Buckinghamshire County Council

Select Committee

Health and Adult Social Care – Urgent Care Working Group

Date: Tuesday 28 January 2014

Time: 1.00 pm

Venue: Mezzanine Room 2, County Hall, Aylesbury

AGENDA

12.30 pm Pre-meeting Discussion

This session is for members of the Committee only. It is to allow the members time to discuss lines of questioning, areas for discussion and what needs to be achieved during the meeting.

1.00 pm Formal Meeting Begins

Purpose of the committee

The Health and Adult Social Care Select Committee is the designated statutory health scrutiny committee and shall carry out the local authority scrutiny functions for all policies and services relating to the scrutiny of public health, local health services, adult social services

and family wellbeing, including: Public health and wellbeing; NHS services; Health and social care commissioning; GPs and medical centres; Dental Practices; Health and social care performance; Private health services; Family wellbeing; Adult social services; Older people; Safeguarding; Physical and sensory services; and Learning disabilities.

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Members

Mr B Adams
Mrs M Aston
Mr C Etholen
Mr D Hayday
Lin Hazell (C)
Mr D Martin
Mr B Roberts
Mr M Shaw
Ms J Teesdale
Julia Wassell
Mr D Carroll

Co-opted Members

Mrs Freda Roberts, Aylesbury Vale District Council
Mr N Shepherd, Chiltern District Council
Dr W Matthews, South Bucks District Council
Mr A Green, Wycombe District Council
Ms S Adoh, Local HealthWatch

Suggested HASC Urgent Care Working Group Scope of Work

Background papers

- Clinical Commissioning Group (CCG) Response to HASC urgent care questions (Nov 2013).
- Transforming urgent and emergency care services in England: Urgent and emergency care review end of phase 1 report (NHS England, Nov 2013): http://www.nhs.uk/NHSEngland/keogh-review/Documents/UECR.Ph1Report.FV.pdf
- Emergency admissions to hospital: managing the demand (National Audit Office, Oct 2013): http://www.nao.org.uk/wp-content/uploads/2013/10/10288-001-Emergency-admissions.pdf .
- HASC service configuration topic paper.

Scope and Aims

The urgent care pathway design used by Buckinghamshire residents up to the point at which they either receive the advice or treatment required outside of hospital or are admitted as an inpatient. The quality of services will be considered only in so far as this is undermined by the pathway design, and it is not within the scope of this inquiry to assess the quality of every service comprising the pathway (e.g. GP out of hours, 111, A&E, MIIU etc).

By considering up to date evidence published and additional explanations provided by local healthcare commissioners, the working group will aim to arrive at a consensus upon the following:

- The acceptability of the current urgent care pathway design in the county, and its likely future direction in view of the recent NHS England report on transforming urgent and emergency care services.
- Improvements required to the urgent care pathway.
- Improvements required to how the public are informed about the urgent care services available, and the rationale underpinning the design of the local pathway.

Method

The working group will meet on the 28th January in public to discuss the background papers and question local healthcare commissioners. Questions will be invited from the public in advance of the meeting, for the committee members to put to the NHS representatives.

HASC Working Group on Urgent Care in Buckinghamshire: CCG response to questions

At their meeting on 28th October 2013, the HASC working group identified a number of questions for the local Clinical Commissioning Groups to answer. The responses provided were as follows:

1. **What is on offer 'in hours' and 'out of hours' ? E.g. GP, 111, OOH, MIIU, MUDAS, A&E and so on. This should clarify how these vary in different parts of the county. For each service they should clearly describe what it does or doesn't cover (particularly in the distinction between A&E and MIIU), the location and the entry points.**

   Please see below for a description of MIIU and Out of Hours services. This also includes a list of injuries which should be seen at A&E rather than the MIIU.

Service:	**Wycombe Minor Injuries and Illness Unit (MIIU)**
Opening hours:	24 hours a day, seven days a week
Location(s):	Wycombe General Hospital, Queen Alexandra Road, High Wycombe, HP11 2TT
Entry point:	Self-referral/referral via GP surgery/referral via 111
Services:	The scope of the MIIU includes both Minor Illnesses and Minor Injuries. The interpretation of X-rays and other diagnostics/ investigations. Interventions considered in-scope include: a) Lacerations b) Abrasions c) Sprains/strains d) Small area burns e) Minor Head Injuries f) Foreign bodies in skin/eyes/ears g) the manipulation of uncomplicated fractures; h) non-complex regional anaesthesia for wound closure; i) incision and drainage of abscesses not requiring general anaesthesia; and j) minor ENT/ophthalmic procedures. The scope of the service is limited to urgent care and does not include a full range of services such as those which might be provided at an A and E Department or GP practice.
Excluded services:	No patients will be brought by the ambulance service to the MIIU under emergency conditions. Clinical exclusions (adults) which are referred to A and E: • High risk chest pain • Ophthalmological conditions except foreign bodies • COPD / acute shortness of breath

	• Status epilepticus • Heart failure • Burns > 5% • Stroke and transient ischemic attach • Significant DVT • Temporarily unable to walk • Significant haematemesis / haemoptysis • Overdose / intoxicated and not able to mobilise • Deliberate self-harm • Significant head injuries • Acute psychosis / neurosis • Complex fractures/ long bone fracture of legs (other fractures are in scope) • Fever with oncology • Sickle cell crisis Clinical exclusions (children) which are referred to A and E • Complex fracture of upper and lower limbs and likely to require manipulation • Procedure requiring sedation • Overdose / intoxicated and not able to mobilise • Fever with oncology • Sickle cell crisis • Unstable seizures and febrile convulsions • Significant head injuries
Current use/ uptake of this service	Roughly 2,600-3,000 attendances per month
Waiting times/ service levels	Triaged within 15 minutes, average wait less than 90 minutes for treatment. Target all patients to be seen within 4 hours

Service:	**Buckinghamshire Out of Hours Service**
Opening hours:	Monday to Friday: 18:30 to 08:00 Weekends: 24 hours Bank holidays: 24 Hours
Location(s):	Amersham Health Centre, King George V Road, Amersham, HP6 SAY Buckingham Community Hospital, Cantell Close, Buckingham, MK18 1NU Stoke Mandeville Hospital, Orthopaedic Clinic, Mandeville Road, Aylesbury, HP11 2TT Wycombe General Hospital, Queen Alexandra Road,

	High Wycombe, HP11 2TT
Entry point:	NHS 111
Services:	Essential services required for the management of patients and who are, or believe themselves to be: a) ill with conditions from which recovery is generally expected; b) terminally ill; or c) suffering from a long term condition;
Current use/ uptake of this service	5,800-6,100 attendances per month
Waiting times/ service levels	As per clinical requirements determined by 111 service

In addition, the Multidisciplinary Assessment Unit (MuDAS) is open Monday to Friday 9am to 5pm. GPs can refer patients to the Unit for assessment, treatment and therapeutic and/or clinical care.

2. What information on these choices and how to access them is publicised, and where?

Several information and communication campaigns are currently being rolled out to help signpost patients to the right service. These include:

- A social marketing campaign targeting –'one stop resolutioners' – people who research has found use A&E inappropriately for minor issues because it offers a range of services in one place. Material has been developed according to the communication preferences of the demographic and it is being distributed by targeted postcode. The audience is being urged to use 111 as its one stop solution rather than A&E.
- A publicity campaign to promote the benefits of the MIIU for minor injuries. An information video has been produced which will be shown in GP practices and distributed widely via social media. This is supported by literature explaining the services offered at the MIIU.
- A schools competition, to encourage pupils to design materials which make people think twice about using A&E
- Targeted work at GP practice level, to explain to patients the range of urgent care options available for them.

3. The current use/uptake of these services, and waiting times / service levels. Signpost to where this data is publicly available, if at all.

See above

4. **What services were lost when the Wycombe EMC changed to the MIIU? Has what was proposed in 2012 (as per the BHiB proposal) been fully delivered? Could the MIIU be upgraded to an EMC in the future?**

   The changes agreed through Better Healthcare in Bucks were to enable us to bring together services which were previously split across two sites, allowing senior doctors to spend more time with their patients. Evidence shows that when senior doctors are able to work together in larger teams, spending more time with their patients, outcomes for those patients are better. The services which were brought together at Stoke Mandeville Hospital included emergency services, inpatient emergency general medicine, respiratory, gastroenterology, diabetes services and services for older people. A new 24/7 minor injuries and illness unit staffed by GPs and emergency nurse practitioners was opened at Wycombe Hospital and this is catering for over 30,000 people a year. A Multidisciplinary Assessment Unit was opened in Wycombe Hospital at the same time. GPs can refer frail/elderly patients to this service for assessment and treatment on a day basis, meaning that they do not have to go through A&E or be admitted as an inpatient.

   Also through Better Healthcare in Bucks a new specialist centre of expertise for diagnosis and first outpatient appointment for people with suspected breast problems was opened in Wycombe Hospital. This is now fully operation for Wycombe patients and will soon be the centre for the whole of Buckinghamshire.

   Finally, a new receiving unit has been opened in Wycombe Hospital for stroke and cardiac patients. This means that patients who would previously had to go through A&E or the EMC can now be admitted directly to the specialist unit.

   Guidance suggests that a population of at least 500,000 is needed to sustain a district general hospital with a full A&E. The population of Buckinghamshire is just over this meaning it can support the current arrangement for hospitals but the population would need to double in size in order to justify a second A&E. In addition, recommendations last year from the College of Emergency Medicine states that an A&E serving a population of 500,000 should ideally have 10 A&E consultants in order to staff rotas. The Trust 'six consultants were previously spread across two sites, which was not sustainable. Even if the Trust invested in the resources to employ more A&E consultants on both sites, as recent national media coverage has highlighted, there is a shortage of these specialist doctors and it would be very difficult if not impossible to recruit to sufficient numbers to come anywhere near meeting the College recommendations, particularly as the A&Es would not see a big volume of patients.

5. **For each service clarified, please also explain any interdependencies, for example MIIU needs diagnostic facilities, EMC requires intensive care, anaesthesia, blood bank, 24/7 consultant cover etc.**

The MIIU needs diagnostic facilities and also referral pathways to services such as A&E at Stoke, the cardiac and stroke receiving unit and fracture clinics. The Bucks out of hours

service also needs the same interdependencies. The cardiac and stroke receiving unit (CSRU) also needs diagnostic facilities, 24/7 medical cover and intensive care.

6. **More detail on the Clinical and Cost effectiveness of the change from EMC to MIIU, how are Wycombe residents better off because of this? Is their more detail available than what was presented in the BHiB consultation (which justified the changes based on emergency consultant cover, and patient throughput required to maintain consultant skills).**

   The change from the EMC to the MIIU was cost neutral but based on ensuring we could sustain better staffed, safe and high quality services from now into the future. This would not have been possible had the specialist teams continued to be split across the two sites. Evidence behind the changes which was available at the time is published on the Better Healthcare in Bucks website, which is still available to the public. http://www.buckspct.nhs.uk/bhib/?page_id=501. Recently Health Secretary Jeremy Hunt has highlighted the need for larger more centralised A&E units and last month doctors in London repeated the need for fewer A&Es to increase the number of doctors available to treat patients, a move backed by the BMA.

   Next week (11 November) Sir Bruce Keogh will publish his report into urgent care and this is may well further support the fewer but better message, along with other measures such as more GP input to A&Es.

7. **Definition of and distinction between the trauma service provided at Stoke Mandeville (Trauma Unit) and John Radcliffe (Major Trauma Centre).**

   Trauma services work in hub and spoke networks, with major trauma centres supported by traumaunits .A major trauma centre caters for patients with multiple injuries who might need a range of very specialist treatment such as emergency neurosurgery or 24/7 access to trauma and orthopaedic consultants. Such extensive injuries are fairly rare, which is why major trauma centres serve wide geographical populations. A trauma unit such as that at Stoke Mandeville cares for patients with less complex injuries, although still possibly requiring emergency surgery and intensive care

8. **What were the reasons for why SMH was chosen as the site for the county's A&E rather than Wycombe in circa 2005.**

   The Shaping Health Services consultation in 2004 agreed that emergency surgery and trauma services should be transferred to Stoke Mandeville and this took place in 2005. The consultation process was overseen by a multi organisation board chaired by the chief executive of the then Thames Valley Health Authority, and led to:

   - The centralisation of trauma and emergency surgery services at Stoke Mandeville Hospital
   - The development of a planned surgery centre at Wycombe Hospital

- The centralisation of consultant led maternity services and maternity and gynaecology inpatients to Stoke Mandeville Hospital
- The creation of a midwife led maternity unit (MLU) at Wycombe Hospital
- The centralisation of paediatric inpatients and neonatal intensive care to Stoke Mandeville Hospital.

Subsequently the A&E at Wycombe Hospital was no longer supported by a local trauma and emergency surgery service and did not qualify to be a major trauma unit. To reflect this, it was re-designated to an Emergency Medical Centre (EMC) from April 2008 after taking advice from the Strategic Health Authority and a public re-engagement exercise. The EMC was not equipped to receive major trauma (eg following road traffic accidents) but retained most of the features of an A&E.

9. When is the MIIU site having an x-ray suite installed?

Phase two of MIIU estates, which include the X-ray suite, has been delayed due to contractual issues. These are close to being resolved and the latest information we have is that the works are provisionally due to commence in January 2014. The projected time for X-ray unit completion is therefore approximately July 2014.

Buckinghamshire County Council

Select Committee

Health and Adult Social Care Select Committee

BHT Acute Service Configuration Topic Paper (Sept 2013)

Purpose

- Refresh HASC member understanding of the evidence base behind the current configuration of acute hospital services across the Stoke Mandeville (SMH) and Wycombe Hospital sites, drawing on evidence previously submitted to the HOSC/HASC and new evidence.
- Inform future HASC Scrutiny of Buckinghamshire Healthcare Trust (BHT).

Following recent calls for an investigation by the County Council into the provision of urgent healthcare services for Wycombe residents, this paper outlines the evidence for the current location of services, and should assist with isolating issues over the accessibility of services, from issues over the quality of services which was the focus of the work on the Keogh Report by the HASC Working Group. Mindful of this evidence and the Keogh Report issues and associated action plan, the HASC can reach agreement on what further work is required on the urgent care pathway in Buckinghamshire.

2012 Configuration (Better Healthcare in Bucks) Summary

The preferred option which was implemented in Autumn 2012 following the Better Healthcare in Buckinghamshire (BHiB) consultation was to "organise acute services in one network, between two Buckinghamshire acute hospitals (with links to Wexham Park and for vascular services to Oxford University Hospitals)", meaning effectively we have one acute hospital split across two sites 15 miles apart (Stoke Mandeville and Wycombe).

Under the BHiB proposals the vast majority of people would continue to go the same hospital as they did before. The proposals would affect 3% of those patients who use Wycombe Hospital (approx. 7,600 patients out of a total of 225,000 people who came for outpatient, day case emergency or inpatient treatment in 2010/11). With patients requiring specialist urgent care treatment or medical admission for conditions other than stroke and cardiology treated at an alternative hospital. 0.5% of Stoke Mandeville Hospital patients (approx. 1,700 out of over 330,000 people who came to Stoke Mandeville Hospital for outpatient, day case, emergency or inpatient treatment in 2010/11) would be affected comprising those requiring initial assessment or outpatient appointments related to breast care that would be treated at Wycombe Hospital instead.

Justification

The following reasons were summarised by the HOSC in their response to the BHiB consultation, to explain why the changes were necessary:

- Maintaining and improving safety, clinical quality and patient outcomes
- Rising demand for services, particularly as a result of our growing ageing population and new, more complex treatments that are now available;
- The existing duplication of specialist services across two hospitals – Wycombe Hospital (WH) and Stoke Mandeville Hospital (SMH) – is not sustainable over the longer term from a safety and financial viewpoint;
- The European Working Time Directive (WTD) which requires more doctors than previously to be employed to ensure safe 24/7 cover;
- Financial constraints and the need to do more for less[1].

Other evidence provided includes that for a population of Buckinghamshire's size the College of Emergency Medicine recommends that the urgent care department needs a minimum of 10 consultants to meet national requirements. Wycombe and SMH only had 6 between them in 2012, and this number has remained unchanged in 2013 on the SMH site. There is a recruitment issue, and the WTD may be a contributory factor in this.

The Royal College of Surgeons[2] state that "the preferred catchment population size for an acute general hospital providing the full range of facilities, specialist staff and expertise for both elective and emergency medical and surgical care would be 450,000 – 500,000". It is estimated that hospitals of this size account for less than 10% of acute hospitals in England so the RCS concedes as a first step smaller hospitals should have a catchment of at least 300,000. Given the Bucks population, of which not all use BHT, this would preclude a duplication of acute services across SMH and Wycombe.

Coupled with the above, under the previous configuration consultants at the two centres did not see a sufficient number of patients to maintain their skills, putting services and patients at risk.

New evidence: Keogh on the configuration of services

The Keogh report into BHT was critical in a number of areas, and certainly felt with regard to the recent reconfiguration of services that there was a need for greater board oversight and real time evaluation, and that some elements such as patient transfers between sites needed attention. However there was no criticism of the configuration changes made,

[1] The Care for the Future programme that reviewed the clinical and financial challenges across Berkshire and Buckinghamshire ran from 2009-2011 identified that Buckinghamshire Healthcare faced a deficit of between £36.5-43.8 m by 2013/14, with a deficit of up to £350m across the two counties. Coupled with issues around clinical sustainability and service quality this programme concluded the three acute sites should be at Aylesbury (SMH), Reading (Royal Berks) and Slough (Wexham Park).

[2] RCS Delivering Services for the Future (2006)

which were considered positive developments. The following quotes from the Keogh Panel at the Buckinghamshire Risk Summit evidence this:

"*I think it's quite important to say that there was nothing that the panel found that said that the changes were the wrong changes to have been made for patient safety or experience*" (Andrea Young)

"*I just want to reiterate that I don't think we have a problem with the fundamental model in that the centralisation of stroke and cardiac reception being on this site, and the centralisation of unselected emergency care being on the Stoke Mandeville site. It's about the implementation and the quality and patient experience assurance in the delivery of that process*" (Chris Gordon)

These conclusions were reinforced by Chris Gordon when he attended the HASC Keogh Working Group meeting on 14 August 2013.

New Evidence: House of Commons Health Select Committee Report on Urgent and Emergency Services 2013

Whilst generally supportive of centralisation, drawing on evidence cited and provided by the Department of Health (DoH), the report does cite evidence from the College of Emergency Medicine that the benefits may be diminished in rural areas due to the distance patients must travel.

It is worth emphasising that there are different levels of rurality, and the distances involved in reaching a regional centre in a more rural county than Buckinghamshire, will be greater than those between the south of the county and SMH. Overall however this evidence emphasises the need to monitor patient outcomes post configuration, to provide assurance that patients travelling further are not experiencing significantly worse results. The following are extracts from the report:

"*The bulk of the evidence we received made a strong case for centralisation of treatment for patients with certain conditions such as stroke care, cardiac care and major trauma. When implemented successfully, the creation of specialist centres enhances clinical skills and concentrates resources, with demonstrably improved outcomes for patients.*

Centralisation, however, is by no means a universal remedy for the ills of emergency care. Service redesign must account for local considerations and be evidence based. Some rural areas would not realise the benefits from centralising services that London has, therefore the process must only proceed on the basis of firm evidence. The goal is to improve patient outcomes – centralisation should not become the end in itself." (4). The College of Emergency Medicine argued in their written evidence that the benefits of regional centres for patients in rural areas could be entirely negated by increased transport times. These observations merely reinforce the requirement for local commissioners to develop a fully integrated service which responds quickly and effectively to patient need."(23).

DoH evidence to the Health Select Committee:
The Department of Health has defined the various types of A&E facility[3]. If a unit is to receive unfiltered 999 blue light ambulances it must be capable of the resuscitation, diagnosis and immediate treatment of all acute illnesses and injuries in all ages. This will range from major haemorrhage from a stomach ulcer to an overdose in a patient with depression to a finger burn in a child. (EV 69)

The King's Fund (2011) Reconfiguring hospital services document states that there are good evidence based reasons why, in some services, larger units serving a wider catchment area produce better patient outcomes and are more cost-effective. It discusses the good reasons why consolidation of those services onto fewer hospital sites can be expected to drive up quality and drive down costs. The King's Fund cites examples including A&E, maternity and neonatal services, hyper-acute stroke units and heart attack centres. (EV 73)

There is clear evidence of the benefit of centralising services and treatment for a number of defined urgent conditions: major trauma; brain injury; chest injury; heart and lung injury; and major abdominal, pelvic, spine and limb injuries; Stroke; heart attack; major vascular (blood vessel) rupture or blockage; severe neurological disorders; and severely ill children.

It is possible that smaller A&E departments would become less clinically sustainable. Hospital trusts have important interdependencies of services for critical care, radiology, pathology and acute bed numbers. Removing certain groups of patients can therefore reduce the need for these interdependent services. Given the current shortage of medical staff in acute and emergency care, recruitment and retention may also become difficult for smaller units, as staff move towards the larger centres where better care can be delivered. Therefore, any decision to centralise services needs to take into account issues of equality and health inequalities, so that no individuals or groups are disproportionately disadvantaged by the relocation of service and that the benefits of any service change are experienced by whole populations. .. The emergence of networks (hub and spoke) with larger A&E departments working with local urgent care centres is one of the emerging solutions. (EV 75).

College of Emergency Medicine evidence to the Health Select Committee:
Urban areas are most suitable for centralisation of services. Clinicians can work in more than one unit thus retaining skills, patients are not geographically or psychosocially disadvantaged and economies of scale are maximised. In rural areas significant clinical benefit is lost as a result of increased transport times and none of the advantages stated for urban areas pertain. (EV 95).

[3] 1 Type 1—A consultant led 24-hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients.
Type 2—A consultant led single specialty accident and emergency service (e.g. ophthalmology, dental, children's A&Es) with designated accommodation for the reception of patients.
Type 3—Other type of A&E/minor injury units (MIUs)/Walk-in Centres with designated accommodation for the reception of accident and emergency patients. A type 3 department may be doctor led or nurse led. It may be co-located with a major A&E or sited in the community. A defining characteristic of a service qualifying as a type 3 department is that it treats at least minor injuries and illnesses (sprains for example) and can be routinely accessed without appointment. A service mainly or entirely appointment based (for example a GP practice or outpatient clinic) or one mainly or entirely accessed via telephone or other referral (for example most out of hours and primary care services) is not a type 3 A&E service even though it may treat a number of patients with minor illness or injury.

New Evidence: Emergency College of Medicine *The Drive for Quality 2013*

Among other things this report clarifies what services are required on an emergency medical site, demonstrating what would be required on the Wycombe Hospital site for a safe A&E / Emergency Department (ED) to be reinstated. *"The College view is that an ED must have 24/7 support services from Acute Medicine, Intensive Care/Anaesthesia, diagnostic imaging and laboratory services, including blood bank. It also remains the view of the College that the required support for an ED is provided by the 'seven key specialties'- Critical Care, Acute Medicine, Imaging, Laboratory Services, Paediatrics, Orthopaedics and General Surgery". (16)*

The relevant extract from this report and associated table are included in the appendices.

Future Hospital Commission: Caring for Medical Patients, Sept 2013

Outlines a way forward in response to the major challenges facing acute hospital services, centred around the needs of patients. Explains what hospitals must deliver and how they move towards this. Includes 7 day working, seamless integration with primary, secondary, tertiary and social care, measuring patient experience, staff training/education, avoiding unnecessary bed moves, reducing hospital lengths of stay. Provides a useful summary of how demographic changes and advances in medicine now required the NHS to deliver its services differently, moving away from the model of district general hospitals in every town. Encourages a move away from specialist care being limited to specific wards, and instead having specialist medical teams providing expert management of chronic disease in the community.

On the configuration of services it states: *The Commission recognises that its findings imply that tough decisions lie ahead. Reconfiguration will almost certainly be needed. No hospital can provide the range of services and expert staff needed to treat patients across the spectrum of all clinical conditions on a 7-day a week basis. We need to develop a new model of 'hub and spoke' hospital care, coordinated across health economies, centred on the needs of patients and communities and based on the principle of collaboration, not just across health services but also with social care, transport planning etc. It is likely that in many areas, large health economies will be served, not by a number of district general or teaching hospitals, but by a smaller number of acute general hospitals hosting EDs (emergency departments) and trauma services, acute medicine and acute surgery. These hospitals will be surrounded by intermediate 'local general hospitals' which, while not directly operating their own ED and acute admitting services on site, will contribute to step-down inpatient and outpatient care, diagnostic services and increasingly close integration with the community.* (para 1.27, page 9).

Appendices

- **NCAT Report on BHiB Proposals 2011 –** Worth reading for a comprehensive summary of the service configuration rationale, and for a clinical assessment and endorsement of this: http://www.buckspct.nhs.uk/bhib/wp-content/uploads/2012/02/National-Clinical-Advisory-Team-NCAT-report.pdf

- **HOSC response to BHiB Consultation 2012 Exec Summary –** A recap of the 2012 HOSC view of the proposals, with recommendations highlight areas of concern (many of which are still to be adequately resolved): http://democracy.buckscc.gov.uk/documents/s24062/Response%20to%20Consultation%20Proposals.pdf

- **Extract (pp 16-17) Emergency College of Medicine *The Drive for Quality 2013:*** http://www.collemergencymed.ac.uk/Shop-Floor/Professional%20Standards/Quality%20in%20the%20Emergency%20Department/default.asp