10.00 to 18.00 on weekdays. The Panel was told that another physician is being recruited and that his/her input would enable the hours to be extended to 19.30 and to Saturdays. Almost all referrals take place in these longer hours/days.

4.55 The MIU at Bridlington has been closed at night for two years because of staff shortages. In January 2008, the Trust Board was told that the night service would reopen shortly but this has not happened.

Ambulances and other transport

4.56 A principal concern for the Joint HOSC, GPs and community groups is the performance of the YAS. Its service was expected by these stakeholders to get worse, to the severe perhaps critical disadvantage of seriously ill people if acute services are withdrawn from BDH. Doubts were also expressed to the Panel about the availability of sufficient paramedics to ensure that potentially life-saving procedures such as thrombolysis would be available to patients who would have a longer journey than currently needed to BDH.

4.57 National statistics confirm that YAS's record at meeting target response times has been, and remains, among the worst in the country; in 2007/8 it was eleventh out of twelve ambulance trusts. Figures published early in 2008 showed that the East Riding had the poorest response within the YAS area. The Panel was also given anecdotal evidence of some individual long waits for ambulance help.

4.58 The YAS, ERYPCT and NYYPCT described detailed discussions over the last year about the provision of ambulance services generally in East Yorkshire and also about specific developments in relation to transferring acute medical services from BDH to Scarborough. As a result of these negotiations, an additional £400,000 per year has been provided to improve the basic performance of the YAS and another £600,000 invested in increased capacity at Bridlington itself (where the ambulance station is on the hospital site). This latter is specifically to ensure that there is sufficient capacity to support the transfer of additional acute medical patients to Scarborough and to provide thrombolysis. It enables additional vehicles and 14 staff to be deployed; this new capacity will be in operation in September 2008. YAS has also recently expanded its fleet of rapid response cars (for which one of the bases is BDH), and a second helicopter has been deployed by Yorkshire Air Ambulance since October 2007.

4.59 The additional ambulance capacity for YAS has been developed using the nationally-recognised database and analyses of demand and patient-flows (where people are taken) which is used for ambulance planning across the country.

4.60 Many of those who gave evidence to the Panel referred to the transport difficulties that moving acute medical services to Scarborough would pose for relatives. As described above (para 3.4), public transport links between Scarborough and Bridlington are limited and neither hospital is close to the local station. The Trust recognised this concern, strongly expressed during the consultation, and at the beginning of June 2008 began a trial bus service, running every two hours every day between the two hospital sites. Full analysis of use of, and user response to, this development was not available by the time this report was prepared. However, we were told that passenger numbers were rising, with just over 700 people travelling in June and numbers up to an average of 50 per day by the end of the month. A letter from an enthusiastic user had been published in the local newspaper.

4.61 The bus link was widely welcomed in principle by other stakeholders in their evidence, though some expressed reservations about its likely value - for example, because the buses operate non-stop between the hospital sites getting to and from which already requires some kind of public or private transport for most people.

4.62 The Trust and the PCT also emphasised the proposals for other service developments at BDH, which would reduce travel for healthcare for many people. These included:

- Additional consultant-led outpatient clinics
- More diagnostic facilities, including the possibility of a CT scanner
- Additional day-case surgery
- The Older Patient Assessment Unit, which would bring together multi-disciplinary teams of clinicians, therapists and support services to organise the most appropriate ways of meeting the needs of each person
- A new renal dialysis unit

The Panel was told that a chemotherapy service, a pharmacy and a GP practice (Bridlington is currently under-provided with GPs) might also be located on the site, but none is a firm proposal.

Community views

4.63 Much local publicity has been given to fears that BDH does not have a future and that the current proposals are another step in a gradual, but never explicit, process of closing it. The Save Bridlington Hospital Campaign Action Group follows events on the site very closely, discusses them on its website, and encourages regular local newspaper coverage. The Panel was told that during the consultation a protest petition signed by 37,000 people was delivered to Downing Street and there was a well-attended street demonstration; another is planned for July 2008. Local GPs and others confirmed the high level of community support for the Hospital.

4.64 The Panel heard about two patterns of change over a long period which underlie this concern. First, acute services have over a period been withdrawn from the site - inpatient surgery, emergency admissions for stroke and gastro-intestinal bleeding, and medically supported (by GPs) births, for example. This has been the result of changes in clinical protocols and employment terms for doctors.

4.65 Secondly, clinical and nurse staffing at BDH has been reduced, partly as acute services have been reduced and also most recently as part of the Trust's response to financial problems. This has had a direct effect on some day-to-day services - for example, the night-time closure of the MIU. But even where services have not been altered, the staffing situation has helped to reduce local confidence in the Trust's commitment to the Hospital and created uncertainty and affected morale among staff. Figures given to the Panel suggest that there has been a fall of about 12 per cent in staff at BDH in the past year.

4.66 The PCTs and the Trust have publicly confirmed their commitment to maintaining and developing BDH as a vibrant healthcare centre. However, community groups, GPs, and trade unions all referred to repeated reassurances and a succession of plans for the hospital which have not been progressed. Some noted the recent plans of the

Trust to recruit more finance staff in Scarborough although clinical and nursing numbers remained lower than in the past.

Integration

4.67 BDH joined Scarborough Hospital in a single Trust in 1999. The tripartite review of the Royal Colleges (2003) noted: "*The opinion of all those we interviewed was that this union has never been satisfactorily consolidated*". We heard this opinion repeated five years on; one presentation referred to "*poor integration and relationships*" [between clinicians] and several individuals spoke of or documented examples of lack of collaboration, failed communication and inadequate consultation both in day-to-day professional intercourse and in relation to change/development plans.

OUR ADVICE

Adding value

Introduction

5.1 The Secretary of State for Health asked the IRP to consider whether the proposals for changes to acute services at Bridlington & District Hospital set out in the decision of the Scarborough and North East Yorkshire Hospitals Trust in April 2008 would ensure the provision of safe, sustainable and accessible acute medical services in east Yorkshire.

5.2 The number of people likely to be directly affected by the proposals in the course of each year is not large in relation to the overall services of the Trust but the changes have also to be seen in the wider context of national guidance on local service delivery, the potential (and historic) use of Bridlington & District Hospital, community concern about the future of the Hospital and well publicised financial pressures facing Trust and its commissioning PCTs. It is therefore not surprising that they have provoked a lengthy and energetic debate.

5.3 During the consultation and over the following months there was a series of meetings between the Trust and the Joint HOSC to clarify and discuss the proposals. When the Trust, supported by the PCTs, confirmed its decision to move acute medical admissions and the CMU from Bridlington to Scarborough, the Joint HOSC decided on referral on the grounds that the proposals were not in the interests of health services in the area.

5.4 In reviewing the Trust's proposals and the objections of the Joint HOSC, we have considered what it and others told us, and the information and perspectives which it and others provided, against the requirements for **safety, sustainability and accessibility** set out in our terms of reference.

The case for change

5.5 Bridlington & District Hospital is an excellent facility, in very good condition, able to serve a substantial local community among whom it has a high level of support. All the NHS management bodies with responsibility for its use and management have publicly endorsed its high value and their commitment to its future. They confirmed this to the Panel.

5.6 The Panel heard fears that the long-term intention is to close the Hospital, probably for financial reasons. We found no evidence that any such plans exist or that there is at present any intention to reduce spending on services there. On the contrary, NYYPCT has stated its support for the future of the hospital and is developing its community services in neighbouring areas while both the ERYPCT and the SNEYHT have announced plans to invest in services on the BDH site itself. There is already practical evidence of this in the new renal dialysis unit, the newly created Neighbourhood Team based there, and the increased ambulance capacity operating from the Hospital. A range of other developments - in day case surgery, outpatient clinics, further specific day treatment clinics and diagnostic services are also in negotiation. It is disappointing that these are not yet being implemented, but we were impressed by the enthusiasm and ideas of many of the clinicians and managers (some of whom who started work long after the consultation) who are now in a position to drive developments forward.

5.7 The background to the referral of the SNEYHT's proposals for change is differing views and expectations - made clear in the evidence we heard – about the range of services which could and should be provided in BDH.

5.8 When it was built to replace three small, old hospitals in the town, expectation in at least some of the local community was that it would be a district general hospital. In practice it has never been that and does not have the catchment population which could justify a full A&E service with the associated diagnostic, surgery, intensive care and range of acute specialties which this would demand. But the Hospital has nevertheless provided some acute services, including general surgery, coronary monitoring and acute medicine. The local community has held these services in particularly high regard both because they provide local access to treatment for some

sudden urgent illness (without the delay of an ambulance journey to Scarborough) and because they are for many people what marks out a hospital from a clinic, nursing home, surgery or other general medical facility.

5.9 The Panel heard that acute services have been reduced over the years for clinical reasons. General inpatient surgery ceased when it became impossible to maintain 24-hour anaesthetic cover and good professional practice required an ICU to be available on-site for such work. More recently patients with gastro-intestinal bleeding or strokes have not been admitted, recognising that BDH does not have the expertise or facilities to treat these cases effectively.

5.10 The current proposals for ending acute medical services at Bridlington & District Hospital, including the Cardiac Monitoring Unit, continue this pattern. They are based on accepting the requirements of good clinical practice in accordance with current national professional guidance to ensure the safety and best treatment of patients.

5.11 The Panel agrees that these changes are essential and notes that Professor Alberti, National Director for Emergency Access, came to the same conclusion. It is clearly no longer acceptable that acute services should be provided in a unit with single-handed consultants who provide cover for one another outside their specialties and who in the normal course of events in a working year will not be available to see patients within their own specialty for substantial periods - because of holidays, training, illness and so on.

5.12 The consultants at BDH themselves and others (including many local GPs) have argued that there is no evidence of safety incidents resulting from the current situation. They also suggested that the service could be sustained by some quite limited investment in additional staff and diagnostic equipment and that patients will get a worse deal if they transfer to Scarborough where the range of treatments available is little different, they get a less personal service and, if they are seriously ill, may suffer as result of the ambulance transfer time.

5.13 To support this view, reference was made to the preferred option in the tripartite review published in 2003 by the Royal Colleges on Bridlington & District Hospital. The IRP is not persuaded that these proposals provide a viable alternative. They required a significant increase in clinical staff at Bridlington to provide services particularly directed at surgical work, which was a major service issue at the time. To implement such a development now would risk undermining the broader viability of acute inpatient services in north and east Yorkshire by diluting the clinical 'critical mass' at Scarborough as a result of splitting it over two sites. There would have either to be additional staff less than fully employed (and therefore diverting resources from other services) or marginal or inadequate staffing providing a less secure standard of service. In taking this view, the Panel recognises that clinical management guidance and staffing needs required by the Working Time Directive and Modernising Medical Careers have significantly altered the environment since 2003. The Panel also notes that the Trust is committed to developing its medical services in line with the model set out by the Royal College of Physicians in *Acute Medical Care - the right person in the right setting first time* and agrees with this approach.

5.14 The IRP is convinced that transferring medical and emergency admissions, including those to the Cardiac Monitoring Unit, is clinically the right way forward. People who are seriously ill need to get to a district general hospital with all the appropriate facilities as soon as possible. Bridlington & District Hospital cannot fulfil this function; the appropriate centre is Scarborough Hospital, or if primary angioplasty is required, to a specialist centre such as at Hull.

5.15 The Trust and the ERYPCT and the NYYPCT must ensure that high quality services and a high quality environment are available in Scarborough and that Yorkshire Ambulance Service is able to respond quickly and effectively to emergency calls. The Panel notes that the Trust is proposing improvements to the facilities at Scarborough as part of the proposed changes at Bridlington and that the PCTs are investing heavily in YAS to ensure appropriate ambulance services are available.

5.16 This conclusion does not imply criticism of the dedication or professional skills of the clinical or nursing staff at Bridlington, who seem to us to have worked very hard in the interests of their patients through a long period of uncertainty. But the evidence we heard shows that the underlying issue for the Hospital is that the population it serves does not and will not provide enough acute cases to employ the staff and equipment needed to make available the high levels of clinical expertise which patients should be able to expect. The withdrawal of training posts by the Deanery has highlighted this problem and helped to precipitate changes, but this has reflected an unsustainable situation rather than causing it.

5.17 Bridlington & District Hospital has a bright future and will continue to be the focus for services for people in the surrounding area. Many of the non-emergency patients currently admitted to its medical wards will still go there and new community support, out-patient and day-case services are being introduced.

Recommendation One

All medical emergency admissions, including those to the Cardiac Monitoring Unit, should transfer from Bridlington to Scarborough Hospital as proposed by the Trust. This transfer should take place as soon as the facilities and staff are in place to handle the extra inpatients at Scarborough.

5.18 Although acute inpatient services have to move, BDH must continue to be a place where people with an urgent clinical problem can get advice and appropriate attention. This includes patients whose GPs consider that they may need to be admitted to hospital and those who suffer injury or a rapidly developing ailment and cannot wait for a GP appointment but can travel at least a short distance (that is, they do not feel it necessary to call an ambulance).

5.19 The Trust is planning to meet the first of these needs principally through the consultant-led Urgent Access Clinic. This is still in its trial stage; the Panel heard that the early results were very positive, though the hours need to be extended. Proposals have also been made for a chest pain clinic and an elderly assessment unit, the latter operating in conjunction with community services. We were told that these might in

practice overlap with the UAC and that channelling all referrals through a single clinic was probably preferable. The panel considered that the long term assessment procedures need to be confirmed, funded and put in place as soon as possible.

5.20 The second urgent access service is the Minor Injuries Unit. The principal community complaint about this is its now long-time closure at night. This originally took place because nursing staff left and were not replaced. In spite of plans announced at various times, it has not reopened. The Panel recognised that this might well not be a priority for the Trust, or a major service to the community, since the average attendance each night had been two and the annual cost of staffing this period about £150,000. The alternative, without calling an ambulance or going to the A&E at Scarborough is the GPs Out of Hours service, which is managed from a base in BDH. The Trust is planning to create a 24 hour service by combining the MIU and the OOH service but negotiations have been held for more than a year without agreement - to the disadvantage of the local community.

Recommendation Two

The Urgent Access Clinics that have been developed at Bridlington must continue and the arrangements for a 24/7 combined Minor Injuries and Out-of-Hours Service must be agreed between the PCT and the Trust without further delay.

Making the transition

5.21 The Trust has a reputation in the Bridlington community for running services down rather than for development and innovation. Even if this is not fully justified, it is essential that effective acute provision is in place to provide high quality services for patients who will go elsewhere once acute services move from BDH - and for their relatives and friends - from the moment the change takes place.

5.22 The Trust has extensive plans for improving the buildings and facilities at Scarborough. The new facilities will not be ready for up to two years. However, clinical requirements mean that changes must happen now and the Panel accept that interim accommodation arrangements will be needed. The plan to (re)open an

additional ward in Scarborough for as long as necessary pending the opening of a new ward block is not ideal but the Panel believes that clinical quality must take precedence over the physical environment in the circumstances facing the Trust. It is not acceptable for change to be delayed for perhaps two years while a new facility is built.

5.23 The Joint HOSC emphasised in its referral of the proposed changes to acute services strong reservations about the local ambulance service. In particular it questioned the ability of the YAS to handle extra demand and to have enough trained staff to make emergency procedures such as thrombolysis available whenever necessary for patients who might previously have been admitted to BDH. However, the Panel heard that extra resources for YAS had been agreed before the referral was made and that additional staff training will be complete, along with the commissioning of an additional ambulance, by September 2008. The ERYPCT, the SNEYHT and the YAS all agree that the extra investment is sufficient to accommodate the anticipated extra numbers of urgent transfers.

5.24 One reason for community opposition to the proposed service changes has been their effect on aspects of accessibility for residents of Bridlington and the surrounding area. Even if the ambulance service reliably and quickly gets acutely ill people to another location for treatment, travel for family and friends to visit will be more difficult, a particular problem when many acute medical patients are elderly. The introduction of the bus service between Bridlington and Scarborough hospitals has been widely welcomed, but its future is not assured and very little has been done to assess and develop other ways of improving access to transport for those who need to get to Scarborough. The Panel considered that this was an important omission

Recommendation Three

A detailed implementation programme, including for transport, must be finalised and actioned by the Trust as soon as possible. It is essential that sufficient capacity is made available at Scarborough and that the ambulance service is ready to meet the extra demands which will be made on it. This includes sufficient staff to carry out thrombolysis whenever appropriate. In view of the extensive managerial changes which have taken place in the Trust over the last six months, the PCTs and the SHA should closely monitor the programme.

Communication and engagement

5.25 A common theme in the evidence from, and discussions we had with, nursing and other staff was lack of clarity about what was being planned by the Trust and lack of consultation about proposals and possible service changes.

5.26 We also saw that close interest from the press and the Action Group meant that every change or service problem in BDH has been immediately publicised, usually with critical commentary. This has put the Trust (and ERYPCT) perpetually on the defensive about its plans for and management of the Hospital, particularly as reductions in staffing over the last two years have appeared to be driven by opportunistic budget saving (through non-replacement of any staff who left) rather than a structured service delivery plan. Positive developments, such as the new renal dialysis unit, seem to have received little recognition.

5.27 This problem has been made worse by a long period of uncertainty - it is now over 18 months since the public consultation began - undermining the confidence of staff and the local community about the Trust's planning process and its commitment to changes put forward. Since their basis was patient safety, this apparent irresolution has created further problems.

Recommendation Four

The Trust must develop a clear communication plan and involve staff in both hospitals and the public fully in the changes.

5.28 The Panel heard that uncertainty extends beyond the immediate management of changes to acute services at Bridlington. The general commitments made to the future of the Hospital are not currently supported by detailed plans for specific improvements to services although many suggestions have been made by staff and other stakeholders and internal assessment, planning and negotiation on a number of these was described to us.

5.29 The potential of the Hospital to improve access (reducing travel difficulty and time) to a wide range of diagnostic services and treatments through more outpatient clinics, more diagnostic facilities and day surgery, the work of the Neighbourhood Team, and treatments such as chemotherapy is widely recognised. But the local community sees discussion of possible new services through the lens of undelivered past ideas and promises, actual service reductions and reported staff shortages. Once again, they see further service reductions planned at Bridlington without being convinced that the talked about developments at the hospital will actually take place.

Recommendation Five

Public confidence will only be rebuilt when it is clear that the PCTs and the Trust are committed to ensuring maximum local access to services and delivering on their commitments. It is therefore essential that proposed new developments at Bridlington are confirmed and then quickly put in place. A decision is urgently needed about how diagnostic facilities at Bridlington can be strengthened.

5.30 The Panel also recognised that, while individual new services would be welcomed by staff and the local community, concern for the future is unlikely to be allayed until a continuing and vibrant role for Bridlington & District Hospital can be confirmed within an agreed strategic plan for health care across north and east Yorkshire as a whole.

5.31 Here too, the Panel was told about strategic planning discussions, led by the NYYPCT and held between NYYPCT, ERYPCT and SNEYHT, but was not persuaded that the problems and opportunities - including co-ordination with social service provision - were sufficiently known to a wider stakeholder group or sufficiently open to their input and involvement.

Recommendation Six

The PCTs and the Trust must move quickly to determine the future role of Bridlington & District Hospital as part of their service strategy for this part of Yorkshire. Staff and the local community need to be fully involved in this process.

A unified Trust

5.32 The SNEYHT is, by national standards, a small Trust but one which has a vital role in providing acute health services to a widely dispersed resident population and a considerable influx of tourists in the summer. If the Trust's hospitals did not exist, many people, especially in Scarborough, the biggest population centre, would have to travel as much as 50 miles for specialist, emergency and inpatient care.

5.33 The Trust recognises that maintaining clinically viable, adequately staffed and cost-effective services for a dispersed population of only 220,000 is a difficult challenge. The Panel supports the view that high priority should be given in planning future service configurations to securing the continuation of acute and emergency services in the area and recognises that this means that acute inpatient services will continue to be based at Scarborough Hospital. But there are many opportunities for other services, including consultant clinics, minor surgery, the delivery of specific therapies and a wider range of diagnostic facilities to be provided at other facilities across the area - including in particular Bridlington & District Hospital.

5.34 The Panel was therefore concerned by the evidence it heard of continuing failures to integrate the work of clinicians across the Scarborough and Bridlington sites now more than nine years after the hospitals came together in a single Trust. This must

limit clinical developments and the use of the Trust's buildings and other resources, and thus serve the needs of its patients less effectively than would otherwise be possible.

Recommendation Seven

The Trust must improve the clinical integration between Scarborough and Bridlington. It should also encourage and strengthen its clinical links with neighbouring larger acute Trusts.

Appendix One

Independent Reconfiguration Panel general terms of reference

A1. To provide expert advice on:

- Proposed NHS reconfigurations or significant service change;
- Options for NHS reconfigurations or significant service change;

referred to the Panel by Ministers.

A2. In providing advice, the Panel will take account of:

i. whether the proposals will ensure safe, sustainable and accessible services for the local population

ii. clinical and service quality, capacity and waiting times

iii. other national policies, for example, national service frameworks

iv. the rigour of consultation processes

v. the wider configuration of the NHS and other services locally, including likely future plans

vi. any other issues Ministers direct in relation to service reconfigurations generally or specific reconfigurations in particular.

A3. The advice will normally be developed by groups of experts not personally involved in the proposed reconfiguration or service change, the membership of which will be agreed formally with the Panel beforehand.

A4. The advice will be delivered within timescales agreed with the Panel by Ministers with a view to minimising delay and preventing disruption to services at local level.

B1. To offer *pre-formal consultation* generic advice and support to NHS and other interested bodies on the development of local proposals for reconfiguration or significant service change - including advice and support on methods for public engagement and formal public consultation.

C1. The effectiveness and operation of the Panel will be formally reviewed annually.

Appendix Two

Letter to The Rt Hon Alan Johnson MP, from Sue Lockwood, Director of Corporate Resources at East Riding of Yorkshire County Council, on behalf of the Scrutiny of Health Committees of East Riding of Yorkshire Council and North Yorkshire County Council, 15 April 2008

Rt Hon Alan Johnson MP
Secretary of State for Health
Richmond House
79 Whitehall
LONDON
SW1A 2NL

Your Ref:
Our Ref: HC/KH
Enquiries to: Helena Coates
E-Mail: Helena.coates@eastriding.gov.uk
Tel. Direct: (01482) 393208
Date: 15 April 2008

Dear Secretary of State

'The Future of Bridlington Hospital' - Public Consultation on the Future of Bridlington Hospital by Scarborough and North East Yorkshire Health Care Trust

East Riding of Yorkshire and North Yorkshire County Council established a joint Scrutiny of Health Committee to consider the above proposals, along with another set of proposals concerning 'A Future for Maternity Services'. The latter set of proposals were referred to you in January 2008 as the Committee considered they were not in the interests of health services in the area.

This letter and the attached report is to confirm the referral in relation to 'The Future of Bridlington Hospital', also on the basis that it is not in the interests of health services in the area.

One aspect of this referral is around the reduction of services to an area which needs them, and hence you may wish to consider this along with the referral made on maternity services.

If you have any questions or require any further information, please do not hesitate to contact Helena Coates, Assistant Democratic Services Manager on (01482) 393208.

Yours sincerely

Sue Lockwood
Director of Corporate Resources

Enc

Appendix Three

Letter to Dr Peter Barrett, Chair, IRP, from The Rt Hon Alan Johnson MP, Secretary of State for Health, 22 May 2008

From the Rt Hon Alan Johnson MP
Secretary of State for Health

DH Department of Health

Richmond House
79 Whitehall
London
SW1A 2NS

Tel: 020 7210 3000

SofS47593

Dr Peter Barrett
Chair
Independent Reconfiguration Panel
Keirran Cross
11 The Strand
London WC2N 5HR

22 MAY 2008

Dear Peter

Referral of the decision by East Riding of Yorkshire Council and North Yorkshire County Council Scrutiny Health Committee on "A future role for Bridlington Hospital" – public consultation on a future role for Bridlington Hospitals, Scarborough and North East Yorkshire Health Trust

Thank you for completing an initial assessment of the documentation relating to the referral from the Joint Overview and Scrutiny Committee of East Riding of Yorkshire Council and North Yorkshire County Council concerning the decision of a public consultation on a future role for Bridlington Hospitals, Scarborough and North East Yorkshire Health Trust.

Your letter of 20 May 2008 states that the IRP would be willing to undertake a full review of the proposals as set out in the referral and I would be grateful if this could commence with immediate effect.

Annex A sets out Terms of Reference for the review.

The panel's advice to me on this case should be provided in accordance with these Terms of Reference. I look forward to receiving your advice.

Yours
Alan

ALAN JOHNSON

TB 21/05

Department of Health

Annex A

Referral of the decision by East Riding of Yorkshire Council and North Yorkshire County Council Scrutiny Health Committee on "A future role for Bridlington Hospital" – public consultation on a future role for Bridlington Hospitals, Scarborough and North East Yorkshire Health Trust

Terms of reference

The panel is asked to advise the Secretary of State by 31 July 2008:

a) whether it is of the opinion that the proposals for the future role of Bridlington Hospital including acute medical and cardiac admissions will ensure the provision of safe, sustainable and accessible services for local people, and if not, why not;

b) on any other observations the panel may wish to make in relation to the proposals; and

c) on how to proceed in the interests of local people, in light of (a) and (b) above and taking into account the issues raised by the Joint Overview Scrutiny Committee of East Riding of Yorkshire Council and North Yorkshire County Council Scrutiny Health Committee in its referral letter of 15 April 2008.

It is understood that in formulating its advice the Panel will pay due regard to the principles set out in the IRP's general terms of reference.

TB 21/05

DH CONT

Appendix Four

Letter to The Rt Hon Alan Johnson MP, Secretary of State for Health, from Dr Peter Barrett, 5 June 2008

Kierran Cross

First Floor
11 Strand
London
WC2N 5HR

The Rt Hon Alan Johnson MP
Secretary of State for Health
Department of Health
Richmond House
79 Whitehall
London SW1A 2NS

5 June 2008

Dear Secretary of State

Referral of the decision by East Riding of Yorkshire Council and North Yorkshire County Council Scrutiny Health Committee on "A future role for Bridlington Hospital"

Thank you for your letter of 13 May about the above.

I am happy to confirm that the Independent Reconfiguration Panel will provide advice in accordance with the terms of reference set out in your letter and, as requested, by 31 July 2008.

The Panel has begun visiting the area. As usual, we are meeting people and hearing views from all sides of the debate.

As you know, in keeping with our commitment to open and transparent working, we will be publishing our advice on the IRP website.

Yours sincerely

Dr Peter Barrett CBE
Chair, Independent Reconfiguration Panel

Appendix Five

Letter to Editors from Dr Peter Barrett, Chair, IRP

Kierran Cross

First Floor
11 Strand
London
WC2N 5HR

3 June 2008

For publication

IRP: Have your say on health review

Dear Editor

The IRP, the independent expert on NHS service change, has been asked by the Secretary of State for Health to carry out a review relating to contested proposals for changes to acute medical and cardiac admissions at Bridlington Hospital.

As part of our review we are calling for residents to come forward and have their say. We would particularly like to hear from local people who feel that they have new information that was not submitted during the formal consultation process or believe that their voice has not been heard. Please contact us by email at: **info@irpanel.org.uk** or by calling **020 7389 8055.** We urge people who would like to meet with us to contact us as soon as possible.

The referral to the IRP relates to the proposals by Scarborough and North East Yorkshire NHS Trust to change acute medical and cardiac admissions at Bridlington Hospital.

Our review will look at whether the proposals will ensure the provision of safe, sustainable and accessible services for local people.

We will be undertaking a number of visits to the area to talk to patients, clinicians, local authority representatives, interest groups and people living and working in the area who believe they have new evidence that the IRP should take into account.

It is important that our reviews are open and accountable to local communities. We will therefore publish our conclusions on our website - www.irpanel.org.uk - once they have been considered by the Secretary of State for Health.

Yours sincerely

Dr Peter Barrett CBE
Chair, IRP

IRP

www.irpanel.org.uk

Press release

3 June 2008

IRP invites Bridlington residents to have their say on future healthcare

This week the IRP, the independent expert on NHS service change, will be visiting the town as part of a new review of local healthcare. The IRP is inviting residents in Bridlington to come forward in particular if they have new information relating to proposed changes to acute medical and cardiac admissions at Bridlington Hospital.

Scarborough and North East Yorkshire NHS Trust has put forward proposals to reconfigure acute medical and cardiac admissions at Bridlington Hospital. These proposals have been contested by the Joint Overview and Scrutiny Committee of East Riding of Yorkshire Council and North Yorkshire County Council. The Secretary of State for Health, Alan Johnson MP, has asked the IRP to provide advice to him on the way forward.

Gina Tiller, Lead Panel Member for the IRP's review, said: "We urge people who would like to contact us to do so as soon as possible. We will be making a number of visits to the town this week and next, listening to all sides of the debate and gathering evidence to ensure that our recommendations are in the best interests of local people. We will then continue to study the evidence and views given to us by patients, healthcare professionals and other interested parties. Following this we will make recommendations to the Health Secretary by the end of July. Our recommendations will address the future safety, sustainability and accessibility of these services."

As part of the review the IRP is calling for residents to come forward and have their say. The IRP particularly wants to hear from those who have new information that was not submitted during the Trust's formal consultation process, or believe that their voice has not been heard. **Anyone who wishes to contact the IRP can do so by emailing info@irpanel.org.uk or by telephoning 020 7389 8055.**

The IRP's final report with its recommendations will be forwarded to the Health Secretary by the 31 July 2008. The final decision on changes to services in the area will be made by the Secretary of State for Health.

The IRP is also carrying out a separate review of proposals by Scarborough and North East Yorkshire NHS Trust to change maternity services at Whitby, Malton and Bridlington Community Hospitals and develop a separate midwife-led unit on the Scarborough Hospital site.

ENDS

For further information, contact the IRP press office on 020 7025 7530 or email IRPpressoffice@trimediauk.com

Notes to editors

1. The full name of the IRP is the Independent Reconfiguration Panel
2. The IRP was set up in 2003 to provide advice to the Secretary of State for Health on contested proposals for health service change in England
3. Under the NHS Health and Social Care Act 2001, NHS organisations must consult their local authority Overview and Scrutiny Committees (OSCs) on any proposals for substantial changes to local health services. If the OSC is not satisfied it may refer the issue to the Health Secretary
4. IRP panel members have wide ranging expertise in clinical healthcare, NHS management, public and patient involvement and handling and delivering successful changes in the NHS
5. Further information, including details of all panel members, is available from www.irpanel.org.uk

Appendix Six

Site visits, meetings and conversations held

Tuesday 3 June 2008

IRP **Chris Howgrave-Graham**

Department of Health, Richmond House

Sir George Alberti: National Director for Emergency Access

Wednesday 4 June 2008

IRP **Gina Tiller, Nick Naftalin, Linda Pepper, Brenda Howard**
Chris Howgrave-Graham, Julian Edwards

Evidence gathering sessions - Bridlington & District Hospital

Mr Iain McInnes: Chief Executive, Scarborough and NE Yorkshire NHS Trust
Ms Lynne Young: Programme Director**,** BDH reconfiguration
Dr Earl Haworth: Clinical Director, Medicine, SNEYHT
Ms Teresa Fenech: Director of Strategy, Planning & Partnerships/Chief Nurse, SNEYHT
Mr Tim Carts: Deputy Ward manager, CMU, Bridlington
Ms Claire Wood: Chief Executive, ERYPCT
Mr Neil Griffiths: Locality Director, ERYPCT
Ms Jane Marshall: Director of Commissioning, NYYPCT
Dr Ian Holland: Medical Director, SNEYHT
Dr Sundeep Soin: GP, Medical Director ERYPCT
Ms Dinah Fuller: Chair, Clinical Executive, ERYPC**T**
Ms Maggie Windle: Nursing Sister, Lloyd Ward
Ms Aly Tipper: Senior Sister, Kent & Johnson Wards
Dr David Eadington: Programme Director, Yorkshire School of Postgraduate Medicine
Mr Bill Redlin: Director of Commissioning, NYYPCT
Mr Martyn Pritchard: Chief Executive, Yorkshire Ambulance Service
Mr Paul Mudd: Asst Director of Operations, Hull and E Yorkshire**,** YAS

Friday 6 June 2008

IRP **Gina Tiller, Nick Naftalin, Linda Pepper, Brenda Howard**
Chris Howgrave-Graham, Julian Edwards

Evidence gathering sessions - Bridlington & District Hospital

Sir Michael Carlisle: Chair, SNEYHT
Suzanne Carr: Non-executive Director, SNEYHT
Dr Tim Houghton: Consultant Cardiologist; RCM representative
Dr Charles Mitchell: Consultant Gastroenterologist
Dr Andrew Volans: Consultant, Emergency Medicine

Mr John Edwards: Chief Reporter, Bridlington Free Press
Dr Anwar Menon: Consultant Physician
Dr Mike Pond: Consultant Physician
Dr Paul Harris: General Practitioner
Dr Anthony Clarke: General Practitioner
Dr Margaret Robertson: General Practitioner
Ms Dawn Emms: Practice Manager
Dr David Wigglesworth: General Practitioner
Dr Depa Sreedhar Reddy: General Practitioner
Ms Lynne Young: Programme Director**,** BDH reconfiguration
Dr Earl Haworth: Clinical Director, Medicine, SNEYHT
Ms Teresa Fenech: Director of Strategy, Planning & Partnerships/Chief Nurse, SNEYHT

Wednesday 11 June 2008

IRP **Gina Tiller, Nick Naftalin, Linda Pepper, Brenda Howard, Peter Barrett Chris Howgrave-Graham, Julian Edwards**

Evidence gathering sessions - Bridlington & District Hospital

Mr Steve Holiday: Representative, Unite the Union
Ms Michelle George: Representative, Unite the Union
Mr Franco Villani: Representative, Unite the Union
Ms Karen Reay: National Officer, Health Sector, Unite the Union
Ms Jean Wormwell: Secretary, PAGER
Ms Margaret Edwards: Chief Executive, Yorkshire & the Humber SHA
Ms Rosamond Roughton: Director of Strategy, Yorkshire & the Humber SHA
Mr John Blackie: Chairman, NY HOSC
Ms Barbara Jefferson: Member, ERY HOSC
Ms Ros Jump: Portfolio Holder, Health & Voluntary Partnerships, ERY
Ms Barbara Hall: Chair, ERY HOSC
Ms Kate Bowden: Team leader, ERY HOSC
Mr Dave Pinder: Health Development Manager, ERY HOSC
Mr Bryon Hunter: Health Scrutiny Officer, NY HOSC
Mr David Belling: Member, NY HOSC
Mr D Heather: Member, NY HOSC
Dr Alistair Robertson: General Practitioner
Mr Ray Evans: PPI Lead, ERYPCT
Dr David Hickson: General Practitioner
Mr Mick Pilling: Chair, Save Bridlington Hospital Campaign Action Group
Ms Claire Wood: Chief Executive, ERYPCT
Mr Neil Griffiths: Locality Director, ERYPCT
Mr Gary Hardman: Director of Nursing & Patient Care, NYYPCT
Mr Iain McInnes: Chief Executive, Scarborough and NE Yorkshire NHS Trust
Ms Lynne Young: Programme Director**,** BDH reconfiguration
Dr Earl Haworth: Clinical Director, Medicine, SNEYHT
Ms Teresa Fenech: Director of Strategy, Planning & Partnerships/Chief Nurse, SNEYHT
Dr Ian Holland: Medical Director, SNEYHT
Monday 7 July 2008

IRP **Gina Tiller, Nick Naftalin, Linda Pepper, Brenda Howard, Chris Howgrave-Graham, Julian Edwards**

Evidence gathering sessions - Bridlington & District Hospital

Ms Lynne Young: Programme Director**,** BDH reconfiguration
Mr Peter Bowker: General Manager, Medicine, SNEYHT
Ms Adele Jordan: Matron, Medicine, SNEYHT
Ms Barbara Monk: General Manager, Surgery, SNEYHT
Ms Jane Slintoft: Nursing Sister, Thornton Ward
Ms Teresa Clayton: Nursing Sister, Thornton Ward
Dr Earl Haworth: Clinical Director, Medicine, SNEYHT

IRP **Chris Howgrave-Graham**

Telephone conversation

Ms Trish Lee: Resuscitation Manager, SNEYHT

10 July 2008

IRP **Chris Howgrave-Graham**

Telephone conversation

Andrew Mooraby: Previously Modern Matron, SNEYHT

Appendix Seven

Information made available to the Panel

Written evidence

1.	Joint HOSC Referral Letter to Secretary of State 15 April 08
2.	Joint HOSC Referral letter document
3.	Bridlington IRP Information Template
4.	Bridlington Consultation Document
5.	Terms of Reference Letter from Secretary of State 20 May 08
6.	Cardiac Arrest calls BEDH and SGH
7.	Snapshot Activity Audit Jan 08
8.	Nurse Assessment
9.	ED & MIU Database
10.	Nightwork
11.	Out-of-Hours
12.	Cover Letter and Submission, Dr M N Pond, Consultant Physician, SNEYHT
13.	Royal College of Physicians Service Review at Bridlington Hospital 11 Feb 03
14.	Letters submitting evidence from Greg Knight MP 18 June and 30 July 08
15.	Report from Dr Alistair Robertson
16.	Letters from Flamborough Parish Council
17.	Assessment of Bridlington Acute Assessment Unit, June 2008
18.	Summary of SUIs Bridlington Hospital, 2004 to 2008
19.	Statement of Concerns, Dr Harris & Partners, June 2008
20.	BMJ 26/02/05 Catheterisation facilities and patients with acute coronary syndrome
21.	Acute MI and distance between home and hospital, Heart, 10 Nov 07
22.	Presentation notes, Dr D Eadington
23.	Article on ambulance response, Yorkshire Post, 27 March 08
24.	Prof Alberti preliminary report on SNEYHT, May 2007
25.	SNEYHT Discussion Document on future of BDH, Nov 2006
26.	SNEYHT Board paper on maternity and BDH acute services, 03 April 07
27.	Extracts from minutes of public board meeting 03 April 07
28.	Minutes, SNEYHT Public Board Meeting, 26 June 07
29.	SNEYHT Board paper on future of BDH, 18 Dec 07
30.	Minutes, SNEYHT Public Board meeting, 18 Dec 07
31.	SNEYHT Board paper on reconfiguration of BDH 01 April 08
32.	Minutes, SNEYHT Public Board meeting, 01 April 08
33.	Dossier of papers, Save Bridlington Hospital Campaign Action Group
34.	Presentation notes - Unite, the Union
35.	Planning document - Bridlington Hospital Service Reconfiguration Project
36.	Minutes, SNEYHT meeting with Unions, 27 May 08
37.	Presentation notes, Joint HOSC
38.	Overview of daily activity at BDH, August 2007
39.	ONS Neighbourhood statistics, East Riding of Yorkshire
40.	Data Observatory comparisons of Bridlington wards with East Riding
41.	SNEYHT presentation notes: The clinical case for change
42.	SNEYT presentation notes: A future role for Bridlington Hospital
43.	A New Start For Community Health Services, ERYPCT, Nov 2006
44.	Isolated Acute Medical Services, RCP, July 2002

45.	Acute Health Care Services, Academy of Medical Royal Colleges, Sept 2007
46.	Acute Medical Care, RCP, Oct 2007
47.	Emergency Admissions, NCEPOD, Oct 2007
48.	Estate Plan, Scarborough Hospital, 2005

Responses to the IRP enquiry line (emails, letters and phone calls)

Emails

1.	S Holliday
2.	C & L Havercroft
3.	D Jacob
4.	R Lines
5.	B McNulty
6.	C Jagger
7.	D Atkin
8.	R Stacey
9.	B Hunter
10.	F Villani
11.	G Wright
12.	J Triffitt
13.	M Memon
14.	K Daniels
15.	Newby & Scalby Parish Council
16.	Thornton le Dale Parish Council
17.	Leavening Parish Council

Letters

18.	Flamborough Parish Council
19.	Dr A C Francis
20.	Bridlington Town Council
21.	The Mothers' Union Diocese of York
22.	Flamborough Pensioner's Group
23.	West Ayton Parish Council

Phone calls

24.	Mr Attersley
25.	Mr Jowitt
26.	Mr Gould
27.	E Willis
28.	R Smith
29.	P Lacey
30.	A Roseby
31.	J Roseby
32.	B Howarth
33.	D Lovatt

Appendix Eight

Abbreviations used in this report

A & E	Accident and Emergency service
BDH	Bridlington & District Hospital
CCU	Coronary Care Unit
CMU	Cardiac Monitoring Unit
COPD	Chronic Obstructive Pulmonary Disease
CT	Computerised Tomography
ERYPCT	East Riding of Yorkshire Primary Care Trust
FTSTA	Fixed Term Special Training Appointment
FY2	Foundation Year 2
GP	General Practitioner
HOSC	Health Overview and Scrutiny Committee
IRP	Independent Reconfiguration Panel
ITU	Intensive Therapy Unit
MI	Myocardial Infarction
MIU	Minor Injuries Unit
MP	Member of Parliament
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NHSLA	National Health Service Litigation Authority
NYYPCT	North Yorkshire and York Primary Care Trust
OOH	Out of Hours
PAGER	Pensioners Action Group for the East Riding of Yorkshire
PCT	Primary Care Trust
PPI	Patient and Public Involvement
SHA	Strategic Health Authority
SHO	Senior House Officer
SNEYHT	Scarborough and North East Yorkshire Hospital Trust
SUI	Serious Untoward Incident
UAC	Urgent Access Clinic
YAS	Yorkshire Ambulance Service

Appendix Nine

Panel membership

* subgroup members that took a lead in this review

Chair

Peter Barrett	Chair, Nottingham University Hospitals NHS Trust Former General Practitioner, Nottingham

Members

Cath Broderick	Independent advisor for involvement and consultation
Fiona Campbell	Independent consultant specialising in health and social policy
Sanjay Chadha	Justice of the Peace Committee member, Multiple Sclerosis (MS) Society
Ailsa Claire	Chief Executive, Barnsley Primary Care Trust Chair/Manager, Yorkshire and Humber Specialist Service Consortia
Nick Coleman	Consultant in Anaesthesia and Intensive Care Medicine University Hospitals of North Staffordshire
Jane Hawdon	Consultant Neonatologist, University College Hospital Clinical Lead for the North Central London Perinatal Network
Nicky Hayes	Consultant Nurse for Older People King's College Hospital NHS Trust Clinical Director of the Care Homes Support Team
*Brenda Howard	Director of Strategy, Nottinghamshire County Teaching PCT
*Nick Naftalin	Emeritus Consultant in Obstetrics and Gynaecology at University Hospitals of Leicester NHS Trust Former member of the National Clinical Governance Support Team
John Parkes	Chief Executive, Northamptonshire Teaching PCT
*Linda Pepper	Independent advisor for involvement and consultation Former Commissioner, Commission for Health Improvement
Ray Powles	Head Haemato-Oncology Parkside Cancer Clinic, London. Former Head of Haemato-oncology, Royal Marsden Hospital
Paul Roberts	Chief Executive, Plymouth Hospitals NHS Trust
*Gina Tiller	Part-time tutor in industrial relations Chair of Newcastle PCT
Paul Watson	Director of Commissioning East of England Strategic Health Authority

Support to the Panel

Chris Howgrave-Graham:	Acting Chief Executive
Martin Houghton:	Secretary to the IRP
Julian Edwards:	Review Manager

Richard Jeavons took up post as Chief Executive of the IRP with effect from the 1 June 2008. He declared an interest and took no part in the review

Appendix Ten

About the Independent Reconfiguration Panel

The Independent Reconfiguration Panel (IRP) offers advice to the Secretary of State for Health on contested proposals for NHS reconfigurations and service changes in England. It also offers informal support and generic advice to the NHS, local authorities and other interested bodies in the consideration of issues around NHS service reconfiguration.

The Panel consists of a Chair, Dr Peter Barrett, and members providing an equal balance of clinical, managerial and patient and citizen representation.

Further information about the Panel and its work can be found on the IRP Website:
www.irpanel.org.uk