NHS
Yorkshire and the Humber
Clinical Senate

Free and full independent and impartial clinical advice

Clinical Senate Review Of Humber Acute Services at Northern Lincolnshire and Goole NHS Foundation Trust and Hull University Teaching Hospitals NHS Trust

On behalf of

NHS Humber and North Yorkshire Integrated Care Board

Final Report

Clinical Senates are independent non-statutory advisory bodies that were established to provide clinical advice to commissioners, systems and transformation programmes to ensure that proposals for large scale change and service reconfiguration are clinically sound and evidence-based, in the best interest of patients and will improve the quality, safety and sustainability of care.

Consideration of the implementation of the recommendations is the responsibility of local commissioners, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of access. Nothing in the review should be interpreted in a way which would be inconsistent with compliance with those duties.

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1. Chair's Foreword

We welcomed the opportunity to work with the Humber Acute Services programme team once again, in considering the possible future configurations of services in the Humber region that aim to provide both sustainable acute services and improved health outcomes.

I congratulate the programme on the excellent and comprehensive work that has been progressed since our last visit in further developing the proposals and reducing the number of options to those which best address the challenges being faced. It is evident that those involved in this process have worked very hard to get to this point and we hope this report helps to make the decisions that are needed a little easier.

We thank colleagues in the Humber and North Yorkshire Integrated Care Board and the trusts for all their work that led up to and included the most recent Senate review. The Senate was very appreciative of being given the opportunity to review the updated options and to learn of the work that had been undertaken in the time between this and the last Senate review in 2022. We also appreciated the opportunity to once again, talk and listen to the clinicians delivering the services directly.

I would also like to take this opportunity to thank the panel of clinical and lay experts who assisted with this review. I very much appreciate their enthusiasm and diligence in reviewing the proposals provided to us.

Chris Welsh - Senate Chair
NHS England – North (Yorkshire and the Humber)

2. Introduction

Following a Yorkshire and Humber Clinical Senate review in 2020 and in 2022, the Senate was approached in December 2022 by the Humber Acute Services (HAS) programme team, supported by its commissioners, to provide further independent clinical assessment on an updated and reduced number of potential models of care. These models set out the options for urgent and emergency care, maternity, neonates and paediatrics, and principles for planned care and diagnostics as part of the HAS programme which seeks to determine the long-term future of acute hospital provision across the Humber.

Specifically, the Clinical Senate was asked to:

1. Provide assurance, from a clinical perspective, that the evaluation process has resulted in clinically viable proposals that ensure services are:
    - more sustainable
    - provide good quality care for the future.
    - support the improvement of health inequalities

2. Provide assurance that the assumptions have been fully considered in relation to:
    - demand for services
    - patient flow
    - travel and access for patients and staff
    - impact on neighbouring providers of secondary care
    - impact on interdependent/related services (e.g.ambulance/community/primary care)

3. Provide assurance that the clinical models have taken account of the relevant clinical interdependencies and if there was anything that has not been included in the proposed clinical models, within the current ability of the system to enact, that should be considered.

2.1 Process of the Review

To carry out this review, the Senate formed an independent expert clinical panel comprising previous review panel members from the Yorkshire and Humber and Northern England Senate councils as well as from the North West Clinical Senate, and other known subject matter experts and lay members. The details and short biographies of the panel can be found in Appendix 1.

The review was carried out over Microsoft Teams on Monday 27 February 2023. The agenda for the review session is included at Appendix 3, while the agreed terms of reference are shown in Appendix 4.

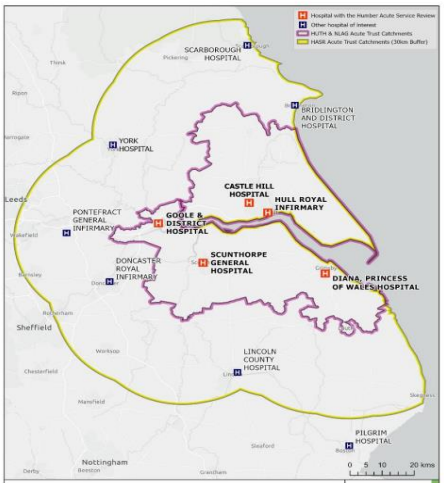
In advance of the virtual review the panel members were provided with a pre-session briefing pack from the HAS team including a copy of the draft Pre-Consultation Business Case and an updated case for change with refreshed models of care (a full list of the supporting information provided to the panel can be found at Appendix 5).

The report was drafted during March and was provided to the Senate panel members for additional comments in March and to the HAS team for factual accuracy checks on 21 March 2023.

3. Overview of the in-scope services

Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) serves 450,000 people living across Northern Lincolnshire and the East Riding of Yorkshire. Hull University Teaching Hospitals Trust (HUTH) serves a population of 600,000 living in Hull and the East Riding of Yorkshire.

The two trusts provide services from five hospitals in the Humber area, Scunthorpe General Hospital (SGH), Grimsby's Diana Princess of Wales Hospital, (DPoW), Hull Royal Infirmary (HRI), Castle Hill Hospital in Cottingham and Goole and District Hospital.



For the purposes of this phase of the review, the services within scope are the fundamental building blocks of acute hospital provision for urgent and emergency care, maternity, neonates and paediatrics and concepts for planned care and diagnostics at the NLaG district general hospitals of SGH and DPoW and the HUTH hospitals.

Tertiary services delivered by HUTH such as cancer, cardiac and major trauma are not in the scope for this review, although interdependencies are being identified and managed alongside.

4. Background

This third formal, and final, review builds on the joint-working in place between the trusts of Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) and Hull University Teaching Hospitals NHS Trust (HUTH) and the Humber and North Yorkshire Integrated Care Partnership (ICP) which brings health, social care and other public service providers together to serve the needs of the communities across the Humber and North Yorkshire (Hull, East Riding of Yorkshire, North Lincolnshire, North East Lincolnshire, North Yorkshire and York).

This review follows two previous formal reviews by the Yorkshire and Humber Clinical Senate that were carried out in 2020 and 2022 and forms part of the NHS England

assurance process aligned to service reconfiguration and a capital Strategic Outline Case (SOC).

NLaG's 2 main sites (DPoW and SGH) currently each offer a full range of services that leads to duplication of provision (see table in section 5) and on-call rotas. The key drivers for changing the hospital services across the Humber region therefore are as follows:

1. There are recruitment and retention issues within the workforce leading to shortages of specialist staff across a number of services.
2. The low volume of patients for some services across the sites leads to challenges in staff being able to maintain their skills.
3. There is an inability to meet a number of core NHS standards of performance as well as standards set in Royal College guidance.
4. There is unwarranted variation in pathways of care in services.
5. The limitations of the ageing hospital estate and the lack of access and use of digital technologies to optimise care.
6. The changing and increasingly complex health needs of the local populations and a rising demand for services.

The options for the future models of care have been designed to address the challenges described above. They have been developed and refined through a robust process involving independent clinical input, discussions in Clinical Design Groups, speciality project groups, a citizen's panel, focus groups and workshops for members of the public, elected members, representative groups and other interested stakeholders.

5. 2023 Senate Review – Models of Care Options

The current models of service delivery from each of the NLaG sites are presented below in Table 1:

Table 1: Current service provision

Diana Princess of Wales Hospital - Grimsby	Scunthorpe General Hospital – Scunthorpe
• 24/7 Emergency Department • Trauma Unit • Assessment unit • Same Day Emergency Care • Short Stay • Emergency Surgery • Critical care and anaesthetics • General Medical inpatients • Care of the elderly inpatients • Cardiology/Gastroenterology/Respiratory inpatients • Trauma inpatients • Acute surgery inpatients • Obstetric led Unit • Neonatal level 1 cots • Neonatal level 2 cots • Paediatric Assessment Unit • Paediatric inpatients • Day case surgery • Elective inpatient surgery • Outpatient clinics	• 24/7 Emergency Department • Trauma Unit • Assessment unit • Same Day Emergency Care • Short Stay • Emergency Surgery • Critical care and anaesthetics • Hyperacute Stroke Services • General Medical inpatients • Care of the elderly inpatients • Cardiology/Gastroenterology/Respiratory inpatients • Trauma inpatients • Acute surgery inpatients • Obstetric led Unit • Neonatal level 1 cots • Neonatal level 2 cots • Paediatric Assessment Unit • Paediatric inpatients • Day case surgery • Elective inpatient surgery • Outpatient clinics

In response to feedback from the previous Senate reviews in 2020[1] and 2022[2], and further subsequent comprehensive evaluations of the models of care under review, the Senate was presented with potential models of care delivered from a hospital configuration involving one hospital in the northern Lincolnshire area being designated as an Acute Hospital (either DPoW or SGH) and the other a Local Emergency Hospital (either SGH or DPoW) with enhancement to some services delivered from HRI.

The panel understood that HRI would provide additional urgent care services, additional diagnostic and planned services and continue to serve the region as a specialist centre, providing the Major Trauma Centre as well as increased capacity in the Level 3 Neonatal Intensive Care Unit. Castle Hill Hospital and Goole District Hospital would remain as a Specialist Elective Centre and Elective Hub respectively.

The Senate was asked to appraise and provide clinical assurance that the models of care are clinically viable, sustainable, provide good quality care and support the improvement of health inequalities. It was also asked to provide assurance that all assumptions and clinical

1 http://www.yhsenate.nhs.uk/modules/reports/protected/files/YH%20Senate%20Report%20-%20Humber%20Acute%20Services%20-%20November%202020.pdf
2 http://www.yhsenate.nhs.uk/modules/reports/protected/files/YH%20Senate%20Report%20%20HASR%20-%20ratified%20final.pdf

interdependencies have been fully considered. Within the Acute and Local Emergency Hospital (LEH) model, 2 variations of possible service distribution were presented:

Option 1: Acute Hospital with Trauma Unit and a Local Emergency Hospital with an Obstetric Led Unit

Option 2: Acute Hospital with Trauma Unit and a Local Emergency Hospital without an Obstetric Led Unit

5.1. Option 1 – Acute Hospital with Trauma Unit and a Local Emergency Hospital with an Obstetric Led Unit

Table 2: Option 1 - Acute and LEH Model with OLU on both sites

ACUTE HOSPITAL	LEH
• 24/7 Emergency Department • **Trauma Unit** • Urgent Care Service • Acute Assessment/Short Stay • Same Day Emergency Care • Emergency Surgery (24/7) • Critical care and anaesthetics • General Medical inpatients • Care of the elderly inpatients • **Cardiology/Gastroenterology/Respiratory inpatients >72 hours** • **Acute surgical inpatients** • Obstetric led Unit with midwifery led provision • **Neonatal level 1 cots** • **Neonatal level 2 cots** • Paediatric Assessment Unit • **Paediatric inpatients >24 hours** • Facilities for planned operations	• 24/7 Emergency Department • Urgent Care Service • Acute Assessment/Short Stay • Same Day Emergency Care • Emergency Surgery **(day case only)** • Critical care and anaesthetics • General Medical inpatients • Care of the elderly inpatients • Obstetric led Unit • Neonatal level 1 cots • Paediatric Assessment Unit 24/7 • Facilities for planned operations

Option 1 describes an Acute and LEH hospital configuration in the northern Lincolnshire area that would consolidate trauma services, acute and longer term inpatient services for surgical patients, children and for patients that need longer stay speciality medical inpatient care to the Acute Hospital site.

Under option 1, trauma services would be centralised to the Acute Hospital site with trauma patients being directly sent and admitted to there. Patients who walk in at the LEH and who require the services of a Trauma Unit would be transferred to the Acute Hospital site. Under both options the trauma provision at HRI remains unchanged.

Urgent and emergency care services for adults and children would be provided from both the Acute and LEH sites and HRI would develop a co-located urgent care service for walk-in patients within its Emergency Department (ED). This urgent care service would be consistent with the current and future urgent care models in EDs in north Lincolnshire.

General medical and care of the elderly inpatient services would be provided from all sites. However, speciality patients requiring a longer stay would be transferred to the Acute Hospital site after 72 hours. Patients that need a higher level of speciality medical inpatient provision >72 hours (gastroenterology, cardiology and respiratory services) would be mainly cared for on the Acute Hospital site.

Patients requiring surgery in an emergency would continue to be treated at the Local Emergency Hospital as an appropriate day case emergency (based on risk assessment), patients needing surgery out of hours or needing to be looked after overnight on a surgical ward would transfer from the Local Emergency Hospital to the Acute Hospital site. Both sites would provide planned surgical care. Critical care and anaesthetic services would be available at both the Acute and LEH site to support urgent and planned care services.

This option describes a paediatric and maternity services configuration that would have a 24/7 paediatric assessment unit on both sites. Children that needed an inpatient stay after an initial 24-hour period would be transferred and cared for on the Acute Hospital site.

With respect to obstetrics, an obstetric-led unit would be provided on both sites with midwifery-led provision also available. The Acute Hospital obstetric service would be supported by up to level 2 neonatal cots whereas the LEH service would be supported by Level 1 neonatal cots only. HRI would increase its level 3 neonatal cot capacity to be able to respond to demand from all three geographical areas.

5.2. Option 2 - Acute Hospital with Trauma Unit and a Local Emergency Hospital without an Obstetric Led Unit

Table 3: Option 2 - Acute and LEH Model with OLU on one site

ACUTE HOSPITAL	LEH
• 24/7 Emergency Department • **Trauma Unit** • Urgent Care Service • Acute Assessment/Short Stay • Same Day Emergency Care • Emergency Surgery (24/7) • Critical care and anaesthetics • General Medical inpatients • Care of the elderly inpatients • **Cardiology/Gastroenterology/Respiratory inpatients >72 hours** • **Acute surgical inpatients** • **Obstetric led Unit with midwifery led provision** • **Neonatal level 1 cots** • **Neonatal level 2 cots** • Paediatric Assessment Unit • **Paediatric inpatients >24 hours** • Facilities for planned operations	• 24/7 Emergency Department • Urgent Care Service • Acute Assessment/Short Stay • Same Day Emergency Care • Emergency Surgery **(day case only)** • Critical care and anaesthetics • General Medical inpatients • Care of the elderly inpatients • Paediatric Assessment Unit 24/7 • Facilities for planned operations

Option 2 is as described in option 1 but without any intrapartum obstetric provision and neonatal care from the LEH and all births (excepting home births) consolidated onto the Acute site. Antenatal and post-natal care would be maintained from both sites and in local community clinics under this option.

5.3. Senate Findings on Options of Models of Care

The Senate panel's findings, aligned to the terms of reference for the review, are contained within the subsections below:

Ask 1: Provide assurance, from a clinical perspective, that the evaluation process has resulted in clinically viable proposals that ensure services are:

- **more sustainable**
- **provide good quality care for the future.**
- **support the improvement of health inequalities**

Urgent and Emergency Care

The Senate acknowledges that consolidation of trauma services is a well-established model of modern healthcare, and it is supportive of the centralisation of trauma care to one site in the northern Lincolnshire region. To ensure it is a safe model it should be accompanied by robust patient risk assessments, triage protocols and pathways that the whole healthcare system follows to ensure a patient receives the right care at the right place at the right time.

The Senate panel heard that both the LEH and Acute sites would be supported by critical care and anaesthetic services which could ensure that the LEH had the capability to stabilise acute and trauma patients before transfer, if required, and to care for medical patients requiring level 1 to 3 critical care. The panel members understood that the numbers of critical care beds may be slightly increased on the Acute site due to the higher acuity of services provided with a corresponding reduction in beds/acuity at the LEH.

The panel acknowledges the positive plans for recruitment alongside HUTH and the development of new roles and it understood that there are ambitions for the critical care workforce to meet best practice standards and recommended guidance (Intensive Care Society[3)] and for the workforce to rotate between the sites to ensure competencies are maintained. These are notable ambitions but the Senate panel, even with the supplementary information provided subsequent to the review discussions, remains unclear about how these challenging ambitions will be achieved.

As with the Senate review in 2022, there remain significant concerns about the sustainability of providing two fully staffed critical care units, and thus two 24/7 emergency departments, in the medium to long term given the current and likely ongoing recruitment

3 https://ics.ac.uk/guidance/gpics.html#:~:text=The%20Guidelines%20for%20the%20Provision%20of%20Intensive%20Care,of%20adult%20critical%20care%20services%20across%20the%20UK.

and retention difficulties, especially at Consultant grade level. The HAS team are advised to consult with the Yorkshire Critical Care Network to ensure that it is supportive of the plans to maintain a second line critical care service on the LEH site.

The panel members heard that partial centralisation of some urgent and emergency surgical services had been necessary and had already been implemented (eg Urology, Stroke, Ear Nose and Throat) and as such the potential consolidation of services to the Acute site, with supporting protocols and safeguards, would be an extension of the current ways of working.

The Senate panel also heard about the work the HAS teams were doing to ensure high risk patients with, for example, gastrointestinal bleeds, heart problems or fractured hips are being, and would be cared for, involving cross site rotas, standard operating procedures and in-reach specialist advice.

The panel was pleased to hear that whilst trauma, and more specialist services would be centralised, there is a notable ambition to ensure that patients receive their care as locally as possible to minimise barriers to accessing care and services and to reduce the amount of secondary care to secondary care transfers.

In relation to the question about health inequalities: the panel heard about the ambitions of the HAS team to ensure they are working with partners in the whole health and social care system to provide comprehensive care in the community through prevention work, virtual wards, community hubs and the use of digital enablers to reduce reliance on the acute hospital sector.

The panel was pleased to receive additional information, subsequent to the review, about the extensive work the HAS team had undertaken in identifying and understanding the local causes of health inequalities and the impact the models of care may have on these. It was clear that the HAS team had carefully considered the impact of any potential change on the local communities and that some mitigations were being planned, for which we applaud the team.

However, the panel noted that inevitably, the groups who are less digitally capable or responsive may simply not be caught by the envisaged mitigations. It is known that the vulnerable groups in society include a disproportionate number of poorer residents and the panel advised some evidence-based view on capturing vulnerable people at "first contact" with services they do use and for this to be included within the HAS programme.

We were assured that the team have foreseen the downside to the innovations that will improve access for the many but may leave some behind. These issues are not unique to the HAS area and should be regularly revisited throughout any redevelopment programme like this.

The Senate's findings on plans for urgent and emergency care led to the view that it was reasonably assured that models of care are clinically coherent, were more sustainable and would provide quality care, however, as expressed above, it

remains concerned about the sustainability of two critical care units from a workforce perspective. Guidance from the Critical Care Network is advised.

The Senate was reasonably assured that the HAS team had considered the impact of the options on health inequalities and that comprehensively addressing any potentially negative impacts, particularly on very disadvantaged groups, remains challenging.

Maternity, Neonates and Paediatrics

The panel is aware that Ockenden recommendations for an obstetric service are for two dedicated, fully established obstetric theatres with associated staffing on each site. The current provision in northern Lincolnshire is one obstetric theatre at DPoW and one at SGH and the panel heard about the current workforce challenges within the midwifery, obstetric and particularly theatre teams in relation to this standard with expansion needed at both SGH and DPoW to meet the standards. Therefore, the panel remain uncertain and concerned about the system's ability to meet the Ockenden recommendations including the recruitment and retention of the workforce required to provide and sustain two obstetric led units, as described in option one (table 2).

Option two, described in table 3 of this report, involves one obstetric led unit at the Acute site and no intrapartum provision on the LEH site, which reflects a model of care previously commented upon in the Senate review in 2022. The findings of that review were that this model would provide an opportunity to consolidate all obstetric and midwifery staff onto one site which would bring about all of the benefits associated with safe levels of staffing, concentration of skills and expertise and the opportunity to provide high quality care to patients sustainably. However, it also noted that that model would result in the displacement of a significant amount of obstetric activity to other neighbouring trusts, regardless of which site was designated as the Acute and LEH sites. Those findings remain extant.

The panel heard that under both potential options for maternity services, gynaecology services and antenatal clinics would continue on both sites ensuring local provision for the local populations.

The panel understands that the potential plans for neonatal service provision have been developed in conjunction with the Yorkshire and Humber Neonatal Network. Option 2 describes consolidation of all neonatal activity to the Acute site with option 1 having level 1 neonatal cots on the LEH to support the obstetric service.

The panel observed that in every situation where there are different levels of service provision at different sites, there will be a need for commonly agreed and understood patient pathways, patient transfer and standard operating protocols to ensure the delivery of safe care.

The potential plans for paediatric services are the same under both options and describe a 24/7 short stay paediatric assessment unit at the LEH with paediatric inpatient services consolidated on the Acute site. The panel heard that whilst some local flexibility may be possible for a slightly extended stay at the LEH, in situations where a child needs to

receive care for a longer time, a transfer between sites would be required. Panel members felt that consideration could be given for longer periods of lower acuity care at the LEH, particularly for some children with chronic diseases receiving, for example, IV antibiotics where home treatment may not be possible.

The panel was pleased to hear about the ambition to deliver a transport service between sites for patients and family members and for options of temporary family accommodation to be provided near the Acute site for those that may require it. It also heard of an initiative which is a nurse led, consultant supported service that aims to reduce the need for inpatient care and can also allow for swifter discharge from the paediatric wards to the home.

As previously advised, under this model of care there would need to be established and commonly agreed pathways for those patients that require transfer between sites, and the pathways should aim to stop children being moved around unless it is necessary.

The Senate's findings on plans for neonatal and paediatric services provided it with reasonable assurance that models of care are clinically coherent, were more sustainable and would provide quality care. With respect to maternity services, the Senate remains concerned about the deliverability and sustainability of two obstetric led units due to workforce concerns.

The Senate was reasonably assured that the HAS team had considered the impact of the options on health inequalities and that comprehensively addressing any potentially negative impacts, particularly on very disadvantaged groups, remains challenging.

Ask 2: Provide assurance that the assumptions have been fully considered in relation to:

- **demand for services**
- **patient flow**
- **travel and access for patients and staff**
- **impact on neighbouring providers of secondary care**
- **impact on interdependent/related services (e.g.ambulance/community/primary care)**

The Senate panel offers up the following observations in relation to the assumptions underpinning the development of the options of models of care:

Since the Senate's last review, the North Yorkshire and Humber Integrated Care System (ICS) commenced in July 2022. This will offer an opportunity for more seamless working across the system as it matures.

The panel did hear about an increasing demand for services based on an ageing population and a population with increasingly complex health needs and it heard about some mitigations to reduce elective and non-elective demand and increased community and primary care services that would reduce the need to attend hospital. However, the panel was not clear on the degree of surety that all the many enablers could be enacted in community, primary and secondary care in a timely way that would not impact patient care.

It also heard about the assumptions made about the impact on ambulance services which would result in an increased demand but that this could be met. The panel recognised that Doncaster and Bassetlaw Teaching Hospitals NHS Trust (DBTH) has been involved in discussions about the models of care, but it was not clear to the panel whether DBTH and other neighbouring acute providers considered the potential impacts of the options to be manageable.

It was evident that bed occupancy and length of stay assumptions had been considered. The panel observed however that the bed occupancy assumptions were calculated using average occupancy rates which may not allow for seasonal fluctuations in demand for beds which could significantly impede patient flow. Therefore, it may be useful for the HAS team to undertake and demonstrate modelling undertaken to stress test bed occupancy in the different options to ensure there is sufficient capacity to meet demand.

Travel and access for patients and staff have been comprehensively modelled and the Senate was pleased to see the mitigations under consideration and the development of a transport group and action plan.

It was understood that neighbouring organisations were aware of the potential models of care and the Senate felt that it would be advisable to understand whether neighbouring organisations can manage the impacts of the potential options.

The Senate was reasonably assured that the HAS team had considered the above assumptions in the development of the options.

Ask 3: Provide assurance that the clinical models have taken account of the relevant clinical interdependencies and if there was anything that has not been included in the proposed clinical models, within the current ability of the system to enact, that should be considered.

The Senate was very pleased to see that the mapping of interdependent services had been carried out and had informed the development of the models of care.

There was a view that some of the models may need wider discussions with all stakeholders that may be impacted by the proposed models, for example the fractured neck of femur pathway.

In the scenario where women may opt to deliver their babies at Doncaster Royal Infirmary due to proximity, the Panel wondered whether outreach antenatal care could be provided in the locality in the option where SGH were the LEH but with no OLU should the numbers be significant enough?

Continued engagement with colleagues in the local authority is advised to ensure all elements of the health and social care system are working in tandem towards the same goals and ambitions.

Whilst the panel recognises the current position whereby operational imperatives have prevented the co-location of interdependent services, it may be helpful for the HAS team to have a clear position that interdependencies will be managed strategically to deliver the ideal interdependencies going forward.

The Senate was reasonably assured that the HAS team had taken account of the relevant clinical interdependencies.

5.4. General Comments on Options.

The Senate was pleased to see a reduced number of options under consideration and the HAS team is to be congratulated on the considerable amount of comprehensive work undertaken to achieve this.

The Senate was also pleased to see that modelling had been undertaken and presented on the impact of the options on the workforce, patients and on neighbouring trusts and the mitigations being planned. It was also very encouraging to hear the HAS team recognising the imperative for all health and social care partners to work together to achieve in and out of hospital service transformations and the role of digital solutions within them.

The Senate panel felt it was important to reiterate that the findings from this review and our review in 2022 are consistent in the areas of emergency care, critical care and obstetric led units. The critical challenge remains the recruitment and retention of workforce in these three areas. The 2022 review findings for these three clinical areas are listed below:

- The options involving critical care services being delivered from two sites may be unsustainable due to future workforce challenges.
- The panel felt that it would be difficult to be able to provide a 24/7 emergency department with associated support services on an LEH given the potentially unsustainable critical care provision.
- Any option that maintained 2 Obstetric-led Units (OLU) would be unsustainable on the grounds of patient safety.

6. Recommendations

It remains very clear to the Senate that an immense amount of work has been done over the years and that the programme has worked hard at the Humber Acute Services Review.

Significant progress has been made since the Senate's last review and the panel members were reassured that most of the panel's previous recommendations had been considered and robustly addressed.

The panel offers up the following recommendations arising from this latest Senate review:

1. The Humber Acute Services team are advised to consult with the Yorkshire Critical Care Network to ensure that it is supportive of the plans to maintain a level two critical care service on the LEH site**.**

2. The Senate has made clear that the maintenance of two obstetric units, with the required theatre and midwifery staffing on both sites remains at high risk of being undeliverable/unsustainable. If the HAS programme team wishes to consult on the provision of two Obstetric led units there must be a high degree of confidence that they are deliverable and sustainable, including that they can support two staffed theatres on two sites and can recruit and retain the necessary staff.

3. The HAS team is advised to maintain focus on health inequalities on an ongoing basis to ensure they are not being made worse by the impacts of the programme.

4. It is advisable to include in the programme an evidence-based view on capturing vulnerable people at "first contact" with services that are accessed, to prevent exclusion.

5. It is strongly recommended to gain an understanding from neighbouring organisations as to whether they can manage the impacts of the potential options.

6. It may be useful for the HAS team to undertake and demonstrate modelling undertaken to stress test bed occupancy in the different options to ensure there is sufficient capacity to meet demand.

7. It may be helpful for the HAS team to have a clear position that interdependencies will be managed strategically to deliver the ideal interdependencies going forward.

8. Continued engagement with colleagues in the local authority is advised to ensure all elements of the health and social care system are working in tandem towards the same goals and ambitions.

7. Conclusion

In conclusion, the Senate panel supports the development of an Acute Hospital and Local Emergency Hospital site model with consolidation of trauma services to the Acute Hospital site. This is a widely accepted model of modern healthcare and with appropriate supporting infrastructure and robust system wide clinical pathways including standard operating procedures, this would offer safe and sustainable services for patients and staff.

An Acute Hospital and LEH model of service delivery in children and adult, medical and surgical services, again affords opportunities to consolidate specialised skills and expertise on one site. With appropriate and standardised care and transfer protocols this model can offer safe and sustainable services for patients and staff the Senate does acknowledge the potential impact on patient access and possibly on neighbouring organisations. These will require further consideration.

The panel does have concerns about the deliverability and longer term sustainability of two fully staffed critical care units and thus two emergency departments and further specialist advice and guidance on this matter is recommended.

The Senate review panel members feel that unless there is a significant degree of confidence that the workforce challenges associated with the provision of two obstetric led units in northern Lincolnshire can be satisfactorily and sustainably addressed then the option involving one OLU appears to be more appropriate. Compliance with national standard and guidance is essential. Both options will be required to comply with national standards.

Finally, the panel members recognise that after public consultation further work will be required on the programme and the Senate would be available to consider the final detailed plans.

APPENDICES

Appendix 1

LIST OF INDEPENDENT CLINICAL REVIEW PANEL MEMBERS

Prof. Chris Welsh – Yorkshire & the Humber Clinical Senate Chair

Chris Welsh worked initially as a vascular surgeon at the Northern General Hospital Sheffield before becoming Regional Postgraduate Dean for the Trent Region in 1995. Chris was then appointed Medical Director for Sheffield Teaching Hospitals NHS Foundation Trust in 2001. In 2008 he worked as the Clinical Chair of the Next Stage Review NHS Yorkshire and the Humber, "Healthy Ambitions" before being appointed as Medical Director for NHS Yorkshire and the Humber and then NHS Midlands and East before becoming Director of Education and Quality Health Education England. Most recently Chris has served as Independent Review Director to the South Yorkshire and Bassetlaw ICS Hospital Services Review.

Mr Andrew Simpson - Consultant in Emergency and Paediatric Emergency Medicine

I have been a consultant in Emergency and Paediatric Emergency Medicine at North Tees and Hartlepool NHS Foundation Trust for twenty years. I was Clinical Director of Emergency Care between 2006 and 2916 during which time we had a major reconfiguration of service which included the closure of an Accident and Emergency Department. I am a member of the Northern Clinical Senate and a Care Quality Commission Speciality Adviser for Urgent and Emergency Care.

Mr Eki Emovon - Consultant Obstetrician and Gynaecologist

Consultant obstetrician and gynaecologist and divisional director for children and families division at Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust. I graduated from medical school in 1987 and undertook post graduate training in obstetrics and gynaecology in the southwest of England including a fellowship in reproductive medicine and assisted conception treatments. I was appointed consultant in February 2002. A member of the Yorkshire and Humber Clinical Senate since 2021. I have a passion for clinical governance and was clinical governance lead in Obstetrics and Gynaecology and maternity at my trust for a period of about 9 years.

Prof. Mike Bramble - Honorary Consultant Gastroenterologist

Professor Mike Bramble is a retired Consultant Gastroenterologist and Hon Senior Clinical Fellow in Gastroenterology at James Cook University Hospital in Middlesbrough, having qualified in Sheffield and completed his training in Newcastle upon Tyne in 1982. Appointed Visiting Professor at the University of Durham in 1997 he went on to become Medical Director for South Tees Hospitals NHS Trust in 2005 until 2010. From 2010-2018 he continued as a part time Gastroenterologist, mainly endoscopy.

Nationally, he was Vice-President of the British Society of Gastroenterology and Chairman of the BSG Endoscopy Committee 2000-2002. In 2000 he was appointed by the DoH to be the Gastroenterology representative on the national CJD Incidents Panel, stepping down in 2006

In 2013 he was appointed to the Board of Sunderland CCG for a 4-year period as the designated Secondary Care Doctor. He has extensive experience in clinical governance and service reconfiguration (including work with the previous Modernisation Agency).

Currently a member of the North of England Clinical Senate, he is also a trustee with two local charities.

Dr Simon Clark - Consultant Neonatologist

Neonatal consultant for the last 18 years. Vice President for Policy at RCPCH for last 2 years. Chair of Faculty for Advanced Clinical Practice in South Yorkshire and Bassetlaw for last 4 years. Previously, Officer for Workforce Planning at RCPCH, Head of School for Paediatrics across Yorkshire and Humber and Clinical Lead for Neonatal Department at Sheffield Teaching Hospital NHS Foundation Trust.

Dr Tolu Olusoga – Consultant Psychiatrist & Deputy Medical Director

Dr Tolu Olusoga is an Old Age Psychiatrist who has worked in the Yorkshire region for the last 18years with extensive experience and interest in medical management and leadership roles as well as interest in service quality improvement. He currently works in a memory clinic in Knaresborough and is currently the Group Medical Director for (North Yorkshire and York locality) in Tees, Esk and Wear Valleys NHS Foundation Trust.

Dr Rod Lawson – Respiratory Physician

Since being appointed as Consultant in Respiratory Medicine Dr Lawson has participated in community clinics and services. He has led the weekly Sheffield COPD MDT, which has input from hospital and community services, including nurses, physiotherapists (including pulmonary rehabilitation), mental health workers and doctors. His research has included the first RCT confirming the efficacy of pulmonary rehabilitation in a community setting, as well as collaborative projects with radiology, physiotherapy and academic GPs. He has been a member of the Sheffield Advisory Group of the CCG and predecessors for two decades and was previously joint respiratory lead for Yorkshire and Humber.

Dr Katie Elliott – GP & CRUK Strategic GP NCA Doctor Representative

Dr Katie Elliott is a Cancer Research UK GP and the Clinical Director (primary care) for the Northern Cancer Alliance. She is a GP appraiser and a member of the North East and Cumbria Senate Council.

At the centre of her work is general practice and patient care with the emphasis on improving equity of access to cancer services and optimising the use of resources. Her work is focused on early diagnosis, pathways and diagnostics Katie is committed to addressing inequalities in access and ensuring the public are involved in the improvement of NHS services. She continues to work closely with the North East and Cumbria Learning disability network cancer project which includes improving access to cancer services and screening for people with learning disabilities.

Debbie Freake – Director of Integration

Debbie trained in Newcastle, working as an inner-city GP before taking on medical and other NHS leadership positions. With 20 years of board level experience across acute and community sectors and both commissioning and provision, she has led on a range of service transformation, integration and reconfiguration programmes. Now semi-retired her last NHS position was as Director of Integration at Northumbria Healthcare NHS FT.

Andrew Hodge – Director of AHPs

Andrew Hodge was formerly Consultant Paramedic for Yorkshire Ambulance Service focusing on the clinical leadership and practice development of the paramedic profession's contribution to the urgent care agenda. With a special interest in developing advance practice roles to manage appropriate cases in the community, Andrew has led on the introduction of specialist and advanced paramedic roles in pre-hospital care and the community including primary care paramedic rotation. Andrew also developed the Trust's improvement plan for paramedics delivery in end of life care across Yorkshire as part of the region's end of life care network.

Now part of The Mid-Yorkshire Hospitals NHS Trust, Andrew is Director of Allied Health Professions responsible for developing the strategic planning and professional leadership of the AHP workforce across secondary and community care.

Dr Robin Mitchell – Clinical Director

Dr Robin Mitchell graduated in Medicine from Edinburgh University in 1980. He trained in Anaesthetics and Intensive Care in Lothian and Trent Regions prior to taking up a post as Consultant Anaesthetist in Durham in 1989.

Robin was a member of the project team for the new hospital development in North Durham from 1991 to 1998. He was Clinical Director for Anaesthetics from 1993 to 1996, and subsequently was appointed as Medical Director for North Durham from 1996 to 2000.

In his clinical specialty, he maintained a broad range of interests including critical care, obstetric anaesthesia, paediatric anaesthesia and anaesthesia for colorectal surgery. He continued clinical work until 2011.

He undertook a further term as Executive Medical Director for County Durham and Darlington NHS Foundation Trust from 2011 to 2013, and then continued as Responsible Officer and Deputy Medical Director from 2013 to 2016.

Robin was appointed as Clinical Director for Northern Clinical Networks in 2013 and also holds an ex-officio seat on the Northern Clinical Senate Council.

Dr Trevor Cleveland – Consultant Vascular Interventional Radiologist

Trevor Cleveland is Consultant Vascular Interventional Radiologist at Sheffield Teaching Hospitals. He initially trained in General Surgery before moving into Radiology and Interventional Radiology. He has been a Clinical Director for Vascular Services, elected member of the Faculty Board of the RCR, RCR Interventional Radiology Committee member and President of the British Society of Interventional Radiology. He has, and does, hold several roles in the Cardiovascular and Interventional Radiology Society for Europe and is a UK representative on UEMS. Throughout he continues to deliver local, national, and international teaching and research projects.

Lesley Heelbeck – Midwife

I have been Head of Midwifery at Gateshead Hospitals Foundation Trust for the past 8 years. During that time, I have led the team to an outstanding rating by the CQC, supported and led the implementation of the 'Saving Babies Lives Care Bundle' and developed the midwifery leadership team. We are currently transforming our midwifery model of care to deliver the Maternity Continuity of Carer programme. NE Senate – Liverpool Women's Hospital Counterfactual Case – Final Report 20 March 2017- March 2018 part-time secondment to NHSE Nursing and Quality CNE as Midwifery advisor and Nominated Head of Midwifery to represent NE HOM/Deputy Director of Nursing NHSE at Northern Maternity Board. I have supported the Clinical Network with the Maternity transformation agenda and Senate reviews in the past. Representative on Northumberland Tyne and Wear and Durham local maternity system executive steering group and board. 2010-Requested to act as Lead external Midwife/Supervisor to assist Clinical Governance Lead at University College Hospital Trust in London to investigate a series of untoward risk incidents within the maternity services. 2010-Acted as a consultant to Director of Nursing and Midwifery services for the Turks & Caicos Islands to advise on the development of practice and risk management and governance structures. Worked alongside midwives and Consultant Obstetricians for 1 month across 2 Islands. Developed governance strategies and reports to improve patient safety and experience. Have experience as working as expert witness. Have completed several preliminary legal reports. I have significant experience at senior management level of managing and developing large clinical teams. I have a proven track record of service transformation and development to ensure that women, babies and their families have the best outcomes and experience at the heart of these changes.

Mr Woolagasen Pillay – Deputy Dean & Vascular Surgeon

Deputy Postgraduate Dean, Health Education England, Working Across Yorkshire and the Humber.

Vascular Surgeon, Doncaster and Bassetlaw Teaching Hospitals Foundation Trust

I have many years of experience in senior clinical leadership and in the management of service delivery and redesign. My focus is on delivering the best patient care and experience.

Dr Alexandra Battersby - Consultant Paediatrician

Alex Battersby is a consultant paediatrician at the Great North Children's Hospital. She trained in paediatrics and paediatric immunology, infectious diseases and allergy throughout the North East working in both DGH and tertiary hospitals. Her current role is as a General Paediatrician. She is the clinical lead for the implementation of Healthier Together across the North East and Cumbria and is acting head of Paediatric Emergency Admissions at the Great North Children's hospital. She has an interest in research, having obtained a PhD in Paediatric immunology during her paediatric training and is now working on research into Social Prescribing in the West End of Newcastle to look at the impact on children living in one of the most deprived areas of the country.

Dr Eric Kelly – GP

Dr Eric Kelly qualified in Leeds in 1994, where he initially undertook training in paediatrics, working in Leeds, Manchester, Harvard and London before deciding to enter General Practice. He undertook GP training in Rotherham, working initially in Doncaster where he developed an interest in commissioning. Whilst in Doncaster he was involved in local, regional and national initiatives to improve outcomes for children and young people.

Dr Kelly moved to Bassetlaw in August 2015 and joined the Bassetlaw CCG Governing Body in November 2016. He has also chaired the GB from 2017.

Stephen Elsmere – Lay member

Following 40 years of working both for and with the NHS I turned to supporting the patient experience, working with my 3 local NHS Trusts, the CQC, NICE., the Government (on Brexit health negotiations), and Universities e.g. Oxford and Sheffield as well as having 10 years of experience supporting the Y & HCS with their independent reviews.
I have continued to mentor new NHS starters from the patient viewpoint and despite returning briefly to work again with the NHS to support their Covid vaccination programme, I am once again functioning fully in attempting to speak actuality to power from the patient point of view.

Sue Cash – Lay Member

Sue Cash has been a member of the Y&H Clinical Assembly since early 2017, and has taken part in reviews of mental health services, community hospitals, and acute services configuration.

Mrs Lizzy Roebuck

Elizabeth Roebuck is a HCPC registered Paramedic who has worked for North East Ambulance Service NHS Foundation Trust since 2006. She has predominantly worked in the frontline emergency, urgent, and unscheduled care environment in a busy urban area as a Paramedic and Advanced Practitioner. She has also worked in an acute trust as a critical care and anaesthetic Research Practitioner after obtaining a Master's degree in Clinical Research. Currently she maintains the post of Clinical Audit and Effectiveness Manager and works part time within the Urgent and Emergency Care Regional team as a Clinical Fellow following a successful fellowship application with the Faculty of Medical Leadership and Management. Her interests lie in improving patient care across urgent and emergency care.

Mr Steve Canty

I am a Consultant Trauma & Orthopaedic Surgeon at Lancashire Teaching Hospitals since 2008, with a special interest in Knee Surgery. I have previously been the Clinical Director for Orthopaedics, Associate Divisional Medical Director for Oncology, Head & Neck, and Trauma. Since 2019 I have been the Divisional Medical Director for the Surgical Division. I am also the Chair of Lancashire & South Cumbria MSK and T&O Network, and the GIRFT North West Regional Clinical Specialty Lead for Orthopaedics and MSK. I have been a member of the North West Clinical Senate Council since 2022. I am also a Medical Lead for the Lancashire & South Cumbria New Hospitals Programme.

Martyn Farrer

Consultant Cardiologist, South Tyneside and Sunderland NHS Foundation Trust

Appendix 2

PANEL MEMBERS' DECLARATION OF INTERESTS

There were no declarations of interest.

Appendix 3

ITINERARY FOR VIRTUAL REVIEW

Introduction		
Scope and Terms of Reference	Prof Chris Walsh	1:00 - 1:10pm
Overview presentation		
Background	Ivan McConnell	1:10 – 1:40pm
Models we have discounted (and why)	Claire Hansen	
Overview of the proposals and impacts / key issues	Claire Hansen	
Breakout Rooms		
Urgent and Emergency Care – overview of model, impacts and workforce assumptions	Anwer Qureshi, Mat Thomas, Alastair Pickering, Richard Owen-Smith,	1:40 - 3:30pm *(including 10 min break)*
Maternity, Neonatal Care and Paediatrics – overview of model, impacts and workforce assumptions	Jenny Smith, Preeti Gandhi, Jane Warner, Debbie Bray, Kate Wood, Makani Purva	1:40 - 3:30pm *(including 10 min break)*
Summary and Q&A		
Feedback from breakout rooms	Prof Chris Walsh, Willy Pillay	3:30 - 3:40pm
Final Q&A	Prof Chris Walsh	3:40 - 4:00pm

Appendix 4

NHS
Yorkshire and the Humber
Clinical Senate

CLINICAL REVIEW

TERMS OF REFERENCE

(for Clinical Senate review of Pre-consultation Business Case options)

TITLE: Humber Acute Services Review

Sponsoring Organisation: NHS Humber and North Yorkshire Integrated Care Board (ICB)

Other organisations requesting this advice: Northern Lincolnshire and Goole NHS FT (NLaG), Hull University Teaching Hospitals NHS Trust (HUTH),.

Terms of reference agreed by: Ivan McConnell, Director Humber Acute Services, Chris Welsh, Chair Yorkshire and Humber Clinical Senate and Jeanette Unwin, Clinical Senate Manager.

Date: 16 February 2023

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1. CLINICAL REVIEW TEAM MEMBERS

Prof Chris Welsh
Dr Alexandra Battersby
Mr Andrew Hodge
Dr Andrew Simpson
Dr Debbie Freake
Mr Eki Emovon
Mrs Lizzy Roebuck
Dr Eric Kelly
Dr Katie Elliott
Midwife Lesley Heelbeck
Dr Martyn Farrer
Prof Mike Bramble
Dr Robin Mitchell
Dr Rod Lawson
Dr Simon Clark
Mr Steve Canty
Stephen Elsmere
Sue Cash
Dr Tolu Olusoga
Mr Trevor Cleveland
Mr Willy Pillay

2. AIMS AND OBJECTIVES OF THE REVIEW

Question:

From the initial Clinical Senate review held in January 2020 and subsequent review of the shortlisted models of care held in April 2022, can the Clinical Senate provide a final independent clinical assessment on the models of care proposed for public consultation?;

The request of the Clinical Senate is:

a. To provide assurance, from a clinical perspective that the evaluation process has resulted in clinically viable proposals that ensure services are:

- more sustainable

- provide good quality care for the future.
- support the improvement of health inequalities

b. To provide assurance that the assumptions have been fully considered in relation to:

- demand for services
- patient flow
- travel and access for patients and staff
- impact on neighbouring providers of secondary care
- impact on interdependent/related services (e.g. ambulance/community/primary care)

c. To provide assurance that the clinical models have taken account of the relevant clinical interdependencies and is there anything that has not been included in the proposed clinical models, within the current ability of the system to enact, that should be considered.

Objectives of the clinical review (from the information provided by the commissioning sponsor):

To provide independent clinical assurance to the Hospital Trusts and ICB on the proposed models of care/options being taken forward to public consultation which will inform the final proposed models' evaluation. The advice from the Clinical Senate will be received by the Executive Oversight Group and Integrated Care Board and will inform the NHSI Gateway 2 review on the proposed models carried forward to consultation.

Scope of the review:

The Humber Acute Services review will determine the long-term future of acute hospital provision across the Humber. This phase of the review is looking at the fundamental building blocks of acute hospital provision for urgent and emergency care, maternity, neonates and paediatrics and concepts for planned care and diagnostics. Models of care for each of these have been designed through a process of clinical design, patient involvement and modelling and are now subject to inclusion in a Pre-Consultation Business Case subject to NHSEI Gateway review.

The Senate will answer the above questions using the pre-reading pack which will be shared at least two weeks prior, and build upon the information received during the previous panel reviews held in February 2022 (informal) and April 2022 (formal) and discussion with clinical and commissioning leads at that visit.

3. TIMELINE AND KEY PROCESSES

Agree the additional Terms of Reference: February 2023

Receive the evidence and distribute to review team:

- By w/c 20th February 2023 the draft PCBC and associated pre-reading pack will be circulated.

Meetings and Teleconferences:

- **Clinical Panel briefing** – w/c 20th February 2023 (if required)
- **Clinical Panel Final review –** 27th February 2023 1-4pm

Draft final report submitted to Humber Acute Services Executive Oversight Group: 30 March 2023

Commissioner Comments Received: within 10 working days of the draft report being received

Senate Council ratification; at the end March Council meeting or ratification by email if earlier ratification required

Final report agreed: following Yorkshire and Humber Senate Council ratification

Publication of the final report on the website: After purdah (w/c 8th May 2023)

4. REPORTING ARRANGEMENTS

The clinical review team will report to the Senate Council who will agree the report and be accountable for the advice contained in the final report. The report will be given to the sponsoring commissioner and a process for the handling of the report and the publication of the findings will be agreed.

5. EVIDENCE TO BE CONSIDERED

The review will consider the pre-consultation business case and associated documents.

The review team will review the evidence within this documentation and supplement their understanding with a clinical discussion and information shared with the panel.

6. REPORT

The draft clinical senate report will be made available to the sponsoring organisation for fact checking prior to publication. Comments/ correction must be received within 10 working days.

The report will not be amended if further evidence is submitted at a later date. Submission of later evidence will result in a second report being published by the Senate rather than the amendment of the original report.

The draft final report will require formal ratification by the Senate Council prior to publication.

7. COMMUNICATION AND MEDIA HANDLING

The final report will be disseminated to the commissioning sponsor and NHS England and NHS Intelligence (if this is an assurance report) and made available on the senate website. Publication will be agreed with the commissioning sponsor.

8. RESOURCES

The Yorkshire and the Humber clinical senate will provide administrative support to the clinical review team, including setting up the meetings and other duties as appropriate.

The clinical review team will request any additional resources, including the commissioning of any further work, from the sponsoring organisation.

9. ACCOUNTABILITY AND GOVERNANCE

The clinical review team is part of the Yorkshire and the Humber Clinical Senate accountability and governance structure.

The Yorkshire and the Humber clinical senate is a non-statutory advisory body and will submit the report to the sponsoring organisation.

The sponsoring organisation remains accountable for decision making but the review report may wish to draw attention to any risks that the sponsoring organisation may wish to fully consider and address before progressing their proposals.

10. FUNCTIONS, RESPONSIBILITIES AND ROLES

The **sponsoring organisation** will

i. provide the clinical review panel with agreed evidence. Background information may include, among other things, relevant data and activity, internal and external reviews and audits, impact assessments, relevant workforce information and population projection, evidence of alignment with national, regional and local strategies and guidance. The sponsoring organisation will provide any other additional background information requested by the clinical review team.
ii. organise their clinical and commissioning input into the Senate clinical review panel and fund the travel costs of the visiting panel
iii. respond within the agreed timescale to the draft report on matter of factual inaccuracy.
iv. undertake not to attempt to unduly influence any members of the clinical review team during the review.
v. submit the final report to NHS England for inclusion in its formal service change assurance process if applicable
vi. provide feedback to the Clinical Senate on the impact of their advice when requested through contribution to a case study.

Clinical senate council and the **sponsoring organisation** will:

i. agree the terms of reference for the clinical review, including scope, timelines, methodology and reporting arrangements.

Clinical senate council will:

i. appoint a clinical review team, this may be formed by members of the senate, external experts, and / or others with relevant expertise. It will appoint a chair or lead member.
ii. endorse the terms of reference, timetable and methodology for the review
iii. consider the review recommendations and report (and may wish to make further recommendations)
iv. provide suitable support to the team and
v. submit the final report to the sponsoring organisation

Clinical review team will:

i. undertake its review in line the methodology agreed in the terms of reference
ii. follow the report template and provide the sponsoring organisation with a draft report to check for factual inaccuracies.
iii. submit the draft report to clinical senate council for comments and will consider any such comments and incorporate relevant amendments to the report. The team will subsequently submit final draft of the report to the Clinical Senate Council.
iv. keep accurate notes of meetings.

Clinical review team members will undertake to:

i. commit fully to the review and attend all briefings, meetings, interviews, and panels etc. that are part of the review (as defined in methodology).
ii. contribute fully to the process and review report
iii. ensure that the report accurately represents the consensus of opinion of the clinical review team
iv. comply with a confidentiality agreement and not discuss the scope of the review nor the content of the draft or final report with anyone not immediately involved in it. Additionally they will declare, to the chair or lead member of the clinical review team and the clinical senate manager, any conflict of interest prior to the start of the review and /or materialise during the review.

END

Appendix 5

EVIDENCE PROVIDED FOR THE REVIEW

The HAS programme team the following documentation to the Senate for consideration:

Pre-Consultation Business Case – draft
Updated Pre Reading pack covering:

- Evaluation process
- Options for consideration
- Impacts and mitigations
- Interdependencies and Enablers
- Modelling assumptions

Summary of workforce models
Intelligence on health inequalities