South West London

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Dear Matthew

Thank you for your letter of 6th February. I am sorry to hear that you are unable to attend the next Programme Board meeting. Thank you for arranging for Martin to attend in your place. I thought it may be helpful to respond to your letter straightaway. We also need to make sure that the points you raise are addressed in the appropriate forums. I take each of your points in turn.

1. Clinical Quality and Safety

BSBV is rightly a clinically led programme. Through the Clinical Working Groups (CWGs) we aim to achieve a clinical consensus and where this is not possible we ask for at least a two thirds majority. As you know there has been disagreement about the clinical standards and/or service models by consultants from Epsom Hospital in the urgent care, maternity and newborn, and children's CWGs. When we discussed this you were not surprised, and following your advice we organised separate meetings with the clinicians concerned to make sure that we had fully understood their reservations and that the CWG leaders had a chance to present their proposals. I understand that the clinicians involved were grateful for the opportunity for this further discussion.

Following endorsement of each CWG's recommendations by the Clinical Strategy Group (CSG), I think we do have a strong, clinically coherent platform to build upon but I do not underestimate the further work that needs to take place before these models become a reality.

Turning to your specific points

At the recent urgent care CWG the view was that there would be consistent ambulance service protocols to all urgent care centres to be agreed with the London Ambulance Service and the South East Coast Ambulance Service; however it was made clear that only emergency departments would be considered appropriate conveyance points for care above that which could be delivered in a primary care setting i.e. no emergency 'blue light' conveyance to an urgent care centre. This was explained as akin to the current

protocol for some local care centres at the moment. This approach has been part of the Healthcare for London model for urgent care centres since 2008.

A list of clinical exclusions will be developed with commissioners, providers and the ambulance services to be covered in the post consultation business case in the same way as has been developed in NW London. It was agreed that minor injuries and illnesses would be seen in all urgent care centres and in principle that all conveyances by blue light would be excluded. It was noted by the group that descriptions of clinical guidance on exclusions would be developed and presented in the consultation document. This is an area for discussion at the joint urgent care and long term conditions CWG on 6th March.

The work by the urgent and children's CWGs suggested the following workforce considerations: during hours of operation all urgent care centres are to be staffed by multi-disciplinary teams with at least one registered GP or doctor with primary and emergency care competencies, and one registered healthcare practitioner; all registered healthcare practitioners working in urgent care centres to have a minimum level of knowledge, skills and competence in caring for children and young people, including:

- Recognition of serious illness
- Basic life support
- Pain assessment
- Identification of vulnerable patients

It was not stated that there would be 24/7 paediatric nurses. The presence of an emergency care physician was discussed, but not agreed. It was agreed this would be discussed further outside the meeting.

You are right that the urgent care group has not included paediatric emergency clinicians neither has it included obstetricians, rather access to urgent care has been considered in the children's and maternity and newborn CWGs and of course it is the role of the CSG to bring this together. All the data at the urgent care CWG was signposted as inclusive of all paediatric and adult activity and no specific concern about emergency paediatric provision was noted by the group. The children's CWG was presented with activity, bed and workforce modelling on children short stay units when considering three acute site configuration and agreed with these. This modelling was based on the paediatric flow to children's A&E.

A paediatric A&E consultant has been invited to the children's CWG in this phase but unfortunately has not attended. Some paediatric A&Es e.g. St Helier's, are staffed solely by paediatricians rather than A&E consultants/juniors so their views have been represented at the children's CWG. The children's CWG were unanimous in agreeing that three children's specialist units were not sustainable across the area.

All the CWGs have a forward agenda to continue to address how the models would work in practice.

2. Workforce

It is true that the majority of our focus to date has been on consultant workforce which has been indicated by the London Quality Standards. We have commenced work on broader workforce requirements and this will be addressed by both the individual CWGs and the Workforce Group. I think it would be helpful if the Programme Board could provide focus and drive for this group.

Turning to your specific point, the number of midwives was considered alongside consultant numbers in the decision tree pack at the maternity and newborn CWG but midwife numbers are not a key driver in configuration discussions as the number required relates to the number of births rather than rotas.

3. Out of Hospital Care

The SW London Clinical Commissioning Groups (CCGs) have discussed their preferred programme management arrangements for their out of hospital work and they are due to present the terms of reference for this work to the next Programme Board. I understand that they will be proposing a multi-agency programme board. I think we are all agreed that the successful implementation of the CCGs' plans will require leadership and change from clinicians and organisations across the patient pathways. The CCGs are clear that this is their programme to lead and that it is separate and distinct from the BSBV programme. From a BSBV point of view we need to understand the progress that is being made on their plans as they are built in to our modelling. Your proposal to ask NCAT to review progress at regular intervals to provide external assurance is one that I will put to the CCGs.

4. Consistency in Approach

We have discussed the specific point about the consistency of application of commissioning intentions and estate redevelopment requirements between acute trusts and reached an agreed position.

In terms of demonstrating clearly the modelling, especially workforce modelling, for the different service delivery proposals these should be captured in the decision trees and the CWG reports. As you know, additional information was presented to the CSG on the 3 and 4 A&E/emergency admitting hospital models. From your letter it's clear that there are still questions about the data underpinning the conclusions reached and it would be helpful to discuss these specifics to see if we can address these concerns promptly.

On the makeup of the non-financial scoring moderation panel, I don't think we can modify it at this stage. Three reasons: the composition was agreed at the last programme board; you are not the only organisation who has suggested that you should have more representatives and we haven't acceded to the others; and in any case the members are meant to be representing the clinical community not their individual institutions.

I hope that this response is helpful. We are keen to make sure that issues and concerns are addressed and are happy to respond to points as they are raised.

Yours sincerely

Rachel Tyndall.

Rachel Tyndall
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Better Services Better Value