

## **Review of Burnley Urgent Care Centre**

**By Professor Matthew Cooke and Dr Irving Cobden**

**Report dated 1<sup>st</sup> June 2010.**

### **1. Remit of the Review**

This review was commissioned by NHS North West to review what urgent and emergency care should be delivered at Burnley Urgent Care Centre. The terms of reference of this review were that we would:

- i. Consider whether the Meeting Patients Needs (MPN) Service Model A for Urgent Care has been fully implemented in respect of Burnley Urgent Care Centre and any associated services (including ambulance services) it deems to be relevant.
- ii. Consider whether the service reconfiguration has had the impact expected at the time of the MPN service consultation in respect of use by local people, clinical quality and any other outcomes it deems to be relevant.
- iii. Advise on whether any enhancements to the MPN Service Model could or should be delivered in the Burnley Urgent Care Centre. In doing so the review may refer to examples of good practice elsewhere.
- iv. The review may determine the means by which it proceeds. Its work will be supported by two officers, one nominated by NHS East Lancashire and one by East Lancashire Hospitals Trust.

### **2. Expertise of the Review Team**

Professor Matthew Cooke is a Professor of Emergency Medicine at Warwick Medical School, where he has undertaken extensive research on how emergency care should be delivered, including reconfiguration, as well as clinical research. He has advised internationally on the delivery of emergency healthcare. He is also National Clinical Director for Urgent and Emergency Care at the Department of Health. He continues to work clinically as a consultant in emergency medicine.

Dr Irving Cobden is a Consultant Physician and Gastroenterologist in Northumbria and also a Medical Director with Cumbria PCT. He has worked on Emergency Care for many years both within his own organisations and nationally as Medical Director with the Intensive Support Team for Emergency Care and subsequently the NHS Performance Support Team. He has been a Medical Director of an Ambulance Trust and was on the Royal College of Physicians working party on Acute Medicine.

### **3. Methodology of the Review**

We are grateful to all those who gave their time to assist in this review. All conversations were confidential and therefore the evidence is not referenced to particular sources. Because of this we have not included the written evidence as appendices.

The review included the following individuals:

- User representatives
- Local councillors
- Local and other MPs
- Acute Trust, management, union representatives, medical and nursing staff (including staff in the Burnley UCC and Blackburn UCC and the ED at Blackburn)
- Primary Care Trust managers and clinicians
- North West Ambulance Service
- NHS North West
- External consultants working for the Acute Trust

We collected evidence from a variety of sources and tried to triangulate it wherever possible, using data, interview and written information. A site visit was undertaken on 2<sup>nd</sup> and 3<sup>rd</sup> March 2010. The evidence included:

- Document and data review
- On site interviews
- Observation during the site visit
- Post visit interviews with individuals not available at the time of the visit.

On occasions information was conflicting and then we had to make judgements regarding validity, using data wherever possible to support this or by searching out further information

#### **4. Background Information**

##### ***Principles of Reconfiguration***

The changing face of modern medicine means that more conditions are now best treated by specialist teams. It is recognised that specialist teams need to see a certain number of cases to be safe and increasing numbers of cases treated often adds to their effectiveness. In order to provide this specialist service in a consistent and reliable way 24 hours a day, 7 days a week there need to be a critical mass of consultants and other staff in any single centre. There is also an increasing need for specialised equipment to support the specialist teams. This is the rationale for the need for specialist centres with a larger catchment area than the traditional district general hospital. In general, the more complex and the less common a condition, the more likely it is to benefit for specialist care. There is evidence in some conditions that the disadvantages and risks of extra travelling time to a specialist centre are outweighed by the advantages of specialist care. The ambulance service also has an increasing diagnosis and treatment role so that the longer journey is not a therapeutic vacuum but treatment can be started at home or before arrival at hospital. The evidence behind emergency care reconfiguration is contained in more detail in a recent National Institute of Health Research (SDO) report, co-authored by Professor Cooke available at <http://www.sdo.nihr.ac.uk/projdetails.php?ref=08-1304-063>

However, lower complexity and common problems not needing specialist resources for their care can continue to be treated nearer home. When different hospitals provide different services an important safety issue is that patients go to or are taken to the appropriate facility. This requires good communication of the limitations of any service and the availability of support in making those decisions for both lay people and professionals

### ***Alberti Review***

Sir George Alberti, then National Clinical Director for Emergency Care at the Department of Health, undertook his most recent review on behalf of the National Clinical Advisory Team, including a site visit in October 2008

## **5. Evidence**

The number of attendances at Burnley UCC is lower than initially stated at the time of the reconfiguration. A target figure of 87% was published which has therefore been seen as the level required to show the framework has been successful. This may have been an aspiration maximum but has not been seen as such by some external stakeholders. Latest figures suggest that attendances are now at 77% of the reconfiguration level and that it has been at this approximate level since May 2008. 15-25 patients per month are recorded as being transferred from Burnley UCC to Blackburn UCC (not the emergency department), usually for an orthopaedic opinion or sedation/regional anaesthesia for a minor procedure with a further 70-100 per month to the main emergency department at Blackburn. The survival after cardiac conditions has improved since reconfiguration. The time relationship suggests a causal link but we accept that many other changes have also occurred that could be responsible for this. Participation in the national trauma audit has also demonstrated excellent results for the population of East Lancashire. Risk adjusted mortality has also improved from 2005 to 2009 although complication rates have not improved. Average length of stay has also decreased in line or ahead of national changes. The health economy 4 hour emergency access target performance deteriorated in late 2008 and took approximately one year to recover but is now achieving the 98% operational standard. The daily performance of Burnley UCC (and Blackburn UCC) has been above 98% of patients discharged or admitted within 4 hours for the last six months. The Emergency Department at Blackburn was not achieving 98% at the time of our visit although is continuing to improve. However, a large department that is not seeing the less severe cases because they are seen in the UCC would be expected to have lower performance. In many parts of the country, such departments only achieve 95%, hence why the four hour target is a whole community measure. If ambulance data is studied by PCT then the performance in some areas distant from Blackburn is lower than the national performance standard. It must be remembered that this standard is designed to be a whole ambulance service based standard and therefore like any average calculation half of PCTs would be expected to be below the average. The performance for these outlying areas is however now improving. It also shows that the ambulance service transport very few cases to Burnley Hospital. There is evidence of an increase in patients from the eastern parts of the area choosing to go to Airedale General Hospital for their emergency care rather than Blackburn – this seems not to be inappropriate for many as journey times may be similar.

## **6. Improving Clarity of Purpose**

It was apparent from many sources that there is confusion amongst the public and some NHS staff on the services that are available at the UCC in Burnley. This inevitably means that some people are opting to travel to Blackburn because they know all services are provided there. We were told of leaflets with conflicting information derived from the NHS. We also heard that some people believe that no A&E type services are available at Burnley

### ***Conflicting Public Advice***

It is vital that the public are given consistent reliable advice in a variety of formats. We **recommend (R1)** that the local NHS creates a full directory of NHS services and that this is made widely available to the public and to health and social care professionals. We **recommend (R2)** that there is a clear publicity campaign, using multiple formats, that clearly inform the public of the facilities available at Burnley UCC with guidance on which cases can be dealt with at Burnley UCC and which require people to go to Blackburn or other alternative more specialised emergency departments, and that this publicity is regularly repeated. In order to support this work we **recommend (R3)** that the local NHS ensures all staff are aware of the services available at each location and their limitations, as well as the expectation that any change in service is agreed as clinically indicated.

### ***Telephone Advice Services***

During our review there was no spontaneous mention of using NHS Direct or other telephone services to assist people in determining the best location. There was some discussion of the future use of NHS Pathways and the new three digit number (111) access as a potential for the future. We would **recommend (R4)** that future literature should always include an option for contacting a telephone service for advice on the best location. The local NHS needs to ensure that appropriate information is available to telephone advice services and is not excessively risk averse (hence referring an excess of people to Blackburn).

### ***Elderly Users***

We heard from many sources that there was an impression that it was the elderly of Burnley who were particularly affected by the reconfiguration and were likely to be the group who would refuse to go to Blackburn for their care. There are some elderly care facilities at Burnley Hospital but they do not take emergency or acute admissions. We heard that the community elderly care medicine service was disconnected from the in-patient services in the Trust and that community beds were used in traditional ways rather than as means of preventing admission to secondary care. Many areas of the country now have acute geriatric assessment services with multidisciplinary teams that see selected problems in a day hospital like facility. These cases can then be assessed and managed, for example with increased community support in their home or in a community based ward. The acute hospital facility is then only used for the more acutely ill cases. This multi-disciplinary rapid-access facility can enable more elderly patients to be seen before their condition deteriorates and thus pre-empt the need for admission. Likewise, patients whose clinical acuity has lessened but who still require rehabilitation, treatment and nursing care can be “stepped down” from the acute wards and treated nearer to home. We **recommend (R5)** that the local NHS reviews the provision of elderly acute care for the Burnley area and considers establishing a community run assessment service potentially linked with an intermediate care unit.

### ***Informing Children and Their Families***

We did not hear of any specific initiatives to inform families of the limitations of services for children at Burnley UCC. Staff within Burnley gave varying opinions of the type of children's cases that could be dealt with at the UCC. If staff are unclear, then it cannot be expected that the public will understand. As well as the methods of increasing clarity already described, we **recommend (R6)** that specific initiatives are used to inform families such as communication through health visitors and schools.

### ***The Name of Urgent Care Centre***

Many people told us that they believed the name “Urgent Care Centre” added to the confusion. We agree with the opinion expressed that there are A&E departments in England that provide services similar or less than those provided at Burnley UCC. Equally there are urgent care centres that are based on urgent primary care without the ability to deal with minor injuries or to assess more major medical cases. There is a wide range of names in use including emergency department, A&E department, minor injury service, urgent care centre; primary care centre etc with an overlapping use of these terms. There is work underway nationally to better define what is available at the variety of urgent care services and their nomenclature. We **recommend (R7)** that the SHA leads work to gain consistency across the North West in use of the nomenclature and informing the public what is meant by these terms and links this with national work that is underway in this area. It is important to recognise that a change in name could have an unintended consequence of implying that more facilities are available than is true and hence parents could start taking more seriously ill children to Burnley UCC inappropriately.

These recommendations above would also be supported by a formal emergency care network. Establishing this was recommended by Sir George Alberti but we were informed by various stakeholders that it had not occurred. There is apparently an Unplanned Care Group as part of the MPN framework structure but the lack of knowledge by key individuals is of concern. We **recommend (R8)** that a clinical network should be established involving clinicians and managers from all local urgent and emergency healthcare providers to oversee developments, along the lines of the DH guidance written by Sir George Alberti and Professor Matthew Cooke, in particular it needs to be inclusive of all stakeholders rather than a high level group. A good example of such a clinical network is the one established in Leicester.

## **7. Improving Services That Are Already Available**

In the review it was apparent that the Burnley UCC has the potential to see many cases that are currently going to Blackburn and other more specialised units. We were concerned that some people may not have recognised the full potential of the Burnley UCC to provide a local service for dealing with a variety of emergencies not requiring more specialised care.

### ***Variability of Service***

We heard examples of inconsistency in service availability at the UCC for a number of reasons, often relating to which staff happened to be on duty, despite there being policies in place for some pathways. Examples included procedural sedation, manipulation of fractures/dislocations and facial suturing. Such variation may reduce safety and lead to poor quality of care. Standardisation of what is undertaken, including the examples above, with development of appropriate care pathways and training to ensure safe and effective care is **recommended (R9)**.

### ***Ambulance***

Very few cases (5-6 calls / day) are taken into Burnley UCC by ambulance. Protocols have been established to enable this to occur but do not seem to have been successful. We believe there is more potential for the ambulance services to convey patients to Burnley UCC. We observed several potential barriers.

There was a very restricted group of cases where the ambulance crew could autonomously decide to transport the case to Burnley UCC; we know that other services have a more extended list, including certain children and adults with minor injuries and those suitable for primary care. There were some concerns regarding the potential risk of this because of the training of ambulance crews to undertake assessments to enable such decisions. We believe that this should be possible but acknowledge it would need to be accompanied by a reliable feedback system so that the ambulance service and individuals could learn and improve the system. We heard of barriers to sharing information across the Acute Trust and Ambulance Service which make such audit difficult. There is a system of telephoning the duty A&E consultant for discussion regarding appropriate location but we understand this is rarely used. We also heard that the reception received by ambulance crews at Burnley was very variable and that on occasions the crews were vigorously challenged on why they had come to Burnley: this tended to mean crews choose Blackburn where all cases are accepted and their choice of destination is not challenged. We **recommend (R10)** that the Ambulance Service and Acute Trust develop systems to increase the number of cases transported to Burnley and to audit the safety and effectiveness of this system.

### **Primary Care**

Out of hours primary care is provided within the urgent care centre. During “office hours” there is no primary care provision within the UCC. We heard varying reports of the working between the OOH service and the urgent care centre. We heard of instances where some OOH doctors would lock the door between the two areas and would work completely independently. We **recommend (R11)** that the primary care provision should be 24 hours per day in the Burnley UCC. We **recommend (R12)** that full integration of all primary care and emergency services are made at Burnley UCC such that it is not evident to the patient that there are two providers. We were told that clinical governance issues were difficult to resolve with such integration. It has been achieved elsewhere (e.g. the new emergency and urgent service in Doncaster) and so should not be allowed to obstruct developing a fully integrated primary urgent care and secondary minor injuries service within the UCC.

### **Fracture Care**

Currently patients seen at Burnley UCC who need an orthopaedic opinion are usually referred to Blackburn for an opinion. Several people told us that patients may be transferred to the Blackburn UCC to be seen by an orthopaedic SHO, who then spoke to his seniors on the phone whilst they observed x-rays on the screen. Many such patients are then discharged. In the majority of cases we cannot see what value this adds to the patient over them remaining at Burnley and having a telephone consultation from there with images seen over the PACS system. Equally there are orthopaedic clinics at Burnley and yet the staff in these could not be accessed by the UCC staff for an opinion. We **recommend (R13)** the Acute Trust develops a system of care that allows an orthopaedic opinion to be given for most patients by using local staff at Burnley and the PACS system so the majority of those needing only an opinion do not need to travel to Blackburn. This should be accompanied by a continuing audit of fracture referrals from Burnley to Blackburn to ensure that unnecessary journeys are prevented and that quality of care is maintained

## **8. Ensuring Safety**

Some clinical audits were shown to us. The audit of children’s head injuries showed better recording at the UCC than the A&E but did not look at outcomes. A study of appropriateness of care had data but the conclusions section was incomplete. It appeared that there was a high rate of appropriateness of attendance at the various UCCs and A&E, using expert opinion. We would recommend that some clinical audits should be undertaken that ensure the quality of care is high in Burnley UCC and also compare it to the other centres.

This type of audit will also help to ensure that future changes are safe and improving care. We saw no analysis of any serious untoward incidents or complaints for the UCCs and A&E. Again analysis of this would help to inform future change and we would **recommend (R14)** that such data is routinely available to the emergency care network to both inform the quality agenda but also as a means of monitoring public perception, experience and satisfaction.

### **Staffing of UCC**

The staffing at Burnley UCC has a variety of professionals seeing patients and is a modern model of emergency care. The Emergency Nurse Practitioners work autonomously and can see a wide range of conditions. We met an Advanced Clinical Practitioner from a nursing background with a much broader remit of care. We were surprised that several staff work only at the urgent care centre and do not rotate with the A&E department. Safety may be improved by all staff rotating to the A&E department in Blackburn, so they have experience of cases that may only rarely present at Burnley but also so they develop the relationships with staff at Blackburn that will assist the flow of patients between the two departments by building mutual respect and trust.

The medical staffing at Burnley UCC is by a senior doctor during office hours and by junior doctors after that. At night there is a second year foundation doctor (as well as the primary care doctor). We were concerned to hear that the consultant cover is regularly absent because of other commitments and that this varies significantly between individuals. We **recommend (R15)** that a system is developed to ensure that consultant cover is always available during the hours stated. There are two doctors at night but we heard that roles are heavily demarcated and that the GP is not in a supervisory role. We would also challenge whether having an unsupervised second year foundation doctor is a safe and effective way of providing the service. (We understand that since our visit the deanery have visited and supports the removal of the FY2 doctor). Having two doctors for a very small number of cases overnight does not appear to be a good use of resources and seems to occur more because of inter-organisational issues than because of need. Like most of the country the Acute Trust is having difficulty in recruiting middle grade staff. It is considering alternative means of filling this deficit. It is important that these plans recognise the safety implications of an unsupported foundation year doctor at Burnley. The plans are presently about how to attract applicants and a more imaginative approach may be required. We **recommend (R16)** that the staffing overnight is reviewed and a model of combined OOH and UCC medical staffing is seriously considered. We heard suggestions that Burnley UCC becomes a completely nurse led service. If this were instituted in the way described to us then the type and number of cases that could be seen at Burnley would reduce. The use of term "nurse led" is confusing as new roles and competencies develop; Advanced Nurse Practitioners may be able to see some cases currently seen by doctors but their role and competencies are highly variable nationally. We **recommend (R17)** that medical staffing should continue at Burnley UCC. It may be possible to move to a more primary care focus for the onsite cover or to move to more cases being seen by advanced practitioners. However moving to a primary care focus would bring new challenges for the future model of paediatric care (discussed elsewhere in the report). If this medical staffing change is undertaken then we believe that it should ensure there is no decrease in the service available to the public and, preferably, future models should look to increase the number of common non-complex conditions that can be dealt with at Burnley UCC. We are happy to suggest individuals who can advice on staffing levels and models that include new and extended roles.

### ***Medical Assessment Unit***

In his review, Sir George Alberti suggested that there should be a medical assessment unit on the Burnley Hospital site. This has never been taken forward. The existing medical assessment unit at Blackburn has the features of an excellent unit with consultant cover over a prolonged time period (better than many hospitals in the UK) and has processes that are amongst the best in the country to support early diagnosis and treatment (e.g. being seen by a consultant within two hours of arrival) and specialist in-reach into MAU. It is our opinion that if the resources in acute medicine were split across two sites then the quality of care would decrease overall. If an MAU were to be established at Burnley it would need extra staff and resources rather than sharing those at Blackburn. We **recommend (R18a)** that the MAU at Blackburn should continue with at least the present resources and not be depleted to establish a parallel service at Burnley.

### ***Paediatric Cover***

We were informed that at present there are always staff on duty at the UCC who are competent in basic paediatric assessment and resuscitation but not in advanced paediatric life support. It is important in such units that this is maintained and evidence of this competence can be produced, if significant numbers of sick children present then APLS would be the expected standard of training. It is also important that staff in the unit have appropriate training in child safeguarding. We **recommend (R18b)** that the PCT monitor this as part of their commissioning process (along with levels of staff having adult advanced life support training).

We were told that officially the paediatric team on site do not provide cover for the UCC at present because they cannot guarantee to be available due to their neo-natal commitments. However, we were also informed that in practice they provided an excellent service when a seriously ill child attended the UCC. We believe that the paediatric cover needs to be formalised so that a paediatric response can be guaranteed, as far as possible, to support the UCC staff when a seriously ill child attends.

The planned new system of having a paediatric assessment unit during the daytime at Burnley (but no cover at night) is similar to the system in place in Sandwell and West Birmingham (except that they have a full A&E service on site) and we recommend that they should be contacted to compare models. Having a paediatric assessment unit on site part time may increase the risk of parents bringing their sick child to Burnley at other times (this is recognised to occur as parents will often take their very ill child to the nearest facility rather than phone for an ambulance). Describing the new service to the public becomes more complicated when some services are available part time. In the new model there may be periods when there may be no paediatric or anaesthetic support available because of their commitments to the new maternity unit. The risks of the future proposed model need to be fully understood by all stakeholders. However the model develops full integration of the PAU and the urgent care centre; flexible working between the two will add to the quality and safety of the service. Further discussions of this aspect of the developments in Burnley are underway and should follow the principles of good reconfiguration by involving all stakeholders in open decision making.

### ***Anaesthetic Cover***

The PCT have provided additional funding to increase critical care/anaesthetic cover at Burnley. It is key that any department that may receive those with potentially life threatening illness or injury has anaesthetic/critical care cover on site. Although this cover is present on site at Burnley the availability was reported as poor and not formalised. We had anecdotal evidence of cases where transfer had taken a prolonged period because of treatments being undertaken in the UCC thus delaying transfer to definitive care. However, we did not have any reports of this creating any adverse events.

This cover should however be formalised so that a response mechanism is in place as inevitably some cases of critical illness or injury will self present to the UCC (**R19**). Formalised procedures should also be in place to ensure early transfer to Blackburn or a retrieval team to optimise the patient's condition at Burnley before transfer. The level of cover will have to be managed according to the likelihood of need and local risk assessment of the competing demands of obstetric, emergency and other services for the critical care cover. This risk assessment should be formally undertaken to enable optimal risk management.

## 9. Increasing Services Available at Burnley UCC

### *Ambulatory Care*

Many conditions traditionally treated as an inpatient can now be dealt with in the community or as an out-patient. These conditions are outlined in the NHS Institute's Directory of Emergency Ambulatory Care. This care can often be undertaken locally using standardised pathways, although it may need an initial assessment in hospital to determine suitability. We **recommend (R20)** that the Trust undertakes an analysis of their performance compared to comparator trusts and implements an action plan, to implement ambulatory emergency care at both sites. Improved availability and access to rapid access clinics (next day) may also decrease the number of "emergency" admissions and allow services to be provided locally. The number of appointments needed is likely to mean these are best developed as acute medical clinics rather than specialist services.

### *Elderly Assessment*

As mentioned above, we believe that more elderly people could receive care locally by establishing a community unit with acute facilities within Burnley Hospital

### *Mental Health*

We were told that a significant number of patients with mental health issues present to Burnley UCC. Those cases needing intervention from mental health professionals often waited a long time for that professional to arrive and there were examples of duplication or unnecessary steps in the assessment and admission process relating to the involvement of very junior medical staff from Mental Health. We **recommend (R21)** that a service is developed that can deliver timely mental health support. This could include on site appointments in the UCC for low risk cases or direct access to crisis intervention by patients with existing problems.

### *Fracture Care*

There appears to be potential to undertake more ambulatory fracture care at Burnley. As a first step we **recommend (R22)** that an audit is undertaken of all patients from the Burnley and Pendle area who have ambulatory fracture care at Blackburn to explore why is this necessary and to work towards providing more local care, including on the day of presentation if this is non-operative care.

### *Paediatrics*

We heard conflicting evidence on the future of paediatrics at Burnley from senior members of NHS staff, ranging from only providing a neonatal service to having a paediatric assessment unit based within the UCC. (We believe the latter to be the correct one). The latter option would inevitably increase safety for other children attending the UCC for injuries or primary care conditions. This should be taken in to consideration when decisions are made on the future of paediatric services. The differing views are another example of the local confusion that needs to be rapidly resolved. We **recommend (R23)** that the present situation and plans are publicly clarified as soon as possible.

## 10. Conclusions

We saw no evidence that the present system is unsafe and saw data suggesting that some components had been made safer and more clinically effective because of being able to establish specialised services.

We believe that there is an urgent need for clarification of the role of Burnley UCC to the public and to NHS staff. It is our opinion that more cases could be dealt with at the Burnley UCC particularly if primary care, elderly care and paediatric services and their links with the UCC were improved. Work with the ambulance service could also increase the number of cases going to Burnley UCC by ambulance.

The name of urgent care centre does not reflect the work currently being undertaken compared to other centres called A&E and urgent care centres and there is a need for consistency and clarity in both nomenclature and service provision.

We believe that the centralisation of some services to Blackburn was appropriate and has improved the quality of care for many patients. There are however further improvements that could be made so that the public are better informed of the services already available and some other services are modified to allow patients to be assessed and treated nearer to home.



Professor Matthew Cooke



Dr Irving Cobden

**RECOMMENDATIONS**

No	Recommendation
R1	That the local NHS creates a full directory of NHS services and that this is made widely available to the public and to health and social care professionals
R2	That there is a clear publicity campaign, using multiple formats, that clearly inform the public of the facilities available at Burnley UCC with guidance on which cases can be dealt with at Burnley UCC and which require people to go to Blackburn or other alternative more specialised emergency departments, and that this publicity is regularly repeated
R3	That the local NHS ensures all staff are aware of the services available at each location and their limitations, as well as the expectation that any change in service is agreed as clinically indicated
R4	That future literature should always include an option for contacting a telephone service for advice on the best location. The local NHS needs to ensure that appropriate information is available to telephone advice services and is not excessively risk averse (hence referring an excess of people to Blackburn)
R5	That the local NHS reviews the provision of elderly acute care for the Burnley area and considers establishing a community run assessment service potentially linked with an intermediate care unit
R6	That specific initiatives are used to inform families such as communication through health visitors and schools
R7	That the SHA leads work to gain consistency across the North West in use of the nomenclature and informing the public what is meant by these terms and links this with national work that is underway in this area
R8	That a clinical network should be established involving clinicians and managers from all local urgent and emergency healthcare providers to oversee developments, along the lines of the DH guidance written by Sir George Alberti and Professor Matthew Cooke, in particular it needs to be inclusive of all stakeholders rather than a high level group
R9	Standardisation of care at Burnley UCC with development of appropriate care pathways and training to ensure safe and effective care
R10	That the Ambulance Service and Acute Trust develop systems to increase the number of cases transported to Burnley and to audit the safety and effectiveness of this system
R11	That the primary care provision should be 24 hours per day in the Burnley UCC
R12	That full integration of all primary care and emergency services are made at Burnley UCC such that it is not evident to the patient that there are two providers

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R13	That the Acute Trust develops a system of care that allows an orthopaedic opinion to be given for most patients by using local staff at Burnley and the PACS system so the majority of those needing only an opinion do not need to travel to Blackburn
R14	That audit data is routinely available to the emergency care network to both inform the quality agenda but also as a means of monitoring public perception, experience and satisfaction
R15	That a system is developed to ensure that on site consultant cover is always available during the hours stated
R16	That the staffing overnight is reviewed and a model of combined OOH and UCC medical staffing is seriously considered
R17	That medical staffing should continue at Burnley UCC
R18a	That the MAU at Blackburn should continue with at least the present resources and not be depleted to establish a parallel service at Burnley
R18b	That the PCT monitor APLS and Child Safeguarding training as part of their commissioning process (along with levels of staff having adult advanced life support training)
R19	That anaesthetic/critical care cover should be formalised so that a response mechanism is in place as inevitably some cases of critical illness or injury will self present to the UCC
R20	That the Trust undertakes an analysis of their performance compared to comparator trusts and implements an action plan, to implement ambulatory emergency care at both sites.
R21	That a service is developed that can deliver timely mental health support
R22	That an audit is undertaken of all patients from the Burnley and Pendle area who have ambulatory fracture care at Blackburn to explore why is this necessary and to work towards providing more local care, including on the day of presentation if this is non-operative care
R23	That the present paediatric situation and plans are publicly clarified as soon as possible