Agenda Item 5

HAMPSHIRE COUNTY COUNCIL

Report

Committee:	Health Overview and Scrutiny Committee
Date of meeting:	30 March 2010
Report Title:	Inquiries Received and Action Taken
Report From:	Chief Executive

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1. Summary and Purpose

1.1. This report provides Members with information about the issues brought to the attention of the Committee and the response to these referrals. It sets out the inquiries received, the source of this inquiry and any action taken. Where appropriate comments have been included and copies of briefings or other information attached.

1.2. The approach adopted provides the route through which Local Involvement Networks (LINks) and other partner organisations (Hampshire district councils, NHS organisations, voluntary and independent sector providers and organisations that are representative of social care service users and carers) can raise issues with the Committee.

1.3. Where inquiries raised with the Committee are already subject to monitoring or other performance management activities the action taken will be focused on the local resolution of inquiries through appropriate sign-posting to the agency best placed to respond.

1.4. Where an issue cannot be satisfactorily resolved between the parties concerned then the Committee can consider options for further action.

1.5. New issues raised with the Committee, and those that are subject to on-going reporting are set out in Table One of this report.

1.6. The recommendations included in this report support the Corporate Strategy aim of maximising wellbeing through the overview and scrutiny of health services in the Hampshire County Council area.

Table One: Inquiries Received and Action Taken

Topic/inquiry	Source	Action Taken	Comment
Temporary Closure In patient services at Andover Birth Centre	Winchester and Eastleigh Healthcare NHS Trust	The Trust will attend the meeting to confirm that the Unit is reopening inpatient care (26 April 2010) and the improvements that have been made as a result of the closure. Antenatal and post natal services are not affected by this change. The briefing from the Trust is attached at Appendix One.	.
Recommendation: WEHT provides any additional information requested by members.			
NHS Hampshire	Future arrangements for the provision of community services.	NHS Hampshire has alerted the HOSC to determine the future organisational form for Hampshire Community Health Care: the community health services provider of Hampshire Primary Care Trust . The steps taken to progress this work, and the preferred provider will be confirmed on 30 March. A briefing from NHS Hampshire is attached at Appendix Two	
Recommendation: That NHS Hampshire provides any additional information requested by members in relation to this organisational change.			

Topic/inquiry	Source	Action Taken	Comment
Ambulance performance in rural areas	Bucks, Hants, Oxon JHOSC	This joint review report was sent to all members on 9 February. It can be accessed at http://www3.hants.gov.uk/ambulance-services The response from the Secretary of State to the report is attached at Appendix Three. A formal response from SCAS and NHS commissioners is expected by the end of March.	
Recommendation: Any additional responses provided by SCAS and the wider NHS is shared with the HOSC**.**			
Designation of Burns Centres	South West Specialist Commissioning Group	The response of the commissioners to the issues raised by the HOSC is attached at Appendix 4	
Recommendation: Members confirm their support for the arrangements outlined..			

Section 100 D – Local Government Act 1972 – background papers
The following documents disclose facts or matters on which this report, or an important part of it, is based and has been relied upon to a material extent in the preparation of this report.

NB the list excludes:

1. Published works
2. Documents that disclose exempt or confidential information as defined in the Act.

Appendix One

Winchester and Eastleigh NHS
Healthcare NHS Trust

BRIEFING NOTE ON THE PLANNED RESUMPTION OF INPATIENT SERVICES AT ANDOVER BIRTH CENTRE

18 March, 2010

BACKGROUND

The inpatient service (births and postnatal stays) is due to restart at Andover Birth Centre (ABC) on Monday April 26 – from 9am.

Winchester and Eastleigh Healthcare NHS Trust's maternity team experienced severe staffing shortages last year which meant that the Trust was unable to provide a safe service across its three areas; Winchester, Andover and the community.

As a result, births and postnatal stays at the ABC were suspended over the winter. Before this decision, there had been three occasions when the ABC had closed suddenly due to lack of midwifery staff. A planned suspension, albeit at short notice, posed less of a risk than trying to maintain a service when any reduction in staffing levels could lead to closing the doors without any notice.

All other maternity services based at Andover continued as normal during the suspension which began on 1 December 2009. Antenatal and postnatal clinics, home visits, parentcraft classes, home births and support to consultant obstetric clinics were staffed as normal.

Staffing levels have improved as a total of thirteen midwives return from maternity leave and new midwives begin work at across the service.

There is a national shortage of midwives and so the Trust has done well to boost its numbers. Despite this, staffing remains challenging across the service and could be affected by sudden changes, such as an unusually high level of leavers or sickness absence, etc.

Safety remains the overriding factor in maintaining births and postnatal stays at the ABC. Towards the end of last year – before the suspension – staff from Winchester worked in Andover to try to avoid maintain the inpatient service. However, this depleted the maternity unit at the Royal Hampshire County Hospital (RHCH) and so could not be continued. Out of the total births at the Trust (around 3,000), the average number for the ABC is 200 approx and around 140 home births across the whole area.

NEW MODEL OF CARE – CALLING AHEAD IS CRUCIAL

During the suspension maternity staff - led by midwives at the ABC - developed proposals for a new and highly responsive way of working at the ABC. The new 'model of care' will provide midwife support for births at the centre and also in the community.

Women who are in labour and want support with a home birth or to have their baby at the centre will need to call the ABC on 01264 352517. They should not arrive at the ABC without calling ahead.

It has always been the case that women in labour were advised to contact the ABC beforehand. The new staffing model makes this a necessity because midwives may not be at the centre 24/7. However, we have planned for there to be enough midwives on call to be able

to get to the centre or to a home birth. Postnatal women may also be supported by midwives or maternity support workers, depending on clinical need.

AN IMPROVED SERVICE
The suspension enabled a thorough review of training needs and skill levels across the service. In addition, staff began to work more flexibly across the ABC, RHCH and in the community and this is now a key feature of the Trust's maternity service.

Ensuring that staff are up-to-date with their clinical skills and statutory and mandatory training has been a plus point of the gap in service.

SUPPORT OF STAKEHOLDERS
It is hoped that more women than ever before will have their babies at the ABC – which was refurbished last year. The Trust would be grateful to HOSC members for promoting the ABC to constituents. Numbers of births will be monitored.

EQUITY AND CHOICE
Once the inpatient service has restarted, women in the Andover area will have a fantastic choice of childbirth options. The RHCH is within a reasonable driving distance, home births remain an option for low risk deliveries and the ABC is back in business, offering a low-tech birth in homely surroundings. The Trust would like to provide this level of choice to all and so will monitor where women who use the ABC come from.

The length of stay will be more in line with other NHS birth centres and maternity units. It is now standard practice for women to return home within six to 48 hours of their delivery, depending on clinical need.

The experience of having a baby at the ABC will be different by nature due to small scale setting which is unlike being in a busy labour or postnatal ward. Despite this difference, the Trust wants to see the same quality and cost levels where possible across the two sites.

HOME BIRTHS
These have continued to be supported during the suspension. Every mother who is suitable for a home birth will be able to deliver at home unless there are clinical reasons or exceptional staffing/logistical reasons. The new staffing model has been devised to support home births as well as deliveries at the ABC.
There are around 140 home births across the whole area in a year.

SAFETY
As set out previously, the Trust places patient safety above all other criteria. In this case, the safety of the whole service across two sites and the community is considered. If staffing levels drop suddenly the Trust will always act in the best interests of patients and as a last resort may look at moving staff if this can help by imposing a further suspension.

Appendix Two

NHS HAMPSHIRE

FUTURE ARRANGEMENTS FOR SERVICES PROVIDED BY HAMPSHIRE COMMUNITY HEALTH CARE

1. INTRODUCTION

1.1. This paper has been drafted to provide the Hampshire Health Overview and Scrutiny Committee with a report on the future arrangements for services provided by Hampshire Community Health Care.

1.2. Since its establishment in October 2006, Hampshire Primary Care Trust [PCT] has sought to separate the two core parts of its business: commissioning (NHS Hampshire) and community health service provision (Hampshire Community Health Care). In December 2009, the Department of Health wrote to all Primary Care Trusts in England requiring them to make a recommendation to their Strategic Health Authority [SHA] on the future organisational form for the service delivery arm of their organisation by 31 March 2010. This short timescale has been set in order to provide certainty for staff and a stable foundation for service transformation. Once this milestone is met, implementation of any new provider form will need to be completed by April 2011, or very substantial progress to have been made towards the new organisational form.

1.3. The Department of Health has given the PCT a clear steer on the options available to NHS Hampshire. Whilst there is no prescribed form, the most likely options are:

- integration with an acute or mental health provider;
- integration with another community-based provider;
- social enterprise.

1.4. Other options identified, although unlikely to have widespread application are:

- Community Foundation Trust;
- continued PCT direct provision;
- Care Trust which includes provision.

1.5. Following the publication of this guidance, Hampshire PCT reviewed the range of potential options and determined the mechanism by which a proposal will be taken on the future organisational form for HCHC. A priority for Hampshire PCT was to determine whether it should pursue the option of HCHC becoming a Community Foundation Trust [CFT].

1.6. The guidance is clear that CFTs will be an option for a very few areas - no more than 10 candidates, including the original six CFT pilots. The challenging timetable set by the Department of Health required SHAs to have identified potential CFT candidates by 22 January 2010, with the submission of proposals by 29 January 2010. Following a number of Board meetings and discussions with a wide range of stakeholders, Hampshire PCT decided that it would not put forward Hampshire Community Health Care for consideration as a CFT.

2. PROCESS

2.1. In the light of this decision, the PCT then commenced a project to evaluate potential options for the future organisation form of HCHC and ultimately make recommendation to the South Central SHA by 31 March 2010 on the PCT's preferred solution. In order to support this process, the PCT established a Provider Review Committee to ensure that the perspectives of key stakeholders were included in any recommendation made by the PCT. The PRC consists of PCT Executive and Non-Executives; 3 Primary Care Clinicians; the Chair of the Hampshire LINk; representatives from Hampshire County Council Adult and Children's Services; and HCHC staff side representation.

2.2. The PRC first met on 18th February 2010 and agreed the following:

- approved the Commissioning Case for Change that sets out the backdrop to this change and the commissioning ambitions of NHS Hampshire (attached);
- approved the criteria that would be used to assess options for future organisational form;
- used these criteria to determine which organisational model(s) it believed would best support the delivery of the commissioning strategy and contribute to the vision of Hampshire Community Health Care to transforming clinical models and out-of-hospital care.

2.3. The outcome of the evaluation undertaken by the PRC is that the preferred organisational model will be the '**integration of HCHC with a single acute or mental health organisation that currently has an existing significant service provision role within the Hampshire health system'**.

2.4. In order to assess the potential of organisations to support this objective, the PCT has sought proposals that could be worked up in detail to form the basis of a sustainable clinical and financial long-term solution for HCHC. These proposals will be considered by the PRC on 18 March 2010, prior to ratification by the PCT Board on 25 March 2010.

3. ENGAGEMENT AND INVOLVEMENT

3.1. In addition to the PRC, the PCT has been communicating with a wide range of stakeholders about this process, including the LINk, local community groups, local MPs, Local Authority Chief Executives, primary care practitioners, local Representative Committee members, HCHC staff and staff side representatives. Following the recommendation to the SHA on 25 March 2010, there will be a period of four months where more intensive engagement and involvement with stakeholders will take place. It is important to recognise, however, that the recommendation being made to the SHA relates to organisational form rather than service delivery.

4. RECOMMENDATION

4.1. The Health Overview and Scrutiny Committee are asked to note the progress of the determination of the future arrangements for services provided by Hampshire Community Health Care, and to identify any components of an engagement and involvement process for the next phase of the process.

Appendix Three

From the Rt Hon Andy Burnham MP
Secretary of State for Health

Department of Health

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Tel: 020 7210 3000

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Anna McNair-Scott
Chairman Hampshire Health Overview and Scrutiny Committee
Room 140 Chief Executives Department
Hampshire County Council
The Castle
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Hampshire SO23 8UJ

11 MAR 2010

Dear Cllr McNair-Scott,

Thank you for your letter of 9th February asking me to consider the issues you have raised in your recent report 'South Central Ambulance: Review of Rural Performance'.

I have asked my officials to prepare a detailed response to answer the comments you make, which is attached.

Yours sincerely,

Andy Burnham

ANDY BURNHAM

AG 09.03

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10 March 2010

Dear Councillor McNair Scott,

The Secretary of State has asked me to reply in detail to the recommendations in your report, 'South Central Ambulance: Review of Rural Performance' to which you drew his attention in your letter of 9th February.

Ambulance services are one element of the range of urgent and emergency care services that are provided by the local NHS, which include in and out of hours primary care, community services, A&E, NHS Direct, walk in centres and minor injuries units. Our vision for urgent and emergency care is that patients are provided with 24/7 services which are integrated together, so that patients get the right care wherever they access the health system, and don't have to 'tell their story' multiple times to different services as they move through the system. In both urban and rural areas, the range of urgent and emergency care available needs to respond to the needs of the population, so that patients are not accessing 999 ambulance services due to other components of the urgent and emergency care pathway not providing adequate access to services.

The key to effective provision of integrated urgent and emergency care services is robust commissioning. Based on the Department of Health World Class Commissioning principles, our focus is on working to remove barriers to effective, integrated commissioning of urgent and emergency care services to enable high quality 24/7 provision of these services to patients.

I recognise that reaching patients that need an ambulance in rural areas within response time standards can be a challenge for ambulance trusts. Addressing this challenge requires effective operational practices and a good understanding of patterns of demand by the ambulance trust, alongside a strong commissioning relationship between PCTs and providers locally.

I welcome the fact that this group of OSCs has taken action to focus on improving services in your area. The Department of Health is keen to encourage the NHS to drive up the quality and productivity of services over the coming years, during which time the NHS will be facing significant financial challenges, and the urgent and emergency care sector is an important area where such improvements can be made.

You have asked the Secretary of State to comment on a number of issues relating to national requirements for reporting by ambulance services, in relation to the standard contract for ambulance services and to the way in which ambulance trust performance is evaluated. I will deal with each of your points in turn.

1. Reporting response times separately for urban, semi-urban and rural areas (according to population density) to enable direct comparisons to be made.

As you are aware, ambulance trusts are only required to report response time information for the trust as a whole, indeed this is the same for any measurement of NHS performance; it is across the organisation as a whole irrespective of the whether the organisation is multi-site or the geographical population that it provides services for. Trust performance is therefore assessed on this basis by the Care Quality Commission in its periodic review (formerly annual health check) and by the Department in its NHS Performance Framework. Many NHS services look at performance data broken down by smaller geographical areas, but whether and how they do this is up to local commissioners to decide, as part of their responsibility for overseeing the performance of the provider. As such, I would support in principle the recommendations that you have made in relation to strengthening local commissioning arrangements and the relationships between commissioners and providers, but this is for local determination.

The Department regularly reviews the level of data that it collects to ensure that it is able to adequately monitor NHS performance without placing an unreasonable burden of reporting on the NHS. There are currently no plans to change the level at which ambulance data is collected. Collecting data nationally for urban, semi-urban and rural areas would place a substantial additional reporting burden on trusts and would undermine the responsibility of local commissioners and providers for managing and providing local services.

The Department continues to seek assurance via SHAs that they are working with local organisations to address any particular issues of concern in relation to performance.

2. Identification of quality and patient outcome metrics based on clearly defined care pathways to complement response times and enable direct comparison of outcomes between urban, semi-urban and rural areas.

The Department recognises that time standards alone do not offer a full picture of the quality of care that ambulance services provide. In view of this, the new National Clinical Director for Urgent and Emergency Care, Professor Matthew Cooke, is leading a project to develop quality indicators that will act as a proxy for how well the urgent and emergency care system is functioning as a whole, and a set of quality indicators specifically for ambulance trusts. These quality indicators will be defined nationally, with input from a wide range of stakeholders, and will be measured and used locally by providers and commissioners.

The ambulance service already monitors its performance against a suite of clinical indicators covering a range of conditions, including asthma, cardiac arrest, ST elevation MI (STEMI), diabetes and stroke. These give a measure of clinical quality that goes beyond the existing response time standards. The indicators already form part of the CQC's periodic review (formerly annual health check), and the service is currently piloting an indicator on trauma care with a view to adding this to the list. Some local commissioners take account of these existing quality indicators as part of their commissioning relationship with trusts.

3. Risk assessment at the point of call triage being built into performance outcomes

The triage of the 999 call by a call handler is a vital stage in an ambulance response. This needs to be undertaken quickly and effectively to enable a fast response to be sent to patients with serious and life-threatening conditions. Each call is categorised as A, B and C. This process of categorising calls is in itself a basic risk assessment process.

Your report discusses a number issues relating to call triage, including whether the most appropriate response is dispatched to calls, the need for local knowledge, cross border protocols and whether greater use should be made of GPs and nurses in call triage. These are all issues which should be defined locally. If any additional risk assessment is needed at the triage stage, this can be defined and put into practice as a local protocol, and could be included in contracting agreements locally (see section below relating to the ambulance standard contract).

It would seem disproportionate to extend national reporting of performance to include additional information about risk assessment for each call.

4. An agreed maximum waiting time for responding to different call categories. All calls that exceed this 'floor' to be routinely monitored and published.

There is no reason why this type of 'floor' cannot be agreed locally. In fact, NHS London, the Strategic Health Authority (SHA) for the Greater London area, already has an agreement between its providers and commissioners for a performance 'floor' for each PCT, below which performance must not drop. This is not something, however, that the Department plans to impose nationally. It needs to be based on local agreement and to be related to the needs of individual local areas.

5. An agreed national approach to unscheduled/urgent/emergency care pathways that is able to ensure that resources are deployed across urban, semi-urban and rural areas as effectively as possible. This should include the role, responsibilities and accountability of first responders.

As the NHS prepares for a more challenging financial climate over the coming years, the Department has made clear that the NHS should focus on improving quality and productivity. The urgent and emergency care sector has been identified as an area where there is real potential for making NHS services more efficient, while at the same time providing a better service for patients. This is because, in many areas, the range of urgent and emergency services, including the ambulance service, A&E, out of hours services, NHS Direct, walk in centres, and community services such as district nurses and falls teams do not currently work in a fully integrated way which means that patients do not always receive the service most immediately appropriate to their needs. It is not possible to define separate clinical pathways for the majority of patients needing urgent and emergency care. Where this is possible, e.g. for stroke and heart attack, good information is available on those pathways. To achieve better integrated services, a focus on strong commissioning across urgent and emergency care is needed.

In particular, this means that demand for ambulance services could potentially be reduced if appropriate alternative services were readily available locally. The toolkit 'Tackling Demand Together: A Toolkit for Improving Urgent and Emergency Care Pathways by Understanding Increases in 999 Demand' was published in autumn 2009, following joint work by ambulance providers and PCT commissioners. It includes practical information and tools to help- PCTs and ambulance trusts work through some of the issues and gaps in services that may be influencing rises in ambulance demand. Its aim is to encourage this type of joint working to help strengthen commissioning of urgent and emergency care services and improve good working relationships between providers and commissioners. Local partners in the South Central area may wish to use this toolkit to help strengthen the provision of the multiple, complex pathways that urgent and emergency care patients experience.

First responders (as opposed to Community First Responders and co-responders which are discussed below), are single responders who attend calls, often using a car or motorbike to get to the patient fast, ahead of a

double-crewed vehicle which can be necessary if the patient requires transport. Most ambulance services use this model 'the front-loaded model' of sending first responders out ahead of a double-crewed response. It is for services locally rather than for national government to define the roles and responsibilities of first responders. First responders are accountable to the trust for the quality of their clinical practice in the same way as ambulance crews who work in pairs.

6. Excluding 'running calls' as part of the evaluation of Category A performance

Running calls are unplanned calls that do not come through the 999 telephone system, i.e. when an ambulance crew takes responsibility for a patient whilst they are on the road or at an event.

There are many different possible scenarios for how a running call might occur, for example an ambulance crew might find someone unconscious on the street, which would clearly be a high priority, or they might find someone with a minor injury at an event, which would be a lower priority.

The Department's KA34 guidance sets out a broad framework by which data should be reported, but does not cover every possible scenario. Trusts are expected to put protocols in place locally for how crews will deal with scenarios that are not explicitly covered in the KA34 guidance. National Groups like the national Ambulance Directors of Operations Group regularly share good practice on these types of issues. Where interpretation of the KA34 is necessary, trust Boards locally are responsible for satisfying themselves that their data is accurate, and consistent with both the Guidance and with a high standard of patient care.

7. Community/co-responders not 'stopping the clock' for ambulance response times

It is important that all patients receive a good standard of care, whether they choose to live in urban or rural locations. That is why ambulance trusts need to make the best use of technology to help understand where demand is likely to occur, and to use effective models of staffing.

Community First Responders (CFRs) are volunteers who offer first aid within the local community ahead of the arrival of a further ambulance response. Co-responders are members of the fire service who are trained in first aid to be able to play a similar role to CFRs. Both of these roles form part of service delivery in most ambulance services, and they play an important part in getting potentially life-saving care to patients in rural areas.

The ambulance 8 minute standard is based on clinical evidence relating to cardiac arrest patients and the time in which they require defibrillation. For every minute for between collapse and the commencement of life support, survival rates reduce by 10%, and that after 10 minutes very few patients survive. It is in keeping with the standard, therefore, that CFRs and co-

responders who are trained in defibrillation and first aid should 'stop the clock' for the 8 minute response time standard.

It is worth pointing out that the complementary standard to the Category A 8 minute standard is the Category A 19 minute standard requires that patients requiring transport should receive it within 19 minutes. Ambulance trusts across England routinely meet the Category A 19 minute standard every year. Therefore patients in rural areas who have received a fast response from a CFR or co-responder should receive a back-up response within 19 minutes where transport is required.

The Ambulance Standard Contract

The NHS Standard Contract reflects the requirements and performance standards set out either in DH guidance or as part of the existing commitments or the performance requirements set out in the NHS Operating Framework. However, the contracts are written specifically to allow Ambulance Trusts and the Commissioners to also agree and to record local indicators that are relevant to the local health community or across the SHA.

The introduction of a mandated template for service specifications for all NHS commissioned services provides further opportunity and flexibility for providers and commissioners to record key service requirements and specific patient outcomes. The templates have mandated headings but the content is to be agreed locally.

The clinical performance of services is recorded in the monthly clinical or service quality report. This report was first introduced into the standard contracts in 2008/2009. The clinical quality report provides the opportunity for providers to bring to the attention of the commissioners those areas of concern and success in the delivery of services.

For 2010/2011, the contracts require the provider and commissioner to agree a service development and improvement plan. This plan will record not only the productivity and efficiency gains required but to also the planned development of service over the life of the contract.

Conclusion

You have raised many important issues, and I hope I have explained clearly why many of these need to be addressed at a local rather than a national level, on the principle that responsibility for running and managing services should be held by the NHS locally, not by central government. I hope that your review will assist the South Central area in addressing some of these issues over the coming months.

However I fully accept your assertion that national direction is needed in relation to developing quality measures and I hope that I have offered you reassurance that the Department is already taking concrete action to support

the development of quality measures to be used alongside the existing response time standards for ambulance trusts.

Yours sincerely,

Chris Dowse
Deputy Director - Urgent and Emergency Care
Department of Health

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Appendix Four: South West Burn Care Network – Designation

I apologise for not having previously replied to your letter following the designation visits to Burns Services earlier this year. As you know the designation process has been proceeding and I thought I should update you and, in particular, outline how we will address some of the points raised in your letter. I was grateful that you confirmed that your committee did not view this as constituting a substantial change.

Since the visits earlier this year, we have reviewed access times to services (both via ambulance, helicopter and private car), and completed our public engagement events. We also received confirmation that Plymouth Hospitals NHS Trust wished to be considered for designation as a Burns facility (for minor burns). No other Trusts in the Devon/Cornwall area, which had an appropriate infrastructure, wished to be considered and we have been supportive of this development in order to provide an improved service for residents of Cornwall and Devon, with considerably less travel for those with minor burns. The designation visit took place last month and we are working with the Trust to enable them to commence the service from April, subject to confirmed agreement from HOSC's.

We have also developed a Network work programme which will address many of the areas for further work which you raised. In response to the particular areas which you raised:

- Clarity about thresholds at which transfer is necessary: transfer thresholds from facilities to units and units to centres have now been agreed by all Burns services across the Network. An audit programme will be implemented to review transfers to ensure the system works effectively.

- Engagement of the Ambulance Services and associated training issues for emergency service staff: This will be a priority area, especially with the new transfer thresholds. The need for training in assessing burns is recognised and our Network Clinical Leads for Adults will be responsible for linking with Emergency Departments and responding to their training needs.

- Confirmation of the support available to meet travel and expenses of families: this issue has been raised by several HOSC's and by the public. There is some useful guidance of general support available, published by the Department of Health, and this will be made available by all the Burns services. We are also pleased that Morriston Hospital in Swansea offers free parking and free accommodation for relatives. We accept that there is further we can do to ensure that there is greater consistency and awareness of the support available and our Network Manager will be taking this forward.

- Patients requiring palliative care: we will be carrying out a programme of reviewing all the clinical protocols across the Burns services over the next year to ensure greater consistency. Following your highlighting this area, we will ensure that palliative care arrangements are among the first policies reviewed. Our Network Clinical Leads will be leading this programme.

- Patients with other conditions: this is not something we have yet picked up, but we acknowledge its importance. I will ask the clinical leads to include this in their protocol review.

- Availability of outreach services and support for repatriation: we have established an outreach group which is reviewing the current arrangements for outreach across the Network and which will recommend a model to take this forward. This group has now met several times and this is one of our top priorities to implement post designation. With regard to repatriation, work has commenced in reviewing the levels and types of therapy support that would be needed to enable patients with different degrees of complexity to be repatriated.

- Patient support groups: we acknowledge the valuable role which such groups play and will consider how we can develop and support these. Several attempts have been made to establish adult support groups across the Network but with much less success than paediatric groups. We will be looking to see if there are any lessons that we can learn from other Networks.

While we acknowledge that there is much work to be done, I hope that this assures you that we are making progress on the issues you have raised. Clearly designation itself has taken a considerable amount of work, but as we implement this, we will be able to turn our attention more fully to these other areas.

I hope that this information will enable you to confirm your support for our designation proposals. If you have any queries please do not hesitate to contact either me or Susan Davies, Associate Director of Commissioning.