NHS
Yorkshire and the Humber
Clinical Senate

Free and full independent and impartial clinical advice

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Via email to:
Amanda Bloor
Accountable Officer
Hambleton, Richmond and Whitby CCG

1st February 2019

Dear Amanda

Senate Review of Friarage Hospital Services

Thank you for the opportunity to review your proposals for the reconfiguration of services at the Friarage Hospital, part of South Tees Hospitals NHS Foundation Trust (STHFT).

The objectives of this early advice are to provide you with independent clinical oversight of the proposed clinical model. The clinical model has as yet not been fully costed and we understand that the final options for the service are dependent on their financial viability. You have therefore asked the Senate to consider these clinical models to help shape their development prior to the model being finalised for inclusion in a Full Business Case. You intend to work with the Senate again once the Full Business Case is finalised. The members of the clinical review panel who reviewed the proposals through email and teleconference discussion are listed within the Terms of Reference enclosed with this letter. This is the same panel who visited the Friarage Hospital and spoke with your clinical leads back in February 2018 when this work was first referred to us.

The questions you asked us to consider are:

- *Can the Senate advise on whether the options developed for the clinical model address the issues raised in the clinical case for change (recognising the absence of financial data in the information provided)?*

- *What risks, issues, opportunities or concerns does the Senate advise the commissioner to consider as they reach a conclusion on their preferred option? Please focus on whether all the key clinical interdependencies have been considered and, if there are any gaps in the clinical models presented, what further work we would need to undertake to address them*

The Senate panel received the documentation (listed in the Terms of Reference) on the 2nd January and reviewed the information through teleconference and email discussion. Due to the tight timeline there was not opportunity to organise a discussion between the panel and the commissioning leads. Our questions, which may have been addressed in discussion, have therefore been included within this letter.

I hope this letter provides a constructive summary of our comments and advice at this early stage

in the development of the clinical model.

Can the Senate advise on whether the options developed for the clinical model address the issues raised in the clinical case for change (recognising the absence of financial data in the information provided)?

1. The Senate agrees that the Case for Change is well made and it is clear that your ability to provide some services at the Friarage is clearly compromised. After the considerable delay since our first discussions with you on this issue we are pleased to receive the clinical model which recognises that the current services at the Friarage are not sustainable. The Senate agrees that the option put forward does address the issues in the case for change but there are a number of risks in this model, which we detail in our response to your second question. Broadly, although we realise that this model is in the early stages of its development, for the Senate to be assured that the model addresses the issues in the case for change, we would need more clarity on the range of services that can and cannot be carried out at the Friarage. Clear and safe protocols and decision making are key so that from the outset the aspirations and appetites of clinicians remain realistic.

2. Of most concern to the Senate in the presentation of the model is that the implications of this model for James Cook Hospital and other neighbouring hospitals are not clear. Commissioners will recognise that the Friarage cannot be presented in isolation, it is part of a wider Trust and an Integrated Care System footprint but the ability of James Cook particularly to absorb the intensive care activity and recruit more anaesthetists to provide the anaesthetic cover is not referred to in any detail. We advise that this is clearly set out within the FBC.

3. Our more detailed advice on the model is set out below in response to your second question:

What risks, issues, opportunities or concerns does the Senate advise the commissioner to consider as they reach a conclusion on their preferred option? Please focus on whether all the key clinical interdependencies have been considered and, if there are any gaps in the clinical models presented, what further work we would need to undertake to address them.

Staffing

4. The Senate panel expressed concern that as the services at the Friarage are decreased and the hours of services are reduced the opportunities for staff to maintain their skills and training are affected. We advise that you need to give thought as to how you will keep the Friarage as an attractive place to work and provide those opportunities for medical and nursing staff to access training and research and how you will make that role appealing. Rotating staff through JC to maintain clinical commitments at that site in our view will be key to retaining staff skills, but if that is your intention it has not been made clear. It would be helpful to understand the staff feelings and attitudes towards the change and how you will work with the staff to address their concerns.

Anaesthetic Cover/PACU and Out of Hours Cover

5. The clinical model proposes that there will not be a critical care unit at the Friarage and that critical care capacity at James Cook will be increased to compensate. There will be a consultant or other senior grade anaesthetist on site 8 am to 9pm 7 days a week to respond to emergencies requiring airway support to stabilise the patient and prepare them for transfer to a site will full critical care capability. On site at the Friarage would be a Post Anaesthetic

Care Unit (PACU) providing a high level recovery environment on elective operating days until 9pm, overseen by an onsite anaesthetist. There would be an anaesthetist led retrieval team for emergency transfer supported by appropriately skilled nurses and practitioners.

6. The key to what can be provided in terms of a non-elective service at the Friarage is the anaesthetic cover that is provided. As the consultant rota is not sustainable we agree that an unselected medical take cannot be supported. The focus then shifts to what can be safely provided in a selected medical take. The assessment at the front door will be key and needs to be delivered by appropriately experienced staff. The form of elective services follows from this.

7. The level of "safe" medical admissions, due to the facilities and staff to care for the patient safely out of hours after 9pm, raised concerns within our panel. We note the Royal College of Anaesthetists (RCOA) report, which states on page 15 that colorectal and acute medicine should be moved into JC, but the model presented to us still proposes acute medical admissions at the Friarage and we debated how appropriate this is. Even if the medical take is "selected patients", the patient can still deteriorate and need urgent airway protection and ventilation which is not going to be available after 9pm. We accept that the risks to a patient overnight can be mitigated by good protocols with JC but at 2 am in the morning when urgent consultant advice is required these protocols and a repatriation team may not be enough.

8. What is not clear from the model is whether the Consultant Anaesthetist on site at the Friarage is providing anaesthesics in the theatre suite or is free to provide anaesthetic cover for emergencies. This needs to be made clear. With a 40 minute transfer time between JC and the Friarage we would also expect that there is a separate on call anaesthetist rota at JC for the Friarage but this is also not clear from the documentation.

9. With the PACU model we would also have expected a clear proposal as to how JC critical care will expand to manage the Friarage critical care activity and recruit additional consultants. We understand that the Trust are developing a business case for James Cook critical care but the entire proposed service change at the Friarage hinges on this. In previous discussions we were informed that the JC unit does not have the physical space to expand, and is already struggling to meet the demand, therefore this shift of activity will be problematic. We would also expect the local critical care network to have worked with the Trust in calculating the impact of the Friarage model and for there to be a clear assessment of the impact there may be on other neighbouring hospitals (e.g. Darlington).

Surgical Procedures

10. The Senate debated the complexity of surgical procedures which you propose continuing at the Friarage hospital, a non-emergency site. You propose a significant level of complexity of surgery, particularly in orthopaedics and gynaecology where you propose still accepting ASA Grade 3 patients on a case by case basis. There are examples of other small hospitals with significant levels of surgery without a resident anaesthetist but we would caution against accepting any ASA grade 3 patients even on a case by case basis.

11. Page 42 details how the model would not require a dedicated surgeon on call but a consultant would be allocated each weekday to provide a ward round from 4 pm to 6 pm. At the weekend this would be provided around 10 am to 12 noon by a second consultant on call attending the Friarage. This is a very generic statement with many patients (gynaecology/ ENT/ ophthalmic, orthopaedic patients etc.) who require consultant input for their speciality

and not a general surgical opinion. It is unclear how this will be provided.

12. Health Education England, who are represented on our Senate Council, have also raised concerns about the supervision of trainee doctors on the Friarage site, particularly for surgical patients out of hours as it is referenced that there will be no on call consultant. Health Education England would insist that all training grade doctors have explicit supervision and clear pathways to escalate care 24/7. If this cannot be provided then trainees would be removed from the Friarage. It isn't clear from your proposals who will be providing out of hours care for surgical patients at the Friarage. This cannot be done by unsupervised junior doctors.

Repatriation

13. The model proposes to repatriate patients after surgery or medical care back to the Friarage and the Senate questions how well this has been thought through. We recognise the need to balance inpatient stays at an appropriate hospital with the convenience to the patient and their families of being closer to home. This repatriation however, could be seen as an unnecessary transfer and clinical risk for 1 – 2 days of care. Repatriation of patients is also difficult to achieve and you may find it helpful to reflect on how well you have achieved that with some of your current services. In some cases repatriation would not be appropriate if the patient is recovering from cardiac or vascular surgery for example in case the patient deteriorates and there isn't the appropriate consultant expertise on site. We would suggest that you only consider repatriating patients who require significant rehabilitation and/or reablement.

Paediatrics

14. Currently paediatric services provide a short stay day unit with no weekend or overnight cover. Children with illness are not accepted at the A&E and if such cases present during the opening hours of the paediatric short stay assessment unit (PSSAU) they are managed there until clinically stable. Outside of these hours children are referred to their GP out of hours service or transferred to JC for care and treatment if they are clinically unstable. The new model proposes that paediatric illness and primary care ailments are relocated to the Friarage UTC.

15. The phrase 'paediatric illness and primary care illness' which is used in the documentation covers a multitude of conditions and the Senate questions what range of illness is going to be handled at the Friarage. Commissioners need to be very wary of the level of acuity as parents will not necessarily be able to make that assessment of what is an appropriate level of illness for the Friarage and are more likely to bring their child with any condition.

16. We are not clear why the requirement for staff to be trained in paediatric care is limited to if the PSSAU is staffed by Advanced Nurse Practitioners. The training will be required whatever the staffing model.

17. We advise you to consider the provision of play therapists/ family friendly rooms etc. to meet the needs of children being treated in a UTC and to make this a welcoming space for them.

18. There is also opportunity here to think further about the community paediatric models and how these could be developed in this area. The provider could be at the forefront of developing integrated care models such as hospital at home and virtual ward rounds.

GPs/ Out of Hours

19. We support the proposal to replace the A&E department with an Urgent Treatment Centre (UTC) as defined in the NHSE document "Urgent Treatment Centres-Principles and Standards" published July 2017. The whole model however is reliant on GPs being available and willing to run the UTC and it is unclear if this is achievable. It would be helpful to know more about the local GP recruitment, their age profile and retirement rate to better understand the feasibility of this proposal.

20. It would also be helpful to understand what the current out of hours offer is and therefore how this fits with the proposal for 24 hour opening for the UTC. Commissioners will be aware of the need to maximise the use of the workforce. A 24 hour service will be difficult to staff and 24 hour coverage may not be the best solution based on the activity and clinical need. Under a 12 hour model however, the graph on page 14 shows that there will be 3085 self-presenters who will need to seek care elsewhere when the unit is closed and we question whether the alternative services can cope. Commissioners may wish to consider extending the hours to 8am – 10pm as a compromise solution depending on the pattern of activity.

21. Please note the following specific points:

- On page 12 – it lists one of the core services of the UTC as "general primary care service (dependent on securing a primary care workforce)". This needs further explanation.

- On page 13 – it states that more than 95% of patient numbers attending A&E at the Friarage will safely be able to use the UTC and it would be helpful to understand the evidence for that statement.

- On page 18 – it would be helpful to have more detail of the YAS advanced paramedics who work alongside the GPs in the Out of Hours service.

- On page 22 – it describes the footfall numbers to UTC overnight as low and we suggest that the specific figures are included.

Care of the Elderly

22. We note that on page 26 of the clinical model there is the proposal that people over 85 will be accepted without any NEWS score consideration. This contrasts to younger patients who will be transferred to larger hospitals with critical care facilities and higher levels of staffing if their NEWS score is above a given threshold. In addition you propose that patients with a DNACPR regardless of age will be admitted to the Friarage without consideration of NEWS score. We understand that this is due to the number of patients who attend the Friarage in this age category or who have limited life expectancy and how you want to offer them a local and familiar service. However these approaches could be seen as limiting their care.

23. Not applying the NEWS triage assessment to these patients could be seen as limiting their care and those patients who have stated a DNA CPR and those over 85 years of age should not arbitrarily be limited in their other aspects of care. We therefore recommend that you better demonstrate how you are going to offer these patients holistic care and describe patient selection by an individualised patient centred method. We recommend that you focus on providing a comprehensive geriatric assessment to patients at the Friarage.

24. We very much understand how important the Friarage is in providing services for an ageing population particularly in this largely rural area with poor communication and transport links. Our lay members on the panel have spoken of the difficulty in accessing health care as you get older, the sometimes prohibitive expense of taking taxis to reach your GP for example when you can no longer drive and there is no accessible public transport. They also spoke of the difficulty in navigating the options of where you should go to receive your healthcare. The Friarage is very important to the local community and you have a real opportunity here to develop your care of the elderly service.

25. Please also note our following questions

- Does your bed modelling take into account the ageing population and plans for the next 10 years

- Do you have stratified levels of palliative care to drive the decision making process.

- What are the transfer services available to and from JC – how does this cater for the needs of older people and people with dementia. What facilities do you have to support carers in relation to these transport services?

- Is there adequate capacity in care homes locally to accommodate patients?

Opportunities

26. You asked the Senate what opportunities there are as you reach a conclusion on your preferred option. It is clear that the Friarage will continue to offer valuable services to its largely elderly and rural population. This can be a major site for diagnosis, assessment and outpatient services and in communications to the public it needs to be clear that the Friarage can still deliver the care that most people need most of the time. Your message to the public needs to be clear in setting out what services the Friarage can still provide so that the public can have confidence that they are going to the right place. There are a number of services that are already not provided at the Friarage, and that bypass service works very effectively. This will be a helpful context in setting out this clinical model.

Other Comments

27. Please find below further general comments which you may find helpful as you develop the preferred model.

- We advise that you provide further information about how you will work with your mental health provider and link patients attending the UTC into the mental health services if required.

- You refer to the new housing plans but it isn't clear what modelling you have done to look at the impact of that on your population and your ability to provide services for them.

- We suggest that the graphs on cardiac arrest on page 57 and 58 include the actual patient numbers rather than just the percentages. Our question is whether those cardiac arrest graphs, and other clinical outcomes that are suggested as improved, are actually related to changes in the service model. The numbers of cardiac arrest patients may be so small that

it may not be a valid outcome measure. It may also be seen as a leap to suggest that recently changing the model has improved cardiac arrest outcomes as there may be other factors contributing to this like the ambulance response program (ARP) that has been implemented during this period.

- The threshold for bypass due to illness severity is a NEWS score of 6 except for COPD where a NEWS score of 9 is suggested. This should be clarified; if NEWS 2 scoring is used in those with COPD then it is not apparent why higher scoring patients with COPD should be admitted and triaged for diversion. If the discrepancy is because of use of NEWS rather than NEWS 2 this should be updated in line with national policy. COPD patients with NEWS 2 scores of under 6 could still have an SpO2 of below 88% despite supplemental oxygen. A proportion of such patients will have acute decompensated type 2 respiratory failure and derive prognostic benefit from acute NIV. The capacity for this to be accommodated within level 2 bed provision should be identified.

Conclusion

28. The Senate agrees that the Case for Change is well made and it is clear that your ability to provide a safe service at the Friarage is clearly compromised. We agree that the model put forward does address the issues in the case for change but it requires more detail to clearly set out the range of services that can and cannot be safely carried out at the Friarage. We have identified the key risks as:

    - The PACU hours of operation and anaesthetist cover and whether this is sufficient for the range of acute medicine and surgery still proposed on site.

    - The implications of this model for JC and other neighbouring hospitals have not been made clear. The ability of JC particularly to absorb the intensive care activity and recruit more anaesthetists to provide the anaesthetic cover is not referred to in any detail yet the success of the Friarage model hinges on this.

    - The availability of GPs and other practitioners to staff the UTC model

    - The lack of proposals to maintain staff skills and provide opportunities for medical and nursing staff to access training and research

    - The safety of the planned model of repatriation

    - The potential limitations of care for the frail, elderly population

    - The lack of clarity on the range of paediatric illness which will be managed at the Friarage.

29. Under your plans the Friarage will continue to offer valuable services to its population which is largely rural and increasingly elderly and there is opportunity to convey that message very positively in your communications with the public and to be clear that the Friarage can still deliver the care that most people need most of the time.

30. We hope our comments are helpful to you and we look forward to working with you further when the Full Business Case is complete.

Yours sincerely

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

Copy to: Gill Collinson, Chief Nurse
Lisa Pope, Deputy Chief Operating Officer

NHS
Yorkshire and the Humber
Clinical Senate

CLINICAL REVIEW

TERMS OF REFERENCE

TITLE: Hambleton, Richmond and Whitby CCG. Review of the Friarage Hospital services

Sponsoring Organisation: Hambleton, Richmond and Whitby CCG

Terms of reference agreed by: Gill Collinson, Chief Nurse at Hambleton, Richmond and Whitby CCG and Joanne Poole. Senate Manager for Yorkshire and the Humber Clinical Senate
Date: 3rd January

1. CLINICAL REVIEW TEAM MEMBERS

Clinical Senate Review Chair: Chris Welsh, Yorkshire and the Humber Senate Chair

Citizen Representative: Sue Cash and Peter Allen

Clinical Senate Review Team Members:

Name	Job Title
Sewa Singh	Medical Director, Doncaster and Bassetlaw NHS Foundation Trust
Asem Ali	Consultant Geriatrician Physician, North Lincolnshire and Goole NHS FT
Jeff Perring	Senate Vice Chair, Consultant Intensivist and Deputy Medical Director, Sheffield Children's Hospital NHS FT
Steve Ollerton	GP and Clinical Leader Greater Huddersfield CCG
Rod Kersh	Consultant Physician and Geriatrician, Doncaster and Bassetlaw NHS Foundation Trust, Yorkshire and the Humber Clinical Advisor for Dementia
Chris Scott	Consultant in Anaesthesia and Critical Care Medicine, Sheffield Teaching Hospitals NHS FT
Peter Weaving	GP and member of the North Senate

2. AIMS AND OBJECTIVES OF THE REVIEW

Questions:

Can the Senate advise on whether the options developed for the clinical model address the issues raised in the clinical case for change (recognising the absence of financial data in the information provided)?

What risks, issues, opportunities or concerns does the Senate advise the commissioner to consider as they reach a conclusion on their preferred option? Please focus on whether all the key clinical interdependencies have been considered and, if there are any gaps in the clinical models presented, what further work we would need to undertake to address them

Objectives of the clinical review (from the information provided by the commissioning sponsor): To assist the CCG to consider all the issues in their development of the options to deliver a safe and sustainable service at the Friarage Hospital.

Scope of the review: The Clinical Senate will focus their review on the above questions considering the information provided in the documentation supplied by the CCG and supplemented with information provided at our previous site visit.

3. TIMELINE AND KEY PROCESSES

Agree the Terms of Reference: 7th January 2019

Receive the evidence and distribute to review team:

Following evidence received 20th December and distributed 3rd January

- Clinical Case for Change
- Clinical Modelling Document
- Friarage Engagement Report
- Royal College of Emergency Medicine report
- Royal College of Anaesthetists report

Teleconferences: held 15th and 18th January

Discussion at Senate Council: 24th January

Draft report submitted to commissioners: end January 2019

Commissioner Comments Received: within 10 working days of receipt of the report

Senate Council ratification; Ratify at March 2019 meeting or by email if required earlier

Final report agreed: TBC

Publication of the report on the website: Timeline to be confirmed with HRW CCG

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:

- Clinical Case for Change
- Clinical Modelling Document
- Friarage Engagement Report
- Royal College of Emergency Medicine report
- Royal College of Anaesthetists report

The review team will review the evidence within these documents and supplement their understanding with a clinical discussion and their knowledge gained from the site visit to the Friarage Hospital in February 2018.

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, provider, NHS England (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. 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