Yorkshire and the Humber
Clinical Senate

Free and full independent and impartial clinical advice

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

On behalf of

The Clinical Commissioning Groups of:

NHS Hull, NHS East Riding, NHS North Lincolnshire and NHS North East Lincolnshire.

Final Version 1.0

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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Version Control

Document Version	Date	Comments	Drafted by
Draft v0.1	April 2022	Initial draft report incorporating Expert Panel comments	J Unwin
Draft v0.2	May 2022	Redraft format	J Unwin
Draft v0.3	May 2022	Further additions to content	J Unwin
Draft v0.4	May 2022	Addition of Conclusion	J Unwin
Draft v0.5	May 2022	Incorporation of Senate Panel comments	J Unwin
Draft v0.6	May 2022	Incorporation of Senate Panel comments	J Unwin
Draft v0.7	May 2022	Incorporation of Chair's comments	J Unwin
Draft v0.8	May 2022	Incorporation of additional comments.	J Unwin
Final 1.0	June 2022	Inclusion of factual accuracy comments from programme team	J Unwin

1. Chair's Foreword

Northern Lincolnshire and Goole NHS Foundation Trust and Hull University Teaching Hospital NHS Trust serves a combined population of over one million people. This population is older and with higher levels of deprivation than the national average. Travel between the main hospital sites can take on average 45-50 minutes and the providers face issues with workforce availability, estate, and quality of care challenges all combining to create a complex set of challenges to address with no apparent easy solutions.

We welcomed the opportunity to work with the Humber Acute Services programme team once again, in considering the possible future configurations of services as solutions for the local populations 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 developing the significant range of options to address the challenges being faced. It is evident that those involved in this process have worked very hard to get to this point.

The Senate recognised the first order problem is the recruitment and retention of appropriate workforce for the services to be delivered under the options being considered and we hope this report helps to make the decisions and mitigations that are needed a little easier.

We thank colleagues in the Humber and North Yorkshire Health and Care Partnership and the trusts for all their work that led up to and included the Senate review in April 2022. The significant preparation that was undertaken to ensure the Senate panel were fully appraised of the case for change and the potential solutions was greatly appreciated, as was the opportunity to talk 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 detailed 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, the Senate was approached in January 2022 by the Humber Acute Services (HAS) programme team, supported by all of its commissioners, to provide further independent clinical assessment on an updated set of potential models of care. These models set out the options for urgent and emergency care, maternity, neonates and paediatrics and 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. appraise the combined proposed models of care/service options, providing clinical assurance that those models are sound and evidence-based, are in the best interest of patients, and will improve the quality, safety and sustainability of care

2. review and provide feedback and clinical assurance regarding the output of the evaluation approach ensuring that health inequalities and deprivation are part of the assessment process and that any option which is discounted is evidenced

3. provide overall clinical assurance of the clinical case for change within the Capital Strategic Outline Case (SOC) prior to NHSE/I Gateway review and consultation process

2.1 Process of the Review

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

The review was carried out over a period of three months and involved three stages:

1) **Clinical Panel briefing** which took place on 25 February 2022
2) **Clinical Panel Informal review** which took place on 14 March 2022
3) **Clinical Panel Formal review** which took place on 8 April 2022

The agenda for each of the sessions are included at Appendix 3.

At each stage the panel received a pre session briefing pack from the HAS team (a full list of the supporting information provided to the panel can be found at Appendix 5).

A question and answer log was created, updated and shared by the HAS team throughout the process. All sessions were carried out virtually via Microsoft Teams. The formal review was planned to take place in person, incorporating a site visit to Scunthorpe hospital, however due to significant COVID infection rates at that time, the decision was taken to convert the face to face review to be a virtual review.

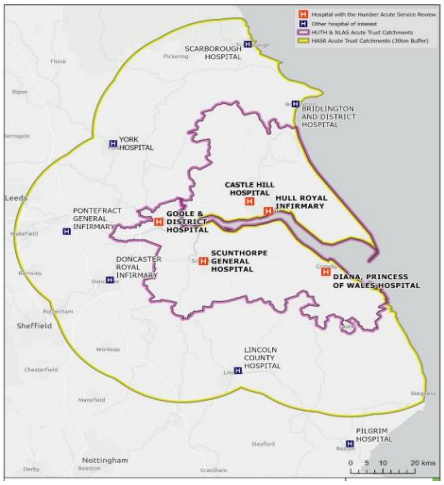
The report was drafted during April and May and was provided to the Senate panel members for additional comments in May 2022 and to the HAS team for factual accuracy on 31 May 2022.

The terms of reference for this review stated that the Clinical Senate was requested to review and provide feedback and assurance that health inequalities and deprivation had been considered. The Panel understood that inequalities and deprivation were being considered by the HAS team but it was not provided with explicit evidence related to the outcomes of the proposed models to review. Furthermore, at the point the Senate was considering the clinical models there were no options that had been discounted by the HAS team for the Senate to provide assurance on so these report focuses on Question 1 as set out in the Terms of Reference.

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 review the services within scope are the fundamental building blocks of acute hospital provision at the NLaG district general hospitals of SGH and DPoW and the HUTH hospitals. The Senate received and reviewed the specific service reconfiguration plans for SGH and DPoW services:

- Urgent and emergency care (UEC)
- Acute assessment
- Inpatients and critical care
- Maternity and paediatrics
- Planned care
- Diagnostics

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

This review follows a previous Yorkshire and Humber Clinical Senate review that was carried out in 2020 and forms part of the NHS England & NHS Improvement 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 which leads to challenges in staff being able to maintain their skills.
3. There is an inability to meet many 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 and have been developed 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. 2022 Senate Review – Models of Care Options

As a starting point, the current models of service delivery from each site are presented below:

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

The Senate panel was then presented with two potential over-arching models of service delivery for DPoW and SGH hospitals to review within the parameters of the terms of reference. The models of care relate to the potential designations of the two hospital sites and the configuration of services this may accommodate within each option.

The potential designations were described as:

1. Acute Hospital with Trauma Unit on one site and a Local Emergency Hospital (LEH) on the other site; and
2. Acute Hospital with Trauma Unit on one site and an Elective Hospital on the other site

Building on the significant amount of clinical input from a range of sources at service level in the design phase of the programme, the Senate was asked to review the overall service configurations of each of the hospital designations and assess the potential impact on the provision of core acute services in the local areas, without assuming or applying a designation to either site.

The panel understood that in all possible scenarios that HRI would provide additional diagnostic and planned services and continue to serve the region as a specialist centre,

providing the Major Trauma Centre for adults and a Level 3 Neonatal Intensive Care Unit and Castle Hill Hospital and Goole District Hospital will remain as a Specialist Elective Centre and Elective Hub respectively.

6. Potential options for an Acute Hospital with Trauma Unit and a Local Emergency Hospital.

To address the challenges facing the health care system in the south of the Humber region the Senate was presented with 6 possible options for delivery of care within a configuration of an Acute Hospital with a Local Emergency Hospital at either the SGH or DPOW site. The Senate was asked to appraise and provide clinical assurance that the options are sound and evidence-based, are in the best interest of patients, and will improve the quality, safety and sustainability of care.

Within this overarching model of care, a range of options of service distribution were presented, with the programme team agnostic as to which site would be the Acute Hospital hosting the Trauma Unit and which site would be the Local Emergency Hospital:

- Option 1 – Two sites with 24/7 UEC and co-located OLU/MLU. One Trauma unit, dual general medical & elderly inpatient provision, consolidated paediatric, surgical and medical specialty inpatients.
- Option 2 – Two sites with 24/7 UEC and co-located OLU/MLU. One Trauma Unit, consolidated adult and paediatric inpatients.
- Option 3 – Two sites with 24/7 UEC. One Trauma unit, dual general medical & elderly inpatient provision, consolidated paediatric, surgical and medical specialty inpatients, one co-located OLU/MLU and one stand-alone MLU.
- Option 4 – Two sites with 24/7 UEC. One Trauma unit, consolidated adult and paediatric inpatients. 1 co-located OLU/MLU and 1 stand-alone MLU.
- Option 5 – Two sites with 24/7 UEC, One Trauma unit, dual general medical & elderly inpatient provision, consolidated paediatric, surgical and medical specialty inpatients, 1 co-located OLU/MLU
- Option 6 - Two sites with 24/7 UEC, One Trauma unit, consolidated adult and paediatric inpatients, 1 co-located OLU/MLU

Glossary of Terms and Acronyms	
24/7	24 hours per day, seven days per week
ED	Emergency Department
LEH	Local Emergency Hospital
MLU	Midwifery Led Unit
OLU	Obstetric Led Unit
UEC	Urgent and Emergency Care

6.1. Option 1 – Two sites with 24/7 UEC and co-located OLU/MLU. One Trauma unit, dual general medical & elderly inpatient provision, consolidated paediatric, surgical and medical specialty inpatients.

Option 1
Acute Hospital • 24/7 Emergency Department with **Trauma** • Assessment unit • Same Day Emergency Care • Short Stay up to 72 hours • General Medicine and Care of the Elderly inpatients • ***Cardiology/Gastroenterology/Respiratory inpatients*** • Acute Surgery inpatients • 24/7 Paediatric Assessment Unit • Paediatric inpatients • ***Obstetric led and Midwifery Led units*** • Neonatal Level 2 • Critical care and anaesthetics
Local Emergency Hospital • 24/7 Emergency Department • Assessment unit • Same Day Emergency Care • Short Stay up to 72 hours • ***General Medicine and Care of the Elderly inpatients*** • Emergency Surgery Day Case • 24/7 Paediatric Assessment Unit • ***Obstetric led and Midwifery Led units*** • Neonatal Level 1 • Critical care and anaesthetics

Option 1 described one Acute Hospital (either DPoW or SGH) in the region that would provide the full range of urgent, emergency care and trauma services with supporting anaesthetic and critical care services. Assessment and short stay (up to 72 hours) inpatient facilities would be provided and longer stay inpatient facilities would be provided for general medical, care of the elderly, medical speciality (cardiology, gastroenterology and respiratory medicine) and acute surgical patients.

The other hospital, a LEH (either SGH or DPoW), would provide urgent and emergency care services plus acute assessment and short stay (up to 72 hours) supported by anaesthetic and critical care services, with day case trauma for suitable cases within an LEH. Emergency day case surgery will be provided and inpatient facilities for general medical and care of the elderly patients.

This option would therefore consolidate trauma services and longer stay inpatient services for medical specialities, and input from critical care and anaesthetics will still be provided for all specialties on the LEH site. Urgent and emergency care services for both adults and children will be provided from both sites. General medical and care of the elderly inpatient beds would be provided from both sites. Acute surgical inpatient services would be provided from the Acute Hospital site with the LEH providing acute day case surgery only.

This option described a paediatric and maternity services configuration that would have a 24/7 paediatric assessment unit, an obstetric unit and a midwifery led unit on both sites with a level 2 neonatal unit on the Acute Hospital site and a level 1 neonatal unit on the site of the LEH. Paediatric inpatients would be consolidated on the Acute Hospital site. This option differs from the current position which is that both sites provide the same level of maternity and paediatric care, both with paediatric inpatient beds, level 2 neonatal cots and both with obstetric led units.

6.2. Senate Findings on Option 1

The Senate panel felt that option 1 presented some challenges, primarily that there would be no medical specialty or surgical inpatient beds available on the LEH site which would result in the potential for patients having to travel across the region to the Acute Hospital site either by means of their own or public transport and in some circumstances, by ambulance from the LEH ED department or after an initial 72 hour stay at the LEH.

The panel acknowledged that there would be a proportion of the patients admitted to the 72 hour stay beds at the LEH who would go home or be cared for within the community but it was likely that there would be patients that would require transfer to the Acute Hospital site for ongoing inpatient care, which could negatively impact their length of stay, recovery and rehabilitation and on their families, given the 45-50 minute travel time between the sites. Similarly, this option may also lead to large numbers of children having to be transferred from the LEH to the Acute Hospital site for ongoing care.

With any models of care that involve the transfer of patients between hospital sites, the panel felt that there would need to be sufficient bed capacity on both sites to ensure that there would not be any negative impacts on patient flow and that patients are able to directly access a bed in a timely way. In a similar way, the panel wondered about the impact of the potentially high number of time-sensitive patient transfers that would be required of the ambulance services, particularly in light of current and ongoing high demand for these services within the communities.

The panel was concerned that the demand for transfers, along with demands to serve two EDs and two OLUs across the geography, could not be met within existing ambulance service resources and would impact on the wider ambulance response times.

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 site. The LEH model would require input from anaesthetics and intensive care support for the services provided to be safe and of a high quality. And whilst we heard that anaesthetics and intensive care support would be available on the LEH site, as it is on both sites currently, the panel members, whilst recognising the desire to maintain local access to inpatient services, felt that it was not going to be feasible in the long term, to maintain 2 onsite critical care units due to the challenges we were informed about with recruitment and retention.

The current high reliance on locum staff to maintain the ED rotas brought into question the deliverability of the model of care that involved two EDs, given that those options would need more staff than now to provide safe levels of staffing in the departments.

The panel heard about the difficulties the Trust experiences in being able to attract and recruit key workforce and it acknowledged that the issues of recruitment and retention may be ameliorated once there is clarity and certainty about the future of the sites. However, there were concerns about the potential impact of staff being displaced from their existing workplaces to a consolidated site on vacancy levels and rotas, especially given the low level of car ownership within some staff groups meaning travel between the sites would be particularly challenging.

The panel felt that the current provision of diagnostic equipment and facilities would be insufficient to sustain 2 sites with 24/7 access, whether they are an Acute Hospital or an LEH. This was the case for the scanning equipment itself and especially the case when considering the likely demand for staff that will result from the Community Diagnostic Centre developments in the region, which may exacerbate local shortages of suitably trained staff to undertake and report on diagnostic scans.

The panel noted the possible future benefits that Artificial Intelligence could bring to these services but that it was not likely to have any major impact on creating capacity within the workforce in the medium term.

The Senate heard about the number of babies delivered at each site, about the current staffing situation with respect to vacancies and unfilled posts in midwifery and junior doctor rotas. In light of the current workforce situation and the Ockenden Report's[1] recommendations for safe obstetric service provision, which is to aim for 24/7 obstetric consultant cover with a full complement of junior doctor and midwifery staff, the Senate panel felt that any option that maintained 2 Obstetric Led Units (OLU) would be unsustainable on the grounds of patient safety. Furthermore, it questioned the feasibility of staffing 2 Midwifery Led Units (MLU) alongside the OLUs given the acknowledged challenges of midwifery staffing with the additional expectation of the roll out of continuity of care teams.

In summary, the panel felt that option 1 that described the development of an Acute Hospital site and a LEH site, could potentially lead to a numbers of patient transfers with secondary transfers being of particular concern with respect to timely and safe transfers and with timely access to an inpatient bed. In modern health care the model of patients travelling to the hospital that can provide the treatment and care they need rather than their nearest hospital, such as for trauma care, is well established.

However, the difference in this option is that the patients would be being transferred to ensure they were being cared for in the most appropriate setting rather than arriving at the most appropriate setting in the first instance. It is well accepted within the health service that such transfers can cause an extended length of stay for most patients, especially for the frail and elderly.

1 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1064302/Final-Ockenden-Report-web-accessible.pdf

It was the opinion of the Senate panel that Option 1 introduces clinical risk due to the unsustainable workforce models, particularly with reference to the maintenance of two OLU and MLUs and two EDs. Furthermore, the patient pathways do not appear to be in the best interests of patients and patient care and the Senate panel felt that it was more clinically acceptable to ensure patients go directly to the best place of treatment initially and not experience secondary care transfers, even if it means further travel distances in the first place for more people. This option would not appear to improve the quality, safety and sustainability of care.

6.3. Option 2 - Two sites with 24/7 UEC and co-located OLU/MLU. One Trauma Unit, consolidated adult and paediatric inpatients.

Option 2
Acute Hospital • 24/7 Emergency Department with **Trauma** • Assessment unit • Same Day Emergency Care • Short Stay up to 72 hours • ***All medical inpatients including general internal medicine and care of the elderly*** • Acute Surgery inpatients • 24/7 Paediatric Assessment Unit • Paediatric Inpatients • ***Obstetric led and Midwifery Led units*** • Neonatal Level 2 • Critical care and anaesthetics
LEH • 24/7 Emergency Department • Assessment unit • Same Day Emergency Care • Short Stay up to 72 hours • ***No General Medicine and Care of the Elderly inpatients*** • Emergency Surgery Day Case • 24/7 Paediatric Assessment Unit • ***Obstetric led and Midwifery Led units*** • Neonatal Level 1 • Critical care and anaesthetics

Option 2 would mirror that of Option 1 with the consolidation of trauma services on one site and with both sites providing urgent and emergency care and supporting services as well as the same configuration of maternity and paediatric services. The variation between Option 1 and Option 2 would be all inpatient medical and surgical beds, for patients requiring a stay of over 72 hours, being provided from the Acute Hospital site with no medical or surgery inpatient beds on the LEH site other than those designated for short stay assessments (for stays of up to 72 hours).

6.4. Senate Findings on Option 2

The panel felt that Option 2 was equally, if not more challenging, due to the potential for even greater numbers of patients being affected. There would be a greater impact on ambulance services secondary care transfers (hospital to hospital) if all inpatient beds were consolidated on one site. As with Option 1 this led to concerns about the transfer and travel times between sites and the resulting impact on patient care, recovery and rehabilitation.

Whilst the panel was aware that the full travel impact assessment work has yet to be fully worked through by the HAS team, it would appear that there could be a significant impact on general medicine and care of the elderly patients from the Scunthorpe area should DPoW be designated as the Acute Hospital and similarly, a significant impact on patients from the North East Lincolnshire area should SGH be the Acute Hospital in relation to the need to travel to access care.

As with option 1, the Senate panel found that Option 2 introduces clinical risk due to the unsustainable workforce models and the patient pathways which would not appear to be in the best interests of patients and patient care. This Option would not appear to improve the quality, safety and sustainability of care.

6.5. Option 3 - Two sites with 24/7 UEC. One Trauma unit, dual general medical & elderly inpatient provision, consolidated paediatric, surgical and medical specialty inpatients, one co-located OLU/MLU and one stand-alone MLU.

Option 3
Acute Hospital • 24/7 Emergency Department and Trauma • Assessment unit • Same Day Emergency Care • Short Stay up to 72 hours • General Medicine & Care of the Elderly inpatients • ***Cardiology/Gastroenterology & Respiratory inpatients*** • ***Acute Surgery inpatients*** • 24/7 Paediatric Assessment Unit • ***Paediatric Inpatients*** • ***Obstetric led and Midwifery Led units*** • Neonatal Level 2 • Critical care and anaesthetics
LEH • 24/7 Emergency Department • Assessment unit • Same Day Emergency Care • Short Stay up to 72 hours • ***General Medicine & Care of the Elderly inpatients*** • Emergency Surgery Day Case • 24/7 Paediatric Assessment Unit • ***Midwifery Led unit only*** • Critical care and anaesthetics

This option describes the same Acute Hospital configuration as Option 1 with the difference between Option 1 and Option 3 being that there would be no obstetric led unit at the LEH, instead it would have a stand-alone midwifery led unit only on-site.

6.6. Senate Findings on Option 3

The concerns the panel had about the configuration of urgent and emergency care, diagnostics and critical care and their potential impacts on patient care under option 1 remain extant with this option.

With respect to the provision of a stand-alone MLU on the LEH site: this model would address the concerns about being able to sustain 2 OLUs in the region, from a medical and anaesthetic workforce perspective. However, the panel did have safety concerns about a stand-alone MLU with respect to the transfer time to the Acute Hospital site should an unexpected clinical emergency arise, the capacity of the ambulance service to respond to such situations and the ability to be able to staff the MLU as well as an OLU and MLU on the Acute site, which is an increase in the number of departments by 1 when compared to the current position. This concern applied to whichever location the MLU would be sited at, however there were additional concerns about the sustainability of the unit if it were to be sited at Scunthorpe given the very low number of births there on a daily basis (4) against the number of midwives that would be required to staff it in a climate of large numbers of midwifery vacancies.

We acknowledge the HAS team aspired to providing choice of place of birth with a stand-alone MLU as part of the offer for pregnant women, in line with feedback from the many engagement events that they had carried out with patients. However, the panel were concerned that the clinical risks associated with giving birth in a stand-alone MLU that is 45-50 minutes away from an acute obstetric and neonatal service, fully able to respond to a clinically worrying event, were fully articulated and appreciated.

Additionally, the panel acknowledged that the stand-alone MLU could result in increased travel and as a result increased risk for those patients most distant from the MLU however, the panel members were more concerned about the risk posed by a unit that was not optimally staffed.

6.7. Option 4 - Two sites with 24/7 UEC. One Trauma unit, consolidated adult and paediatric inpatients. 1 co-located OLU/MLU and 1 Stand-alone MLU.

Option 4
Acute Hospital • 24/7 Emergency Department with **Trauma** • Assessment unit • Same Day Emergency Care • Short Stay up to 72 hours • ***All medical inpatients including general internal medicine and care of the elderly*** • Acute Surgery inpatients • 24/7 Paediatric Assessment Unit • Paediatric Inpatients • ***Obstetric led and Midwifery Led units*** • Neonatal Level 2 • Critical care and anaesthetics
LEH • 24/7 Emergency Department • Assessment unit • Same Day Emergency Care • Short Stay up to 72 hours • ***No General Medicine and Care of the Elderly inpatients*** • Emergency Surgery Day Case • 24/7 Paediatric Assessment Unit • **Midwifery Led unit** • Critical care and anaesthetics

The configuration described for the Acute Hospital site reflects that of Option 2 with a 24/7 ED, critical care and consolidation of all inpatients, surgical and medical, and the full range of paediatric and maternity services.

The LEH would provide a 24/7 ED and Paediatric Assessment Unit (PAU**)** and critical care and anaesthetics**,** but no inpatient facilities for adults or children beyond a stay of 72 hours and in this model a stand-alone MLU would be offered.

6.8. Senate Findings on Option 4

As with the findings for Option 2 the Senate felt that there would be a substantial impact on patient to hospital travel and inter-site transfers if a 24/7 emergency service was provided from both sites but with all inpatient beds provided from one site only. The likelihood of needing to transfer patients from the LEH ED or assessment or short stay bed to the Acute Hospital could be high and the impact on patient safety, experience, recovery and rehabilitation could be adversely affected due to the increased length of stay that arises from such patient pathways.

With respect to the provision of a stand-alone MLU, the observations the panel made about the safety and sustainability of this model under Option 3 are applicable to Option 4 also.

As with all options that may involve large numbers of patient transfers between the sites, the panel were keen to point out that given the pressures on the local ambulance services there may be a need to develop a local patient transfer service that would be responsive, timely and able to meet the needs of the two sites.

The concerns the panel had about the configuration of urgent and emergency care, diagnostics and critical care under Option 1 remain extant with Option 4.

6.9. Option 5 - Two sites with 24/7 UEC, One Trauma unit, dual general medical & elderly inpatient provision, consolidated paediatric, surgical and medical specialty inpatients, 1 co-located OLU/MLU

Option 5
Acute Hospital • 24/7 Emergency Department and **Trauma** • Assessment unit • Same Day Emergency Care • Short Stay up to 72 hours • General Medicine & Care of the Elderly inpatients • ***Cardiology/Gastroenterology & Respiratory inpatients*** • ***Acute Surgery inpatients*** • 24/7 Paediatric Assessment Unit • ***Paediatric Inpatients*** • ***Obstetric led and Midwifery Led units*** • Neonatal Level 2 • Critical care and anaesthetics
LEH • 24/7 Emergency Department • Assessment unit • Same Day Emergency Care • Short Stay up to 72 hours • ***General Medicine and Care of the Elderly inpatients*** • Emergency Surgery Day Case • 24/7 Paediatric Assessment Unit • Critical care and anaesthetics ***(No OLU or MLU)***

This option's configuration for the Acute Hospital site are as described under Option 1 and Option 3. It would provide the full range of urgent, emergency care and trauma services with supporting anaesthetic and critical care services, as well as consolidated surgical and medical inpatient beds.

The LEH would also provide 24/7 urgent and emergency care services for adults and children, with short stay medical and surgical beds and inpatient beds for general medicine and care of the elderly patients with supporting anaesthetic and critical care services. The variation in service configuration of this model is the lack of an OLU or MLU on the LEH site.

6.10. Senate Findings on Option 5

This option 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, the configuration of Option 5 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. This option would also result in the displacement of staff from their existing place of work.

The concerns the panel had about the configuration of urgent and emergency care, diagnostics and critical care under Option 1 remain extant with this option.

6.11. Option 6 – Two sites with 24/7 UEC, One Trauma unit, consolidated adult and paediatric inpatients, 1 co-located OLU/MLU

Option 6
Acute Hospital • 24/7 Emergency Department with **Trauma** • Assessment unit • Same Day Emergency Care • Short Stay up to 72 hours • ***All medical inpatients including general internal medicine and care of the elderly*** • ***Acute Surgery inpatients*** • 24/7 Paediatric Assessment Unit • ***Paediatric Inpatients*** • ***Obstetric led and Midwifery Led units*** • Neonatal Level 2 • Critical care and anaesthetics
LEH • 24/7 Emergency Department • Assessment unit • Same Day Emergency Care • Short Stay up to 72 hours • ***No General Medicine and Care of the Elderly inpatients*** • Emergency Surgery Day Case • 24/7 Paediatric Assessment Unit • Critical care and anaesthetics ***(No OLU or MLU)***

Option 6 reflects that of Option 5, with no MLU or OLU on the LEH site, with all obstetric activity consolidated on the Acute Hospital site. The variation to service configurations compared to Option 5 is that all paediatric and adult inpatient activity would also be consolidated onto the Acute Hospital site.

6.12. Senate Findings on Option 6.

As with Option 2 and Option 4, the configuration of services described under Option 6 would result in potentially significant numbers of patient transfers from home to hospital and between sites, particularly involving the most vulnerable and frail patients. This option does not address the sustainability of providing 2 EDs, critical care and diagnostic departments.

This option does however provide a solution to the challenging position of obstetric and midwifery staff with all staff concentrated on one site. This would lend itself to improvements in safe levels of staffing, concentration of skills and expertise and the opportunity to provide high quality care to patients, sustainably. However, as with the configuration of Option 5, it 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. This option would also result in the displacement of staff from their existing places of work.

6.13. General Comments on all options.

The Senate panel felt it was important to reiterate that within all the options presented for an Acute Hospital with Trauma Unit and a Local Emergency Hospital there were implications (though more marked in some options than others) for further consideration:

All options will have consequences for all aspects of ambulance service activity.

All options describe critical care services being delivered from two sites which may be unsustainable due to future workforce challenges.

With a model predicated on immediate care, up to 72-hour care, post 72 hours to 14 day and subsequent care, it will be crucial to ensure there is matched capacity in each to ensure continued throughput, to prevent delays and bottlenecks. The capacity will need to acknowledge demand surges, for example with winter pressures, and demand in care facilities outside the hospital.

There will be implications for patient and staff travel which will need to be fully understood and mitigated for.

7. Potential model of an Acute Hospital with Trauma Unit and an Elective Hospital

As an alternative to the Acute and Local Emergency Hospital model an alternative model of care was put forward which described an Acute Hospital on one site and an Elective site on the other.

This model was presented with one option.

Acute Hospital with Trauma Unit and Elective Hospital Option
Acute Hospital • 24/7 Emergency Department and Trauma • Assessment unit • Same Day Emergency Care • Short Stay up to 72 hours • All Medical inpatients • Acute Surgery inpatients • Outpatient services • 24/7 Paediatric Assessment Unit • Paediatric inpatients • Obstetric led and Midwifery Led units • Neonatal Level 1 & 2 • Critical care and anaesthetics
Elective Hospital • Outpatient services • Adult elective inpatients • Critical care and anaesthetics for elective care only (Urgent Care Services – available locally)

This option described a 'hot and cold' model of service provision across the two existing hospital sites with DPoW or SGH being designated as the Acute Hospital or Elective Hospital. A further configuration was described which involves a new build hospital in the centre of the region to be designated as the Acute hospital site with routine elective care provided at both Scunthorpe and Grimsby places.

7.1. Senate Findings on Acute Hospital with Trauma Unit and Elective Hospital model

This model of a hot and cold site would address the concerns the Senate panel had regarding the sustainability of providing 2 ED services. Under this model there would be far fewer acute, inter-site patient transfers as all emergency and acute inpatient care would be provided from one site.

The panel was unsure about the sustainability of critical care services being provided from two sites as, even though the critical care provision on the elective site would be more predictable, there may be future workforce challenges that could hamper the ability to staff this level of service provision.

When considering the option of the DPoW and SGH sites for the Acute and Elective hospital there remain some concerns relating to displacement of staff from one site to the other which

may impact upon staff retention given the distances staff may be required to travel to a 'new' place of work.

A new build hospital sited centrally between the two existing hospital sites would appear to offer the best solution in relation to the quality and safety benefits associated with the consolidation of all acute services on one site. This would also go some way to mitigating the risks attached to the requirement for staff to travel large distances to access either of the existing sites, reducing the risk of significant staff displacements and the associated impact on staff retention.

Indicative data presented to the Senate panel suggested that, based on the postcodes of patients that use the services, under this option there could be a significant shift of activity out of the region to neighbouring Trust's hospitals instead. The Senate panel members strongly recommend that further work is required to assess the travel and transport impacts on patients for all the models being considered under the HAS programme to understand the impact on other systems of increased numbers of patients accessing their services.

It would be beneficial for the HAS team to fully understand the impact the models and options would have on staff travel, particularly with consideration to the strategic ambition for the Trusts within the region to become anchor organisations.

It is also suggested that further work would be necessary to assess the impact of all the models and options on health inequalities in the region to ensure that any possible impact is mitigated.

Of the options presented for UEC, this option of a central new build as the Acute Hospital, was found to offer a more robust clinical model which would appear to be in the best interests of the patients and would improve the quality and safety of care in relation to the avoidance of secondary patient transfers and the consolidation of workforce and skills on each site, offering opportunities for workforce development and standardisation of care. However, even if there was funding available for a new build, an interim model will still be needed until any such facility became available, which could be a number of years away.

The question of whether this option would address the sustainability of services remains unclear given the previous comments regarding the provision of critical care on two sites and the unknown impact on workforce retention because of potential staff displacements.

8. Recommendations

It is 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. The panel also recognised that there is still further work required to reduce the number of potential options under consideration to those that are the most viable and most likely to address the challenges in the local health system.

8.1. Models of Care

The Senate heard a great deal about the plans for reconfiguring the delivery of hospital based planned and acute care and we would encourage continuation of the discussions on system wide solutions to the challenges the programme is seeking to address, involving primary, secondary, tertiary and social care to ensure that these plans can work. There will be a need to ensure there are robust links with a primary care system that has capacity to respond to system demands, especially out of hours, to ensure the success of many aspects of the acute care provision.

The Senate received information on the potential numbers of patients that may be impacted by the options presented and the potential impact on other providers in the region because of patient movement and choice. Further in-depth travel and transport impact assessments will be required to fully understand the implications of each of the options on both patients, staff and the ambulance provider and with neighbouring hospital trusts to reach a common understanding of potential changes in patient flows as a result of any change.

Consideration should also be given to the ambulance service's ability to respond to the patient transfers that may result from the options that were presented and whether a dedicated patient transport service would be of benefit. Any patients transfers from one site to another would need to be carried out in a timely way that did not result in delays to patient care.

There would be a need to ensure that there was sufficient available assessment, short stay and inpatient bed capacity, including at times of surge and increased demand, at the Acute Hospital and LEH sites, under those relevant options, to prevent delays or bottlenecks in patients accessing care. There would also be a need for well-developed plans on how patients will be discharged both quickly and safely, and for adequate capacity to be built out of hours to ensure throughput.

It is imperative to assess the impact of the proposed options on the health inequalities in the local populations, a process which would normally be ongoing throughout a programme such as HAS, to ensure that any proposals do not lead to an adverse impact and that appropriate mitigations are put in place.

8.2. Workforce

The Senate agreed that the first order problem is the recruitment and retention of appropriate workforce for the services to be delivered and, whilst this was not presented as an option for the Senate to consider, it is possible that a new build, single site option might have the most benefit for workforce recruitment and retention.

The programme team are encouraged to undertake an in-depth staff travel and transport impact assessment to fully understand the effect of the options on staff displacements and the impact this would have on workforce retention as well as the ambition to be an Anchor organisation.

To address recruitment and retention difficulties in some staff groups the panel encourages consideration of a system-wide, multi professional workforce model, incorporating new roles like advanced care practitioners and advanced paramedics able to work within the whole system and with an aim to avoid admissions.

To address current and future workforce constraints, the Senate encourages the Trusts to work closely with local universities and medical schools to encourage and promote more local people to train in health care professions. This will encourage a local supply of workforce more likely to remain in the area.

8.3. Digital

The Trusts and partner organisations are encouraged to implement an electronic medical record system that would attain a digital maturity of level 5 against the Healthcare Information and Management Systems Society (HIMSS) standards. This would enable interoperability between systems that would support patient care in hospital and non-hospital settings.

A high level of digitalization will be a key enabler to effective and efficient clinical care across both sites. In particular the development of telemedicine is encouraged to allow access to clinical expertise that would reduce the need for travel and patient transfers.

9. Conclusion

The initial request of the Senate was threefold as set out in the Terms of Reference.

1. *To appraise the combined proposed models of care/service options, providing clinical assurance that those models are sound and evidence-based, are in the best interest of patients, and will improve the quality, safety and sustainability of care.*

The Senate has assessed all the options and has provided comments for each one presented. Some options appear to be riskier than others and some do go some way to addressing and improving quality, safety and sustainability of care. However, at this stage it is difficult for the Senate to concretely provide clinical assurance on the models given the current uncertainty around the potential impacts on patients and staff and the ability of the whole local health and social care system to be aligned and able to adequately support the acute care plans.

2. *Review and provide feedback and clinical assurance regarding the output of the evaluation approach ensuring that health inequalities and deprivation are part of the assessment process and that any option which is discounted is evidenced.*

The panel was not able to provide any comments about how the evaluation approach could be strengthened and it was not presented with any options that had been discounted. However, with respect to health inequalities and deprivation, the Senate did not receive assessments of how these would impact the success of the options being proposed and

there is a need for the whole system to focus on the potential impacts on public health and on access to care.

3. *Overall provision of clinical assurance of the clinical case for change within the Capital Strategic Outline Case (SOC) prior to NHSE/I Gateway review and consultation process*

There will be a need to broaden the detail of the various options being considered in relation to their potential impact on neighbouring Trusts. A common and agreed understanding would need to be reached about the impacts and what the mitigations might need to be.

We hope our comments are helpful to you in developing your proposals for consultation with the public and for agreeing the future for your services.

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.

Dr 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 Honorary 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 Department of Health 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 & Cancer Research UK Strategic GP, Northern Cancer Alliance 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.

Dr Michael Mawhinney – Head of Nursing & Patient Experience

Michael Mawhinney is the Head of Nursing, Research and Patient Experience at York and Scarborough Teaching Hospitals NHS Foundation Trust. Qualifying as a nurse from Queen's University Belfast in 2009, he has a clinical background in cancer care and critical care. Michael completed his PhD using patient experience and staff experience data to inform new models of care for people with cancer.

Dr Geoff Lawson

Retired Consultant Paediatrician, Sunderland Royal Hospital. Clinical Director of Children's Services for 25 years during which I oversaw development of an independent Paediatric Emergency Department unique to NE England.

Andrew Hodge – Director of Allied Health Professions

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.

Mr David O'Regan – Consultant Cardiothoracic Surgeon

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.

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 a number of 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.

Prof. Steve Robson – Specialist Obstetrician

Stephen Robson is Professor of Fetal Medicine at Newcastle upon Tyne Hospitals NHS FT and an honorary consultant obstetrician at the Trust. He is the Obstetric Lead for the North East and North Cumbria Local Maternity & Neonatal System (LMNS) and has had several national and regional leadership roles related to commissioning and delivering maternity services.

Dr Martyn Farrer – Consultant Cardiologist

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.

Appendix 2

PANEL MEMBERS' DECLARATION OF INTERESTS

There were no declarations of interest.

Appendix 3

ITINERARY FOR THE REVIEWS

Clinical Senate Briefing
Humber Acute Services Review
Friday 25th February 12noon – 2pm

Senate Panel Members Attending:
Prof Chris Welsh
Dr Michael Mawhinney
Prof Steve Robson
Stephen Elsmere (lay member)
Jeanette Unwin
Lesley Heelbeck
Mr David O'Regan
Mr Willy Pillay
Debbie Freake
Dr Martyn Farrer
Dr Trevor Cleveland
Dr Simon Clark
Dr Robin Mitchell
Andrew Hodge
Dr Tolu Olusoga

Senate Panel Apologies:
Mr Eki Emovon
Dr Katie Elliott
Dr Andy Simpson

AGENDA

	Item
1	Programme Overview and Key Milestones
2	Our Exemplary Engagement Programme
3	Potential Models of Care
4	Summary from Clinical Senate Recommendations 2020
5	Evaluation Framework/Approach
6	Our Capital Investment EOI
7	Issues and Risks

Clinical Senate Briefing – Informal Review
Humber Acute Services Review
Monday 14th March 11am – 1pm

Senate Panel Members Attending:
Prof Chris Welsh
Jeanette Unwin
Dr Tolu Olusoga
Mr David O'Regan
Dr Michael Mawhinney
Dr Katie Elliott
Stephen Elsmere (Lay member)
Dr Simon Clark
Mr Willy Pillay
Dr Robin Mitchell
Lesley Heelbeck
Prof Steve Robson
Dr Rod Lawson
Prof Mike Bramble
Dr Geoff Lawson
Oliver Coen (observer)

Senate Panel Apologies:
Mr Eki Emovon
Dr Andy Simpson

AGENDA

	Item
1	Introduction / Purpose of the Review
2	HAS Overview / Recap from Briefing
3	Breakout Rooms for Q&A Discussion: • Urgent & Emergency Care • Maternity, Neonates & Paediatrics
4	Potential Models of Care (presented in breakout rooms)
5	Feedback from Breakout Rooms
6	Next Steps / Close

Clinical Senate Pre-Briefing – Formal Review
Humber Acute Services Review
Friday 8th April 9.30am – 12noon

Senate Panel Members Attending:

Prof Chris Welsh
Jeanette Unwin
Dr Rod Lawson
Dr Andy Simpson
Dr Katie Elliott
Debbie Freake
Andrew Hodge
Dr Robin Mitchell
Mr David O'Regan
Dr Trevor Cleveland
Stephen Elsmere (lay member)
Prof Steve Robson
Dr Simon Clark
Oliver Coen (observer)
Mr Eki Emovon
Dr Alexandra Battersby

Senate Panel Apologies:

Dr Michael Mawhinny
Mr Willy Pillay

AGENDA

	Item
1	Clinical Senate Process
2	HAS Approach
3	Formal Review Agenda
4	Key Points/Themes Raised so Far & Responses
5	Our of Hospital Review
6	Next Steps

Appendix 4

NHS
Yorkshire and the Humber
Clinical Senate

CLINICAL REVIEW

TERMS OF REFERENCE

Sponsoring Organisation: NHS Hull Clinical Commissioning Group

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

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: 7 February 2022

1. CLINICAL REVIEW TEAM MEMBERS

Prof Chris Welsh, Chair
Dr Tolu Olusoga
Dr Rod Lawson
Dr Andy Simpson
Dr Katie Elliott
Debbie Freake
Dr Michael Mawhinney
Mr Andrew Hodge
Mr Eki Emovon
Dr Robin Mitchell
Prof. Mike Bramble
Mr David O'Regan
Dr Trevor Cleveland
Ms Lesley Heelbeck
Dr Geoff Lawson
Prof. Steve Robson
Mr Stephen Elsmere
Dr Martyn Farrer
Mr Willy Pillay
Dr Simon Clark
Dr Alexandra Battersby

2. AIMS AND OBJECTIVES OF THE REVIEW

Question:

From the Clinical Senate review held in January 2020, can the Clinical Senate provide a further independent clinical assessment on the developed models of care currently under consideration?;

The request of the Clinical Senate is 3-fold:

4. To appraise the combined proposed models of care/service options, providing clinical assurance that those models are sound and evidence-based, are in the best interest of patients, and will improve the quality, safety and sustainability of care

5. Review and provide feedback and clinical assurance regarding the output of the evaluation approach ensuring that health inequalities and deprivation are part of the assessment process and that any option which is discounted is evidenced

6. Overall provision of clinical assurance of the clinical case for change within the Capital Strategic Outline Case (SOC) prior to NHSE/I Gateway review and consultation process

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

To provide independent clinical assurance to the Hospital Trusts and CCGs on the proposed models of care/options, which may be subject to a public consultation. The advice from the Clinical Senate will be received by the Clinical and Executive Programme Group and will inform the NHSI Gateway 2 review and the potential models which are 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 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 based on the information provided in the documentation and virtual briefing session and through information received at the panel visits (informal February 2022 and formal visit March 2022) and discussion with clinical and commissioning leads at that visit.

3. TIMELINE AND KEY PROCESSES

Receive the Topic Request form: 25th January 2022

Agree the Terms of Reference: by 14th February 2022

Receive the evidence and distribute to review team:

- By mid-February the briefing summary of the proposed models of care and initial evaluation
- By end-March in preparation for the formal review – the evaluation report

Meetings and Teleconferences:

- **Clinical Panel briefing** – 25th February 2022
- **Clinical Panel Informal review –** 14th March 2022
- **Clinical Panel Formal visit –** 8th April 2022

Draft report submitted to Humber Acute Services Executive Oversight Group: 31 May 2022

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

Senate Council ratification; at the 19 July 2022 Council meeting or ratification by email if earlier ratification required

Final report agreed: following Council ratification

Publication of the report on the website: by 30 August 2022.

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 following key evidence:

- Case for Change report (2019)
- Clinical Senate recommendation report (November 2020)
- Proposed models of care and summary of the initial evaluation
- Workshop outputs
- Engagement survey reports and outputs
- Evaluation report

The review team will review the evidence within this documentation and supplement their understanding with a clinical discussion and information shared with the panel at the visit in April 2022.

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 CCG and Trust provided the following documentation to the Senate for consideration:

HAS Clinical Senate Briefing – 25/02/2022
HAS Clinical Senate Briefing – 14/03/2022
HAS Pre-brief for Clinical Senate Panel – 08/04/2022
Draft Pre Consultation Business Case v0.5
High level planning Clinical Assumptions v10.0
Transfer Conditions
Travel analysis spreadsheet
UEC Transfer Conditions
Question and Answer log