NHS
Yorkshire and the Humber
Clinical Senate

Clinical Senate Review

for

Transformation of Acute Services on behalf of Eastern Cheshire CCG

Version 1.0

October 2018

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1. Chair's Foreword

1.1 East Cheshire NHS Trust is a small Trust, serving a population of over 204,000 with 225 core general and acute beds. It faces many challenges in trying to sustain its current range of specialties in a small district general hospital. Much has already been done to make the services it provides as effective as possible with major trauma, acute stroke and cardiac services provided in neighbouring Trusts. It benefits from a stable leadership team and few workforce issues and it has a 'good' rating in its Care Quality Commission (CQC) report published in April this year. However as a small District General Hospital (DGH) it faces the challenges of maintaining small acute speciality teams to provide a 24/7/365 service. Consequently there are issues in the resilience of its small teams, in maintaining the skills of its staff, in meeting all Royal College staffing standards (particularly consultant presence and patient reviews), and in maintaining its middle grade workforce. In addition it is vulnerable to winter surges in demand and struggles to maintain flow through its hospital. Given the small activity levels the Trust is challenged financially with the resulting difficulties in maintaining the estate and investing in digital technologies.

1.2 The Senate was pleased to be invited to work with the commissioners to consider a model of sustainable services for its population. There have been many reviews before us including the McKinsey review in 2014, an Ernst and Young review in 2016 and the NHS I Cheshire review in 2017. We are assured that the local health economy is now focused on working to provide a solution and that changes will be made as a result of this latest work.

1.3 We were asked to provide an independent clinical assessment of whether the scenarios presented were clinically feasible and to identify risks, issues, opportunities and concerns. We hope that this report provides a balanced clinical assessment of those scenarios and that it assists commissioners in moving forward to achieve the changes required.

1.4 We thank the commissioners and the Trust for their hospitality during our 1 day site visit to Macclesfield Hospital in September which gave us the opportunity to better understand the geography, the challenges and the proposed solutions and to talk to clinicians delivering the services.

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

Chris Welsh, Senate Chair

2. Summary of Key Recommendations

2.1 With a small district general hospital (DGH) there are significant challenges in maintaining small acute speciality teams who only manage small numbers of patients. Changes do need to be made to the services provided at Macclesfield Hospital to ensure that patients receive care in line with national standards. But we also need to ensure that as many patients as possible continue to receive most of their care locally. This will include outpatient, diagnostic and day case facilities although they may need to travel for specific inpatient procedures. To enable this it is essential that a well-grounded and organised clinical partnership is developed in the near future with another provider. This clinical partnership needs to recognise the importance of historic and existing patient flows. On the basis of the information available this is a clinical partnership with Stepping Hill Hospital, Stockport for some of the services.

2.2 Our independent clinical assessment of the scenarios is that all of these are feasible but the sustainability of each scenario is mainly driven by the local healthcare system's views on the constraints. Due to our concerns particularly with the sustainability of the paediatric and neonatal service our advice is that Scenarios 2 or 4 are our preferred scenarios. The 'no change' scenario does not have our support. Scenarios 5 and 6 also do not have our support as from the information received we recommend that trauma and orthopaedics and Accident and Emergency (A&E) remain at the site. There is an argument to be made for transferring emergency general surgery as detailed in Scenario 3 but this has to be combined with a solution for neonatal and paediatrics to be a scenario that receives our support. Scenario 1 has some potential but there is not the service by service detail to really understand what these operational changes will be and how they will result in the services being sustainable and financially viable.

2.3 In the near future we recommend that the neonatal unit is reclassified from a Local Neonatal Unit to a Special Care Unit and that discussions commence with the neonatal network to develop rotational working and training opportunities to maintain staff skills.

2.4 Our other recommendations are:

- to develop proposals to expand the frailty service as part of the proposed solution for the Trust and to ensure that community and social care resources are an integral part of the frailty service and the scenarios
- to provide further thought to the sustainability of the critical care service and its ability to support the acute medical model
- to commence discussions with North West Ambulance Services to enable modelling of the impact of each of the scenarios on their service and to accelerate the discussion with partner organisations on their ability to absorb the activity from the Trust. The Sustainability and Transformation Partnerships (STP) approach needs to be much more visible within the scenario discussions.

3. Background

Clinical Area

3.1 East Cheshire NHS Trust is an integrated community and acute trust employing 2,585 staff, providing community and hospital healthcare across an area of Cheshire to a population of over 204,000. The trust consists of three hospitals providing inpatient services at Macclesfield and Congleton and outpatient services at Knutsford. Community health services are delivered from locations including Knutsford and Congleton hospitals, clinics, GP premises and patients' own homes. They include district nursing, intermediate care, occupational health and physiotherapy, community dental services, speech and language therapy, palliative care and sexual health.

3.2 Acute services provided at Macclesfield District General Hospital include urgent and emergency care, medicine, surgery, critical care, maternity, children and young people's services, end of life care and outpatients services. The Trust also provides a number of hospital services in partnership with other local trusts and private providers, including pathology, urology and renal dialysis services

3.3 The Trust has an average weekly demand of:

- 996 A&E attendances
- 31 babies delivered
- 2 day case and 1 elective inpatient paediatric spell
- 13 day case and 7 elective inpatient general surgery spells
- 23 day case and 14 elective orthopaedic spells
- 3 critical care spells

3.4 The Trust has community services that cover:

- Community health inpatient services
- Community end of life care
- Community health services for adults
- Community health services for children, young people and families
- Community dental services

3.5 As a small DGH the Trust faces the challenges of maintaining the range of specialties it currently provides in terms of the resilience of its small teams, in maintaining the skills of its staff, in meeting all Royal College staffing standards and in maintaining its middle grade services.

Role of the Senate

3.6 The Senate was approached by the Cheshire and Merseyside Health and Care Partnership (C&M HCP) in April to work with Eastern Cheshire Clinical Commissioning Group (CCG) in reviewing the sustainability of acute services in East Cheshire NHS Trust.

3.7 The C&M HCP advised the Senate that they had commissioned KPMG and the NHS Transformation Unit to support the development of the service change proposals for the acute services at this Trust and it is these proposals that the Senate would be asked to advise on. Due to the conflicts of interest within the local Senate, the Yorkshire and the Humber Senate was approached to provide the formal clinical advice on the preferred option into the Stage 2 assurance process.

3.8 A timetable was agreed for this work but regulators then requested further work to be undertaken to take into account broader plans for services outside of hospital. As a consequence of this request timescales changed and the CCG confirmed that they would not be in a position to progress to Stage 2 of the service change assurance process in 2018. However, recognising that the focus of the Senate's review was to provide assurance regarding the robustness and feasibility of the hospital service proposals it was agreed that we would continue to work to our original timescale. We would, however, be asked to advise on the clinical sustainability of the developing scenarios and not on the preferred option.

3.9 The specific questions the Senate was asked to address are:

Can the Clinical Senate provide an independent clinical assessment of whether the six scenarios currently under consideration are clinically feasible and sustainable given the volumes of activity, case mix, local health needs etc? Please indicate whether there are other scenarios which we should be actively considering.

Can the Senate outline any risks, issues, opportunities or concerns that we should consider as we further develop and refine these scenarios?

Process of the Review

3.10 In May 2018 the Senate Council was informed of the request from C&M HCP and discussed the approach we should take to this review. Work commenced on assembling the expert clinical panel for the review. In July 2018 representatives from the Trust and the CCG were welcomed to the Senate Council to provide an overview presentation of the issues facing the Trust. The Senate Council further refined our approach to the review in the light of this discussion in agreement with the commissioning lead. The supporting information was received from the CCG and distributed to the panel on 10th September and discussions took place with all panel members during the following week. The Terms of Reference were agreed in early September.

3.11 A site visit to Macclesfield Hospital took place on 24th September and the itinerary of the site visit is included at Appendix 3.. There were an additional 3 members of the panel who were unable to attend the visit but still contributed to the teleconference and email debate. The details and short biographies of the full panel can be found in Appendix 1. The clinical panel followed up the site visit with a teleconference discussion on 3rd October where the requirements for additional activity information were agreed.

3.12 The additional information was received on 13th October and the panel commented on this information through further email discussion. The report was drafted during the final weeks of October and provided to the commissioners for comment on 1st November. The headlines of the report were communicated to the commissioners on 24th October in advance of their receipt of the full report.

3.13 The Senate took the information received from the clinicians during the visit at face value and based their recommendations on the evidence received, which is listed at Appendix 5, The Senate also took into account the clinical conversation and discussion during the visit to Macclesfield Hospital.

3.14 Whilst working with East Cheshire the Senate also worked with commissioners in South Sefton CCG, to a similar timeframe, to review the proposals for the sustainability of acute services in Southport and Ormskirk NHS Trust. We therefore had the benefit of comparison in these reviews. The Senate took the decision to treat the two reviews separately, and assemble 2 different expert panels, as whilst there is a lot of similarity between the challenges facing these Trusts in Cheshire and Merseyside there are also significant differences.

4. Recommendations

Can the Clinical Senate provide an independent clinical assessment of whether the six scenarios currently under consideration are clinically feasible and sustainable given the volumes of activity, case mix, local health needs etc? Please indicate if there are other scenarios which we should be actively considering.

4.1 Our commentary is focused on responding to the request to independently clinically assess the six scenarios. In doing so we thought it would be helpful to firstly consider the key clinical specialties and how the scenarios will address the issues with those services.

4.2 Sub-scale but not sub-standard was the message we received in the evidence presented. We agree with that to a large extent and the CQC report from April rates the Trust as overall 'good'. There has already been a large amount of work done with partner organisations to ensure the services are delivering effective care. This combined with the generally good levels of recruitment and the stable leadership means there are fewer challenges for the Trust compared to other providers.

However the small scale of a number of the acute specialist teams does mean that reconfiguration is required to deliver sustainable services that we define as:

- sees and treats **enough patients** to operate a safe and efficient service
- has an **appropriate workforce** to meet staffing needs
- has **interdependent clinical services** in place and in reach to operate core services safely and effectively
- is likely to be deliverable within the **resource envelope** that is likely to be available

Urgent and Emergency Care

4.3 The service incorporates a 24 hour A&E service, minor injuries, acute medicine, emergency surgery and critical care. There are drive-by policies for patients affected by heart attacks, stroke, major trauma and complex paediatric cases. There is also a GP led acute visiting service and a GP out of hours service run by the Trust. Co-located in A&E is a GP led primary care centre to which patients are streamed if more appropriate.

4.4 This is one of the 10 smallest A&Es in the country with a total of 50,444 attendances in 2017/18 with 20% of those attendances by children.

4.5 There is a 28 bedded Medical Assessment Unit (MAU) where patients may be managed and treated for up to 48 hours before being discharged or moved to a specialty ward. This is supported by the frailty team, and an Acute Assessment Unit (AAU) which enables assessment of patients that are referred by their GP for up to 6 hours before the decision to admit.

4.6 We agree that there is some innovative practice which has stabilised the number of A&E attendances but there are issues with the service, most notably:

- The inability to meet the Royal College of Emergency Medicine standards for A&E consultant staffing at weekends
- The reliance on locum cover in the middle grade rota
- The inability to meet 4 hour and 12 hour performance standards due to the lack of available beds, particularly in the winter, and the lack of flexibility in the system.
- The large number of medical outliers resulting in patients being moved from ward to ward during their stay and being more likely to have a longer length of stay.
- The inability to discharge elderly patients quickly due to the lack of access to community and social care resources

4.7 In discussion with colleagues in acute medicine it was noted that amongst these issues they highlight the gaps in the workforce (particularly A&E nursing and vacancies in the medical MAU), difficulties in meeting the 4 hours standard, and the high bed occupancy (due to lack of community and social care resources to allow the smooth discharge of elderly patients).

4.8 Their views were that the scenarios presented would not help to address these issues and suggested that expansion of the frailty service needed to be considered further. They also suggested expansion of alcohol and drug detox services.

4.9 We also discussed the impact of the scenarios on their service and the team expressed their concerns with running a service where surgical/ paediatric and obstetrics and gynae patients will need to be transferred out and the pressure this will place on the service. In particular the team expressed their concerns with losing the paediatrics service and the safety issues of A&E staff needing to manage sick children who present at A&E without any supporting service on site. Some scenarios propose the development of an on-site Paediatric Assessment Unit but the staff felt it would be difficult to recruit to this model. The staff view was that if surgery is re located then the ITU will become unsustainable.

4.10 Our advice is that the Macclesfield population needs a local A&E service and that scenario 6 is therefore the least attractive of the scenarios. We acknowledge that there are some issues with the staffing of the service, particularly at weekends, but many of the other issues could be addressed through improving the bed availability within the Trust and developing community resources to facilitate the discharge of elderly patients. These are issues outside of the performance of the A&E department which need to be addressed within the agreed service model. None of the scenarios currently discuss the opportunities to expand the frailty service.

Recommendation: *to develop proposals to expand the frailty service as part of the proposed solution for the Trust and to ensure that community and social care resources are an integral part of that frailty service and the scenarios*

Emergency General Surgery, Emergency Trauma and Orthopaedics and Inpatient Planned Care

4.11 Emergency general surgery is provided 24/7 and the team of 5 consultants manage the planned general surgery and general surgical emergencies. Out of hours the management of an acute surgical problem is provided by the on call emergency surgery rota. Vascular surgery is provided at MRI (Manchester Royal Infirmary) with outpatient clinics only at Macclesfield. The urology service is provided by Stockport with day case surgery and clinics only at Macclesfield. The plastic surgery service is provided by Wythenshawe Hospital with clinics only in Macclesfield. Paediatric trauma at less than 2yrs old goes to Manchester and complex trauma goes to MRI or Salford.

4.12 Surgical care is provided on two wards with a further ward for trauma and orthopaedics patients, the largest specialty. Demand for other specialties is relatively low and 91% of the care is day case.

4.13 There are many service strengths including the committed workforce with good inter service working relationships. They already have excellent day case surgical rates and partnership arrangements in place for some services. There is a high day case rate for breast surgery and a reconstruction service provided locally. In addition the NELA and Colorectal audit were satisfactory:

- https://www.acpgbi.org.uk/surgeon-outcomes/east-cheshire-nhs-trust/
- https://www.nela.org.uk/Individual-Hospital-Report

4.14 Within general surgery and trauma and orthopaedics we see the main issues as the:

- Inability to meet the 14 hour target for consultant review as it is not cost effective to provide this given the low activity levels
- The small numbers of emergency general surgery cases in particular laparotomies and the challenge of maintaining staff skills
- The low volumes of planned complex cancer and paediatric surgery presenting a risk to maintaining skill sets
- High expense to cover theatre overnight which is rarely used
- The recruitment gaps in junior doctors across general surgery
- The Trust performing below the national average for some fixation methods for hip replacement, the longer average length of stay and the higher mortality
- The inability to recruit to a specialist orthogeriatrician
- The single handed small services e.g. haematology and the lack of resilience in the system leading to long waiting lists for many services
- The lack of medical beds. The demand for medical beds therefore exceeds capacity leading to significant numbers of medical outliers creating cancellations of planned surgical procedures
- The increased length of stay due to the delays in transfer of care to the community

4.15 In discussion with Trust colleagues in general surgery they confirm their main concerns are the delays to discharge and the resultant medical outliers leading to cancellations of planned procedures. They express concern with the long journey time to Stockport (45 minutes away) if the local service is not retained. Trauma and orthopaedics colleagues also report the main issue as being the lack of available beds, particularly in the winter and see the lack of social care being the reason for the increased length of stay. There are 240 fractured Neck of Femur cases a year and they expressed concern that colleagues at Stockport would not be able to cope with the volume of trauma patients from this site and that the local elderly frail population needed a local service. The limited orthogeriatrician service was also seen as an issue.

4.16 Scenarios 3, 4, 5 and 6 would all transfer emergency surgery to a partner site and options 3 and 4 would retain trauma and orthopaedics locally.

4.17 General surgery is a very limited service with a very small number of inpatients on a weekly basis and therefore the service will not be in a position to meet 7 day and Royal College standards. The concerns we have highlighted therefore mean that this service does not meet our definition of sustainable but removing this service alone (Option 3) would in reality only free up a couple of surgical beds and not give the opportunity to increase the medical bed capacity, which is one of the main issues presented. It would seem sensible therefore that if the decision is to remove general

surgery on the grounds this is unsustainable this should be done in conjunction with another service to create the space to improve flow.

4.18 The Trust would need to consider the knock on effect of removing general surgery on the Gastro Intestinal (GI) bleed rota and the slight reduction in need for critical care beds. In addition if general surgery moves then paediatric patients requiring surgery, mainly appendectomy, would need to travel to Stockport or Manchester. There would also be no general surgical support out of hours for other services. This latter issue could be mitigated by cover during office hours if general surgery continues to provide day-case surgery and clinics at Macclesfield but robust pathways would need to be developed for out of hours including weekends.

4.19 There is an opportunity here for the hospital to become a centre for high volume day-case general surgery.

Critical care

4.20 The limited take of highly complex surgical patients means that the demand on the critical care unit is mainly from medical patients. The Trust is commissioned for 4 level 3 and 2 level 2 beds. Patients in the unit remain under the care of their admitting consultant supported by the anaesthetic team who provide 24 hour cover. A critical care outreach team, support the identification of acutely unwell patients on the wards and in transitioning patients from intensive care to the ward environment. In 2017/18 the critical care unit admitted 362 patients with 132 of them having at least one day of level 3 care and 230 patients having one day of level 2 care.

4.21 The Trust performance in the Intensive Care National Audit and Research Centre (ICNARC) data is good but there are significant challenges due to the small size of the unit. These are

- The inability of the service to meet Guidelines for the Provision of Intensive Care Standards[1] (GPICS) for staffing particularly a Lead Consultant in Intensive Care Medicine that does not have other clinical commitments
- The inability for a consultant intensivist to be available 24/7 and to be able to attend within 30 minutes
- The Matron role which has responsibility for covering critical care, AMU and A&E

4.22 Due to its small size the unit is expensive to run and it is not cost effective to invest heavily in the unit to meet the GPIC standard. We did not have opportunity to meet with any critical care staff to discuss their views. Only scenario 6 does not retain the critical care service. With all other options retaining A&E and acute medicine the critical care unit would need to be retained[2] and the sustainability of that service to support the acute medical model needs further thought. If the view is that it is unsustainable to continue to provide the critical care service due to the inability of the service to meet the national standards then option 6 has to be the preferred scenario.

[1] Guidelines for the Provision of Intensive Care Standards 2016
[2] The Clinical Co-dependencies of Acute Hospital Services (SEC Clinical Senate) December 2014

Recommendation: To provide further thought to the sustainability of the critical care service and its ability to support the acute medical model

Primary Care and Frailty Services

4.23 There are 2 intermediate care wards, one in Macclesfield hospital and another in Congleton. Outpatient care is provided across the 3 hospital sites and a range of community locations.

4.24 Following discussion with the clinical teams there appears to be an excellent interface with intermediate care services and primary care but there is scope to improve the pathways of the frail elderly and to further expand the ambulatory care services. In addition the uptake of SAFER is inconsistent across the acute and integrated community care directorate and there is scope for improvement. The two geographically separate intermediate care wards do not allow staff to be used efficiently.

4.25 In discussion the teams preferred option is to transfer obstetrics, inpatient gynaecology, neonatal care and inpatient paediatrics to a partner site. Their view is that this will have the least adverse impact on the general medical services. Concerns were expressed at the options to move general surgery and or trauma off site due to the structures that would then need to be put in place to support the medical in patient bed base.

4.26 The clinicians also discussed the possibility of moving the intermediate care unit offsite freeing up capacity.

4.27 The proposals presented to the Senate focus on the secondary care model but the success of this depends on the support within primary and community care. In discussion it was noted that there is a strong local General Practice compared to many other areas, particularly with regards to workforce. All practices are signed up to a comprehensive "GP-plus" type contract that commissions services that practices in other parts of the country would not deliver. The 22 practices are all members of a single community interest company which holds a variety of contracts for services beyond traditional General Practice. There are 5 established community teams/networks built around practices with a wider multidisciplinary offer which includes some secondary care input (e.g. care of the elderly).

4.28 It is expected that scenarios 1 to 4 would not have much impact on General Practice. Scenario 5 would have some impact due to the transfer of the trauma service and the effect this would have on the local frail elderly population. Scenario 6 is not supported by the GPs due to the removal of the local A&E service and the presumed lack of A&E capacity at Stepping Hill. Primary care colleagues also highlighted that Macclesfield is an area with high deprivation and the cost of travelling to access some services may be prohibitive for some patients.

4.29 It is noted that none of the scenarios really discuss the expansion of the frailty service and the development of increased community services to provide a service closer to home. This would be an improved service for the patients and improve the flow of patients through the hospital services. We understand that this is a separate piece of work but the two parts of the jigsaw need to be connected to develop one cohesive service for the patient.

Women and Children's Services

4.30 The obstetric unit delivered 1619 babies in 2017. The workforce is small and covers both in hospital and community services. Midwives work on both antenatal care and the obstetrics ward with the aim of maintaining their skill sets and providing continuity of care. An 8 cot Local Neonatal Unit (LNU) is provided (including one high dependency cot). The unit accepts infants born after 31 weeks or after 32 weeks gestation for twins. Paediatric inpatient services comprise of a children's ward with 10 cots, 6 beds and 5 paediatric observation beds. The Trust has 2 beds for higher dependency babies and patients requiring paediatric intensive care are stabilised and transferred. The gynaecology services include gynaecology cancer, an outpatient clinic and in inpatient service but the numbers of patients using inpatient gynaecology and cancer services are very small.

Paediatric Service

4.31 There were many positive aspects of the service discussed during our visit. The paediatric team is reported to have a good working relationship with the A&E team, the anaesthetists and the regional transport teams. The staff retention is reportedly good suggesting a good working environment and there are no reported concerns from trainees in the General Medical Council (GMC) survey on the quality of senior support and supervision provided by the consultants.

4.32 However the paediatric inpatient middle grade rota is fragile (a national issue) and within inpatient paediatrics a consultant review within 14 hours of admission is not always achieved. The paediatric consultant rota is made up of 7 Whole Time Equivalents (WTE) consultants. They stay at the hospital up to 6 pm on their on call days and cover 1: 7 weekends. To comply with the guidance Facing the Future: A Review of Paediatric Services[3] Macclesfield hospital should be classified as a medium hospital (2500-3000 admissions) and would need a medical consultant cover of about 9.3 WTE. Whilst there is no suggestion that the service provided at Macclesfield is clinically unsafe, the lower number of consultants than recommended for the number of admissions may imply that there is less senior paediatric cover out of hours (including weekends) than at comparable departments nationally, and this may carry higher clinical risks than other units. We identified other issues which lead us to question the longer term sustainability of this service. These are primarily concerned with the medical workforce, their numbers and their training needs.

[3] Facing the Future: A Review of Paediatric Services, Royal College of Paediatric and Child Health (April 2011)

- The Royal College of Paediatrics and Child Health (RCPCH) has recommended the consultant of the week model[4] to ensure continuity of care for children. This is yet to be implemented
- Weekend services are currently stretched in the winter and other busy periods. Consultants support their colleagues over these busy periods by providing cross cover to each other, even when not on call over the weekends. With a 1:7 consultant rota and ongoing concerns of shortage of doctors on tier 2 rotas nationally, this model of working may not be sustainable over long term
- Maintenance of skills is a concern for all the consultants and tier 2 medical staff due to the reduced number of sick neonates born at Macclesfield
- Maintenance of skills is also a concern for the anaesthetists due to the reduced number of elective paediatric surgeries, and overall reduced number of sick children attending the emergency department and sick neonates being born in the hospital
- Three nurses staff the paediatric ward overnight. This is less than the recommended staffing ratio when the paediatric ward is full[5]. Although retention is reportedly good in Macclesfield for paediatric nurses, additional recruitment may be required and any issues with this will lead to concerns of long-term sustainability of the paediatric services

4.33 Our advice is that the paediatric and neonatal services will need considerable investment and recruitment of additional consultant and nursing staff to meet standards and even then the maintenance of their skills is an issue. Also, the maintenance of skills of anaesthetists is important and close attention should be given to the number of paediatric surgeries and exposure of anaesthetists to paediatric emergencies and critical care to keep up their skills.

4.34 Without addressing the above-mentioned issues, the services are not sustainable in the long term and for this reason the Senate advises that scenarios 1 and 3 are not felt to be the right solution for paediatrics.

4.35 In view of the above-mentioned issues, working collaboratively with a clinical partner trust, is the sustainable long-term option as described in scenarios 2, 4, 5 and 6. Macclesfield should continue to provide paediatric outpatient care. If the Trust pursues these scenarios then pathways for sick children and paediatric attendances into A&E will need to be formulated to ensure that any sick child in the community can access the right level of care appropriately.

[4] Facing the Future - Standards for acute general paediatric services; RCPCH 2015
[5] Defining staffing levels for children and young people's services, RCN standards for clinical professionals and service managers: August 2013.

Neonatal Care

4.36 The neonatal unit is very well thought of by the parents who are very complimentary about the service. The unit however is challenged due to the low levels of activity. Using the British Association of Perinatal Medicine (BAPM) 2011 criteria in 2017/18 the days of care figures provided were:

- Intensive Care 21
- High Dependency 215
- Special Care 856
- Normal Care 25

4.37 Based on these activity levels the unit would need 3 cots per day on average. Even based on an 80% occupancy level they need only 3.7 cots with the activity being predominantly in special care. The unit is currently labelled as a Local Neonatal Unit (LNU) which is defined by the British Association of Perinatal Medicine (BAPM)[6] as providing special care and high dependency care and a restricted volume of intensive care (as agreed locally) and would expect to transfer babies who require complex or longer-term intensive care to a Neonatal Intensive Care Unit. The majority of babies over 27 weeks gestation will usually receive their full care, including short periods of intensive care, within the Local Neonatal Unit. Local Neonatal Units may receive transfers from other neonatal services in the network if they fall within their agreed work pattern. In the same guidance BAPM recommends a medical staffing rota for a LNU at a higher level than those required for a Special Care Unit.

4.38 A Special Care Unit is defined as providing special care for their own local population with some high dependence services as agreed by their local network. Special Care Units also provide a stabilisation facility for babies who need to be transferred to a Neonatal Intensive Care Unit for intensive or high dependency care and receive transfers from other network units for continuing special care.

4.39 From the activity information provided and the discussions with staff it is evident that the Macclesfield Unit operates more as a special care unit, particularly due to medical staffing overnight. We recommend that the unit is rebadged as a Special Care Unit which will reduce some of the pressures of medical staffing. It makes little difference to the operational working of the unit but makes the standards being aspired to more realistic.

4.40 With regards to nursing standards, the current aim is to run the shift with 1 Qualified in Specialty (QIS) nurse (who is a neonatal Intensive Care Unit (ICU) trained registered nurse) plus one registered nurse or midwife. If there is an emergency on the delivery unit the QIS is not usually able to attend as this would leave the unit without anyone trained in a neonatal specialty, plus only one member of staff would be left on the unit. Inability to provide a QIS nurse to support the medical staff at unexpected resuscitation in the labour ward and theatres is not ideal, neither for the junior trainee nor for maintaining QIS skills for nurses and the overall standards of neonatal service.

[6]BAPM Service Standards for Hospitals Providing Neonatal Care 2010

Recommendation: the neonatal unit is reclassified from a Local Neonatal Unit to a Special Care Unit and that discussions commence with the neonatal network to develop rotational working or training opportunities to maintain staff skills.

4.41 Even as a Special Care Unit the sustainability of a unit with 3-4 cots at a low dependency will be challenging. Risk will also be increased over time if staff are deskilled. Staff will not be able to maintain Neonatal Life Support skills due to not attending deliveries and this causes difficulties. It is not uncommon to have unexpectedly sick babies at delivery despite mitigating for most eventualities with in utero transfer protocols. Even with a robust system for transport by an external team, the management of the very unexpectedly sick ITU baby for short periods only carries risks. The safe management assumes that:

- the transport team are not busy elsewhere and can respond quickly
- the QIS is not deskilled with stabilisation and management of an extremely sick ITU patient,
- there is only one emergency at any one time,
- the other babies are stable enough for the focus to be away from them for a period of time,
- the medical staff are available and senior enough to manage the situation (and cover other paediatric areas such as A&E, delivery unit and paediatric wards) whilst awaiting the transport team.

4.42 Currently the Trust report that no safety concerns have been raised about running a small neonatal service but the panel expressed concern that the service is not sustainable and at risk of an event.

4.43 Our advice is that the neonatal services are not sustainable with the low numbers of deliveries in Macclesfield and the acuities of care of the admitted babies, The maintenance of skills for consultant and neonatal staff is a very important concern in the long term. It is unlikely that the neonatologists of the future will choose to work in such a small unit. Even if there is considerable investment and recruitment of additional consultant and nursing staff to meet standards it is likely that despite the additional investment, the neonatal services may still continue to be sub- scale with the associated issues of maintenance of skills. Our advice is that moving neonatal services to a partner trust is the sustainable option and discussions should be had on whether partner trusts can absorb the additional workload from Macclesfield. Without the service the Trust cannot provide an obstetric led maternity unit. The loss of neonates will also result in the loss of paediatric trainees which will impact on the ability to run the paediatric A&E.

4.44 Scenarios 1 and 3 do not address the fragility of the neonatal service which is a major concern to the Senate.

4.45 There are models explored within other neonatal networks of rotating staff through neonatal intensive care units to allow the staff to maintain skills and the Trust may wish to explore that with their network and to explore the possibility of receiving more special care babies from other neonatal units to keep the size of the unit viable.

4.46 Similarly there is a potential to explore the possibility of special care babies being cared for at home by parents and supported by a neonatal outreach community team rather than an in-patient unit. This would ensure care closer to home as soon as possible and is highly desirable whether the in patient service changes or not. The Trust may wish to explore how many of the SC babies are suitable for outreach care and potential bed days saved by such a model.

Obstetrics and Gynaecology

4.47 The maternity service is one of the smaller units in the country as it delivers only around 1600 babies per year serving the local population of Macclesfield and some of the surrounding area. There are pockets of deprivation within this population.

4.48 The service has a stable and committed workforce. The consultant body is formed of 7 Consultants who share obstetrics and gynaecology commitments and all contribute to the once rota. They also provide 40 hour daytime cover to delivery suite. This is somewhat below previous Royal College Recommendation of 60 hour cover (https://www.rcog.org.uk/globalassets/documents/guidelines/rcogfutureworkforcefull.pdf) but would be acceptable within the updated Royal College of Obstetrics and Gynaecology opinion (https://www.rcog.org.uk/globalassets/documents/guidelines/working-party-reports/ogworkforce.pdf).

The age range also does not indicate imminent stress from pending retirements.

4.49 The middle grade rota is filled by stable associate specialist grades and the first tier rota is filled by rotating junior doctors. There are no identified medical staffing concerns. Likewise, the midwifery staffing levels indicate a stable workforce with no indication of strains caused by pending retirements or difficulties in recruitment.

4.50 No clinical concerns were brought to the attention of the review and the review panel were impressed by the enthusiasm and the constructive approach of the clinical leadership in the unit. There are working relationships with neighbouring tertiary units which enables joint management of complex feto-maternal medicine. The obstetric team are able to access support from other surgical specialisations if needed. The practice in the unit enables midwifery staff to work in the community and on delivery suite and this enables a range of skills that puts the unit in a good position towards fulfilling the vision of Better Births[7] and continuity of carer. The unit is also engaged with the regional maternity network and sees itself in a good position to meet expectations. Although there is a shared delivery suite, midwifery staff enjoy considerable autonomy and consultant and other medical staff input only in complicated obstetrics. There are 2 midwifery led rooms.

[7] Better Births, Improving Outcomes of Maternity Services in England, National Maternity Review

4.51 The issue with the service is fundamentally its size. This primarily relates to the costs. The NHS CNST cost for this Unit is 98% of Tariff. The breakdown of this is unknown to the Review, but clearly requires to be addressed with CNST and mitigated. Currently it is not cost effective for the Trust due to the limited activity levels and requirements to meet staffing standards. The fragility of the neonatal service is the key factor here in considering whether the options that retain the obstetric service are really viable.

4.52 All consultants provide obstetrics and gynaecology care. The gynaecology Day Case rate is currently 72%, which is significant. The service is well regarded and no clinical risks concerns were brought to the attention of the Review.

Ambulance Services

4.53 The Trust has confirmed that as yet there has been no discussion with the North West Ambulance service on any of these scenarios. We recommend that these conversations need to commence.

4.54 In discussion, the colleagues in the ambulance service expressed concern with the scenario 6 which would result in the closure of the A&E due to the additional 30-45 mins transport times. This would have the added effect that crews would be out of area and therefore would be used for other jobs within that area, leaving the local area with reduced cover.

4.55 The crew services did compliment the hospital fragility team, but suggest that more engagement could help reduce patient attendances both by ambulance crews to patient's houses and the subsequent transportation to A&E. This echoes the comments made by other teams and noted in this report.

Recommendation: *To commence discussions with North West Ambulance Services to allow them to model the impact of the scenarios on their service and to accelerate the discussion with partner organisations on their ability to absorb the activity from the Trust. The STP approach needs to be much more visible within the scenario discussions.*

The Scenarios

The No Change Scenario

4.56 For the reasons detailed in this report we have concerns with the sustainability of a number of services and the organisation and therefore we do not support the option of no changes being made to the services in the Trust.

Scenario 1 - Operational Changes

4.57 On initial discussion there is much to be said for the proposal to make operational changes and support some services through partnership working. We have to consider whether we are judging this small DGH on the right national standards or should we be looking at a 'good enough' service to keep those services local, an issue being debated across many NHS organisations. The nearest partner organisation is Stockport which is a 45 minute journey and with its pockets of deprivation some of the Macclesfield community will find it harder to access services further away.

4.58 This option, however, has very little detail behind it. The operational changes, and the relationships with their partner organisations, would need to be considered on a service by service basis. We also question how realistic this option is given the level of investment that would be needed for some services to meet national standards, particularly the 14 hour consultant standards.

4.59 Even with the increased workforce the size of some of these services means that long term sustainability is a real issue and we are not clear how these are addressed by this option. This is particularly in terms of the neonatal and paediatric services. The right partnership working could result in this being a satellite unit for these services potentially but there is a lot to be worked through in terms of investment, rotation of staff and the details of that partnership approach. Similarly we are not clear how will this option support the fragile surgery services and provide that bed capacity to improve the flow of medical patients.

Scenario 2 - Women and Children's Collaboration. Obstetrics and inpatient paediatrics provided at a partner site but consider collaborating with that partner to continue to deliver outpatient gynaecology and paediatric services and antenatal care locally, as well as supporting home births

4.60 Pages 12 -15 detail our concerns with the fragility of the paediatric and neonatal service and this option would address those issues although we have no knowledge currently of the ability of neighbouring Trusts to absorb this activity.

4.61 This scenario would result in a significant increase in travel time for the local population to receive obstetric led care and inpatient paediatrics and gynaecology services although with the latter the numbers are very small. The priority, however, is for patients to access a safe service. We have previously outlined how the paediatric and neonatal services will need considerable investment and recruitment of additional consultant and nursing staff to meet standards but even with that investment the size of the units gives rise to concern about the ability of staff to maintain their skills. Our advice is that these issues outweigh the arguments to keep the inpatient elements of the services local.

4.62 This option would free up space to extend the number of medical beds and improve management and care for these patients. The A&E department could be sustained if this is not open to children although it would reduce its size further and potentially impact on its ability to attract trainees. We recognise Emergency Department (ED)

staff concerns about their ability to manage the acutely ill child who presents in the ED without paediatric inpatients on site but robust protocols can be developed to support the staff.

4.63 We are not sure if other options have been considered like a stand-alone Midwifery Led Unit (MLU) on site but with the small size of the service we doubt whether this will be cost effective to run. There are examples across the country of MLUs operating at below the modelled activity due to public concerns regarding access to an obstetric unit in the event of complications. We also recognise that there is a risk with a standalone MLU that mums will present there who are not eligible

4.64 Developing a Paediatric Assessment Unit on site is being considered as part of this option although we agree that there is a lack of national evidence to support this and we question the ability to recruit staff to this unit and maintain their skills.

Scenario 3 – Surgical Collaboration (retaining Trauma and orthopaedics locally). Retain the Trauma and orthopaedic inpatients ward in support of the increasingly frail population but transfer emergency surgery to a partner site. Collaborate with that partner to develop a rapid access short-stay Treatment Centre for elective/ scheduled NEL daycase activity. Grow day case activity where there is opportunity (e.g. breast surgery). Affordability will be improved by increasing activity, closing theatres overnight and operating a hospital at night team overnight.

4.65 Pages 8-10 outline our concerns with the surgical services at the Trust. We agree with many aspects of this proposal. These aspects are:

- To retain trauma and orthopaedics locally to support the frail population. With 240 Neck of Femur cases a year we agree that there is benefit in keeping a local service for the elderly frail population but the limited orthogeriatrician service will need addressing
- Transferring emergency surgery to a partner site would address the concerns raised regarding the small size of this service and the ability to maintain staff skills
- Developing the day case activity further to be the core business of the Trust does make sense and there is the opportunity to do this in breast surgery for example

4.66 However this model does not address the concerns with the long term sustainability of the paediatric and neonatal service and for this reason we cannot support it as the preferred solution. Other issues to consider are:

- This does not substantially free up bed space to expand medicine. This model would only free up the equivalent of 2 beds a week which does not make up a meaningful difference
- This will further reduce the activity in critical care which would further challenge its sustainability and would have a knock on effect to the upper GI bleed rota

- General surgeons are needed on site to support the ED service, gynaecology and the medical wards. This can be managed during the day if general surgery continue to provide day case surgery and clinics but robust pathways would need to be developed for out of hours including weekends
- The impact on surgical trainees and the ability to attract staff to the Trust

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Scenario 4 – Women and Children's surgical collaboration (retaining trauma and orthopaedics inpatients locally). This is a combination of scenarios 2 and 3. NEL general surgery and inpatient surgery and obstetrics, neonatal and inpatient paediatrics to be provided on a partner site.

4.67 As a combination of scenarios 2 and 3 our earlier comments on these sections are applicable and there is merit in combining these options.

4.68 What has to be considered is the knock on effects for anaesthesia and critical care and the services that are left to maintain them. Our earlier comments regarding the impact on A&E and the removal of general surgery support for other departments need to be considered. As we have commented earlier we do not have the information on the ability of partner organisations to absorb the activity and how this model would impact on the ambulance service.

Scenario 5 - women and children's surgical collaboration (not retaining Trauma and orthopaedics locally). This is a combination of scenarios 2 and 3 with NEL general surgery, inpatient surgery and obstetrics, neonatal and inpatient paediatrics to be provided at a partner site but trauma and orthopaedics inpatients would not be retained only trauma and orthopaedics day case on site.

4.69 We do not agree with this option and have concerns with the proposal to remove trauma and orthopaedics from the hospital due to both the impact on its elderly frail population and the impact this would have on maintaining a critical mass of services. We understand that there are similar models like Cheltenham and Gloucester but those hospitals do not have a 45 minute transfer time between them.

Scenario 6 - Urgent Care Centre and Women's and Children's and surgical collaborations (not retaining trauma and orthopaedics inpatients locally). This is also a combination of scenarios 2 and 3 but behind an urgent care centre therefore not requiring critical care and unable to offer inpatient medical specialties. A frailty unit and intermediate care would be retained.

4.70 This option would result in Macclesfield DGH no longer being a significant hospital. The hospital is important for the Macclesfield community and it runs a busy A&E unit and our advice is that it must continue. This scenario has the potential to be a solution but would leave the Macclesfield population in the middle of a geography where they have to access services through complex pathways to a range of different hospitals. Again the impact on the ambulance service and the capacity of other centres is unknown. As there is so much that Macclesfield DGH has to offer and as it is so important for the community, both as an employer and provider of care, this seems an extreme and unnecessary solution.

4.71 Our independent clinical assessment of the scenarios is that all these are feasible and the sustainability of these is mainly driven by the system's views on the constraints. The constraints include, though are not limited to:

- Stakeholder appetite to engage in these models
- Partner organisations capacity to deliver
- Method of engagement with the system's workforce i.e. how complex will it be to sell the idea
- Ability to recruit/shift to new roles

4.72 Due to our concerns particularly with the sustainability of the paediatric and neonatal service our advice is that Scenarios 2 or 4 are our preferred scenarios. The 'no change' scenario and scenarios 5 and 6 do not have our support for the reasons identified in this report. There is an argument to be made for transferring emergency general surgery as detailed in Scenario 3 but this has to be combined with a solution for neonatal and paediatrics to be a solution that receives our support. Scenario 1 has potential but there is not the service by service detail is not available to really understand what these operational changes will be and how they will result in the services being sustainable and financially viable.

4.73 Please find below our comments on the second question ***Can the Senate outline any risks, issues, opportunities or concerns that we should consider as we further develop and refine these scenarios.***

4.74 We understand that these scenarios are broad ideas that need much further work to develop the detail behind these. There are however a number of issues which we feel have not yet been fully considered in these early stages:

- The impact on the critical care service which is integral to the viability of scenarios 1 – 5 and the ability of the Trust to continue to receive acute medicine. The impact on this service has not been fully considered within the scenarios.
- The discussions with partner organisations seem to be in the very early stages and yet are integral to all the solutions. The STP view needs to be presented. At the moment there is uncertainty as to how these scenarios relate to other service changes in neighbouring Trusts.
- The increasingly elderly population needs to be factored into the longer term modelling.

- The success of these scenarios is dependent on the integration with primary and community services but this is not presented within the information so that we do not have a sense of the system working together for the population.
- Many of the hospital services discussed the need to improve the frailty service within the hospital and the community and this is not addressed in any of the scenarios
- The discussions with the ambulance service need to commence to engage them in the feasibility of the models.
- An important risk in taking forward any proposals about any change to services is the immediate effect on the current workforce. There are several examples of the mere discussion about possible changes results in members of the workforce moving elsewhere, further destabilising the delivery of sustainable service. Much thought and work will be required to mitigate against causing unnecessary instability.

4.75 There are also a range of opportunities that could be considered further:

- The scope for becoming a centre for minor surgery could be further explored, particularly for breast surgery. There is real opportunity to grow the service
- There are opportunities to develop a first class frailty service for the elderly population which would need investment but would work to improve the flow of the patient through secondary care back into the community
- Focus on improving the model for rehabilitation services but this would require the employment of substantive orthogeriatricians.
- There are examples of neonatal community outreach teams which could support and enhance the care for neonates locally.
- Maternity services could potentially be provided on site by an alternative provider
- Treat and transfer models for individual clinical conditions

5. Summary and Conclusions

5.1 With any small DGH there are significant challenges in maintaining and sustaining acute speciality services, managing small numbers of patients with a small workforce whose skills must be maintained. Changes do need to be made to the services provided at Macclesfield Hospital to ensure that patients receive care in line with national standards but also ensuring that as many patients as possible continue to receive most of their care locally through continuing to provide outpatient and diagnostic and daycase facilities although they may need to travel for specific inpatient procedures. To enable this it is essential that a well-grounded and organised clinical partnership is developed in the near future with another provider(s) which recognises the importance of historic and existing patient flows.

5.2 Our independent clinical assessment of the scenarios is that all of these are feasible and the sustainability of these is mainly driven by the system's views on the constraints. Due to our concerns particularly with the sustainability of the paediatric and neonatal service our advice is that Scenarios 2 or 4 are to be preferred.

5.3 As an action for the near future we recommend that the neonatal unit is reclassified from a Local Neonatal Unit to a Special Care Unit and that discussions commence with the neonatal network to develop rotational working and/or training opportunities to maintain staff skills.

5.4 None of the proposed scenarios discuss the need to improve the frailty service and this needs to be included within the preferred solution. In addition, we recommend that the impact on the critical care service which is integral to the viability of most of the scenarios receives further thought.

5.5 Looking wider than the Trust is essential to the success of any of the scenarios. The discussions with partner organisations, including the ambulance services, seem to be in the very early stages and yet are integral to all the solutions. Our advice is that these discussions need accelerating to understand this system wide STP view. Similarly we do not have a sense of how the community services are being developed as part of the solution and we are concerned that the different parts of the system are not working together to provide a cohesive and integrated pathway for the patient.

APPENDICES

Appendix 1

LIST OF INDEPENDENT CLINICAL REVIEW PANEL MEMBERS

Council Members
Prof. Chris Welsh, Yorkshire & the Humber Senate Chair

Assembly Members
Dr Kirtik Patel
Consultant General Surgeon, Sheffield Teaching Hospitals NHS Foundation Trust

Dr Nabeel Alsindi
GP & Clinical Lead for Primary Care and Long Term Conditions, NHS Doncaster Clinical Commissioning Group

Lay Members
Keith Spurr
Peter Allen (did not attend 24th September visit)

Clinicians from Other Senates
Dr Suganthi Joachim
Clinical Director, United Lincolnshire Hospital NHS Trust

Dr Molla Imaduddin Ahmed
Locum Consultant Paediatrician, University Hospitals of Leicester

Dr Stephanie Smith
Emergency Paediatric Consultant & Clinical Director, Nottinghamshire Children's Hospital

Dr Marwan Habiba
Consultant Gynaecologist, University Hospitals of Leicester and Associate Medical Director Clinical Strategy, NHS England (Midlands & East)

Dr Robert Ghosh
Executive Director of Clinical Improvement, Isle of Wight NHS Trust

Michael Rattigan
Paramedic, East of England Ambulance Service

Dr Indi Gupta
Divisional Clinical Director, Basildon & Thurrock University Hospitals

Sarah Rattigan
East of England Neonatal Transport Clinical Service Manager, Cambridge University Hospitals NHS Foundation Trust

Ed Smith (did not attend visit 24th September)
Clinical Director for Emergency Medicine and Deputy Medical Director, York Teaching Hospital Foundation Trust

Linda Purdy (did not attend visit 24th September)
Consultant Nurse Acute Medicine, The Queen Elizabeth Hospital NHS Foundation Trust

Biographies

Professor Chris Welsh - Chair of the Yorkshire and the Humber Clinical Senate

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 Kirtik Patel - Consultant General Surgeon

Consultant Upper GI and Bariatric Surgeon at Sheffield Teaching Hospitals NHS Foundation Trust. Current additional roles include those of Upper GI Cancer MDT Lead and Clinical Lead of Upper GI Surgery. MSc in Medical Leadership at Sheffield Hallam University and recently a Clinical Lead within the Seamless Surgery service improvement team. He is a Specialist Advisor for CQC, Course Director of the Sheffield Basic Surgical Skills course and a postgraduate educational supervisor.

Dr Molla Imaduddin Ahmed - Paediatric Respiratory Consultant

A locum paediatric respiratory consultant at University Hospitals of Leicester. He is a member of the East Midlands Children's Clinical steering group and clinical senate assembly. He was a member of senate panels on six reviews conducted by the East Midlands clinical senate. He is a fellow of the Royal Society of Public Health and has been awarded "Certificated Change Agent' by Horizons Group at NHS Quality and School for Healthcare Radicals. He chaired the East Midlands Trainees group on quality assessment of postgraduate training. He represented the trainees from East Midlands on the RCPCH trainees committee (2014-2017), which works on matters of relevance to trainees nationally. He was the trainee QI lead at FMLM and has spoken at and helped organise national level QI events.

Dr Robert Ghosh - Executive Director of Clinical Improvement

Robert is the Executive Director of Clinical Improvement at the Isle of Wight NHS Trust. He trained to consultant level in neurology, intensive care and general medicine. He now concentrates on strategic improvement work and clinically provides a headache service in London. His areas of interest in improvement include reconfiguration and refinement of urgent and emergency care, consolidating trust escalation procedures and establishing discharge pathways within acute trusts. He appraises medical directors for NHS England Midlands & East.

Dr Suganthi Joachim - Clinical Director for Theatres, Anaesthesia, Critical Care and Pain

I have been a Consultant Anaesthetist at Pilgrim Hospital, Boston for 17 years. I am actively involved in service improvement, management, education and training. I have extensive experience in perioperative care of patients undergoing elective and emergency surgery. As I work in Pilgrim Hospital, Boston which is 60miles from Nottingham, my objective includes delivering high quality and safe care closer to home and safe transfer of children needing tertiary care. My work involves anaesthetising the elderly on the vascular, trauma and emergency lists. I have special interest in paediatric anaesthesia and have been the clinical lead for this area since 2001. I am a member of East Midlands General Paediatric Surgery network and I have undertaken peer reviews and a member of the commissioning guide development group for Paediatric Torsion.

I have been a Foundation Programme Director from 2004-2016.

I am currently, a member of the Chapter development group of the Royal College of Anaesthetist for Guidance on Provision of Anaesthetic Services post-operative care.

Currently I am Clinical Director for Theatres, Anaesthesia, Critical Care and Pain at ULHT.I am also the trust Lead for General Paediatric Surgery. I am also one of the Board directors for the Lincolnshire Refugee Doctors Project.

Dr Nabeel Alsindi – GP and Clinical Lead for Primary Care

Has been a GP in Doncaster for 4 years having worked in a variety of different practices in Doncaster and during my GP training in Sheffield. I currently work part-time as a salaried GP at Bentley Surgery. I've been Doncaster CCG's Clinical Lead for Primary Care for 3 years after completing a Commissioning Fellowship, responsible for developing our Primary Care Strategy. I am also a member of NICE's Technology Appraisal Committee.

Keith Spurr – Lay Member

Following retirement from HR Consultancy I have been involved in a number of activities within the NHS including; Patient Representative on East Midlands Clinical Senate for three years, Patient Lead South Lincs Diabetes UK in which I organise 4 Diabetes UK Peer Groups, in Lincolnshire and Rutland and a lay member of Diabetes UK Research Group. I

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am a Member of Stamford Neighbourhood Project Team and a member of Lakeside Stamford PPG (30,000 patients) organizing health education events. I am a member of Nuffield Trust Research Team investigating specialist/generalist in small hospitals (under 800 bed)

Dr Indi Gupta - Divisional Clinical Director

I qualified in 1992 and have been a Consultant Geriatrician and Physician at Basildon and Thurrock University Hospitals since 2004. I led the Geriatric Medicine and Stroke Department for 5 years from 2009 till 2014 and have been the Divisional Director for Medicine since then. I am actively involved in the redesign and reconfiguration of clinical pathways in our local STP in Essex i.e. MSB.

Michael Rattigan – Senior Paramedic Mentor

Michael started his career as a carpenter before joining the Royal Navy. After a long time as a Navy medic he left the forces to become a paramedic with east of England Ambulance Trust. He is currently enjoying his new career as a senior paramedic mentor. He is studying for his Master's degree in critical care. In his spare time Michael is in the medical wing of the RAF reserves. He is passionate about making services better for the patient and their families.

Sarah Rattigan - Neonatal Transport Clinical Service Manager

With 32 years of nursing experience (general, paediatric and neonatal). Sarah is the Clinical Service Manager for the East of England Neonatal Transport Team. She has held senior nursing leadership and management posts since 1998 covering neonatal and paediatric intensive care units, neonatal transport and paediatrics. Between 2007 and 2016 she held the posts of network lead nurse, deputy director and director.

With a Master's degree in Leadership and the NHS Leadership Academy Senior Leaders Award, Sarah is committed to improving the health experience across the system for users and staff.

Dr Marwan Habiba – Consultant Gynaecologist & Associate Medical Director Clinical Strategy

A Consultant Gynaecologist at the University Hospitals of Leicester and Honorary Reader at the University of Leicester. He graduated in Medicine in 1982 and became a Member of the Royal College of Obstetricians and Gynaecologists (1991) and a Fellow of the RCOG (2004). He obtained an MSc (1986) on the use of emergency contraception, a PhD (1998) on laboratory aspects of the effects of hormone replacement therapy on the endometrium and a PhD (2000) on the ethics of health screening. He has many publications in his areas of interest included health service delivery and research, medical ethics and abnormal uterine bleeding particularly the impact of uterine adenomyosis. Marwan is the Chair of the Clinical Ethics Committee and the New Intervention Procedure Authorizing Committee (NIPAG) at the University Hospitals of Leicester. He joined the Leicester City & Rutland-Primary Care Trust in 2009 and subsequently the Leicester, Leicestershire and Rutland PCT

Cluster as an Assistant Director focusing on Clinical Strategy and Quality of Care. He became the Clinical Lead for the Maternity Strategic Clinical Network for the East Midlands and the Associate Medical Director, Clinical Strategy, for NHS England Central Midlands in April 2013.

Dr Stephanie Smith – Paediatric Consultant Clinical Director

An Emergency Paediatric Consultant at Nottingham Children's Hospital where she has been the Clinical Director for the last 3 years. She has nearly 30 years of paediatric experience and currently works as an acute paediatrician including evening shifts, hot weeks, clinics and on calls. Stephanie was Named Doctor for Safeguarding for Nottingham University Hospitals NHS Trust for 15 years so has considerable experience in this field. She is a member, and previous chair, of the Intercollegiate Committee for Emergency Standards of Care for Children and Young People based at the Royal College of Paediatrics and Child Health (RCPCH). Stephanie has been the lead reviewer for several RCPCH Invited Reviews around the country. She is currently the chair of the APLS (Advanced Paediatric Life Support) working party for the Advanced Life Support Group (ALSG).

Dr Ed Smith, Consultant in Emergency Medicine & Clinical Director Emergency Medicine

Ed Smith MB ChB (Leeds 1995), BSc, FRCP, FRCEM
Consultant in Emergency Medicine Scarborough 2006 – present.
Clinical Director Emergency Medicine 2009 – present.
Deputy Medical Director York FT 2014 – present.
Service Design and Configuration Committee Chairman Royal College of Emergency Medicine 2017 – present (and member of predecessor committee). Recently authored the (in press) 2018 Workforce Recommendations for RCEM.
Interested in Risk and Patient Safety, Service Re-design and culture within health services.

Appendix 2

PANEL MEMBERS' DECLARATION OF INTERESTS

No declarations of interest were made.

Appendix 3

Clinical Senate Visit Agenda

Monday 24th September 2018 at 9:45-16:00

Boardroom 1, 1st Floor, New Alderley House, Victoria Road, Macclesfield SK10 3BL

09:45	Arrival and Introductions	Boardroom 1 New Alderley House
10:00	Presentation • East Cheshire Trust • Eastern Cheshire Clinical Commissioning Group	Boardroom 1 New Alderley House
11:00	Break Out Session including Departmental Visits	Rooms allocated on following slide/ Visits to MDGH Site
13:00	Light Lunch	Boardroom 1 New Alderley House
13:45	Panel Reflection Time	Boardroom 1 New Alderley House
14:30	Plenary Session • Further Questions and Feedback	Boardroom 1 New Alderley House
15:45	Summary and Next Steps	Boardroom 1 New Alderley House
16:00	Close	

Appendix 4

NHS
Yorkshire and the Humber
Clinical Senate

CLINICAL REVIEW

TERMS OF REFERENCE

TITLE: Transformation of Acute Services on behalf of NHS Eastern Cheshire CCG

Sponsoring Organisation: NHS Eastern Cheshire Clinical Commissioning Group

Terms of reference agreed by: Fleur Blakeman, Strategy and Transformation Director, and Joanne Poole, Senate Manager

Date: 18th September 2018

1. CLINICAL REVIEW TEAM MEMBERS

Clinical Senate Review Chair: Prof. Chris Welsh, Yorkshire & the Humber Senate Chair

Citizen Representative: Keith Spurr and Peter Allen

Clinical Senate Review Team Members:

Dr Kirtik Patel
Consultant General Surgeon, Sheffield Teaching Hospitals NHS Foundation Trust

Dr Suganthi Joachim
Clinical Director, United Lincolnshire Hospital NHS Trust

Dr Molla Imaduddin Ahmed
Locum Consultant Paediatrician, University Hospitals of Leicester

Dr Stephanie Smith
Emergency Paediatric Consultant & Clinical Director, Nottinghamshire Children's Hospital

Dr Marwan Habiba
Consultant Gynaecologist, University Hospitals of Leicester and Associate Medical Director Clinical Strategy, NHS England (Midlands & East)

Dr Nabeel Alsindi
GP & Clinical Lead for Primary Care and Long Term Conditions, NHS Doncaster Clinical Commissioning Group

Dr Robert Ghosh
Executive Director of Clinical Improvement, Isle of Wight NHS Trust

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Paramedic, East of England Ambulance Service

Dr Indi Gupta
Divisional Clinical Director, Basildon & Thurrock University Hospitals

Sarah Rattigan
East of England Neonatal Transport Clinical Service Manager, Cambridge University Hospitals NHS Foundation Trust

Ed Smith
Clinical Director for Emergency Medicine and Deputy Medical Director, York Teaching Hospital Foundation Trust

Linda Purdy
Consultant Nurse Acute Medicine, The Queen Elizabeth Hospital NHS Foundation Trust

2. AIMS AND OBJECTIVES OF THE REVIEW

Questions for the Review:

- Can the clinical senate provide an independent clinical assessment of whether the six scenarios currently under consideration are clinically feasible and sustainable given the volumes of activity, case mix, local health needs etc? Please indicate whether there are other scenarios which we should be actively considering?

- Can the senate outline any risks, issues, opportunities or concerns that we should consider as we further develop and refine these scenarios?

Objectives of the clinical review (from the information provided by the commissioning sponsor): The advice will be used by the Health and Care Partnership as part of the Acute Sustainability Work stream work. It will also be used to inform next steps and dialogue with NHS England to progress to the next stage (Stage 2) of the service change process and will be referenced in any Pre-Consultation Business Case, resulting Business Case and related documentation.

Scope of the review: The Clinical Senate will focus their review on the above questions based on the information provided in the documentation The clinical panel will supplement their understanding of the model through discussion with commissioners and a planned site visit by the review team members.

3. TIMELINE AND KEY PROCESSES

Receive the Topic Request form: Received by the North West Clinical Senate on 16th April 2018 and received by the Yorkshire & the Humber Clinical Senate on 30th April 2018

Agree the Terms of Reference: September 2018

Receive the evidence and distribute to review panel: Case for Change, Scenarios and Clinical Strategy received on 7th September 2018 and distributed to the panel on 10th September 2018

Teleconferences and panel visit: The clinical panel teleconferences have been arranged for 19th September and 3rd October. A local site visit has also been arranged for the 24th September for the panel members to meet with clinicians.

Draft report submitted to commissioners: 30th October 2018

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

Senate Council ratification and final report agreed; at the November 2018 or January 2019 Council meeting

Publication of the report on the website: timeline to be agreed with commissioners

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:

- 2018 07 19 Final ECT Acute Services Transformation Case for Change v1.4
- Trust Clinical Strategy
- Potential Scenarios

The review team will review the evidence within these documents and supplement their understanding with a clinical discussion and a planned local site visit.

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 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. respond within the agreed timescale to the draft report on matter of factual inaccuracy.
iii. undertake not to attempt to unduly influence any members of the clinical review team during the review.
iv. submit the final report to NHS England for inclusion in its formal service change assurance process if applicable

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 provided the following documentation to the Senate for consideration:

- 2018 07 19 Final ECT Acute Services Transformation Case for Change v1.4
- Trust Clinical Strategy
- Potential Scenarios
- 2016 10 10 Children's Community Nursing Service Business Case Final v2.0
- 2016 10 10 Community Paediatric Services Business Case Final v2.0
- 2018 10 12 Senate Request – paediatric activity data
- Macclesfield District General Hospital Intensive Care/High Dependency Unit 1 April 2017 to 31 March 2018
- Macclesfield District General Hospital Intensive Care/High Dependency Unit 1 April 2017 to 31 December 2017
- Macclesfield District General Hospital Intensive Care/High Dependency Unit 1 April 2017 to 30 June 2017
- Macclesfield District General Hospital Intensive Care/High Dependency Unit 1 April 2017 to 30 September 2017
- Maternity and Newborn Implementation Plan for Better Births Final