Yorkshire and the Humber
Clinical Senate

Free and full independent and impartial clinical advice

Clinical Senate Review

Of the 'Shaping Care Together' programme -

Southport and Ormskirk Hospital NHS Trust on behalf of Southport and Formby CCG

Version 1.0

November 2021

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

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

Yorkshire and the Humber Clinical Senate
England.yhsenate@nhs.net

Version Control

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1. Chair's Foreword

Southport and Ormskirk Hospital NHS Trust (S&O) provides acute and community services for a population of approximately 258,000 across Southport, Formby and West Lancashire. However, as a small Trust, sustaining services in two hospitals only seven miles apart it faces many challenges and there are areas of care that need to improve. The most recent Care Quality Commission (CQC) report (2019) rated the Trust overall as 'Requires Improvement'.

The CQC found that within the 'care' domain the Trust was rated as good but across all other domains of safety, effectiveness, responsiveness and well-led, it was rated as requiring improvement. The Trust faces challenges to provide integrated, sustainable and safe care in light of issues with the age, quality and utilisation of its estate and problems attracting and retaining staffing from many professional groups. In addition, the ageing population that the Trust serves has highlighted the need to improve working links and practices with social care.

We very much welcomed the opportunity to revisit the Trust and the Clinical Commissioning Groups' (CCG) plans to address the local challenges in considering the new models of care for its population following the previous Yorkshire and Humber Clinical Senate review in 2018. We were keen to understand how the ambitions and plans for the future had developed in the intervening period and this report should be considered alongside the final report from our previous work.

We were asked to review and comment upon on the models of care for frailty, urgent and emergency care, planned care, gynaecology and sexual health services, maternity and neonatal services and paediatrics in relation to: whether they described sustainable solutions for the Case for Change and we were asked to provide advice on strengthening the clinical and care leadership and participation.

Additionally, we were asked to give advice as to whether the evidence that was provided to us, and the described innovations and improvements, would improve patient outcomes and whether the options reflect relevant clinical guidelines and best practice. Lastly, we were asked to consider if there were any unintended consequences / interdependencies of the options that need to be taken into account.

In order to help the Senate undertake this latest review, we were given revised documentation and updated models of care from the Shaping Care Together programme team and heard directly from senior clinicians and nursing staff on what their aspirations and plans were as the health and care economy were beginning to move out of the COVID response phase. We also heard from the programme team how S&O will be forming a new partnership with neighbouring St Helens and Knowsley Teaching Hospitals NHS Trust.

This report collates the Senate panel's independent clinical views, reflections and recommendations on the latest of these proposals and also for the potential for the new relationship with its neighbouring provider to address some of the long standing challenges that S&O face in relation to the ability to attract and retain staff and improve the quality and safety of care provided that we hope will be useful to the Trust, commissioners and programme team.

We thank the commissioners and the Trust for their organisation and hosting of the virtual review in September 2021. We would also like to thank the participating staff from the local health system and for the considerable work that led to the presentations and helpful discussions on the day of the review itself.

Finally, I would like to take this opportunity to thank the panel of clinical experts who assisted with this review. I very much appreciate their desire to provide helpful assurance and their diligence in reviewing the evidence provided to us.

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

2. Introduction

Following a Yorkshire and Humber Clinical Senate review in 2018, the Senate was approached in April 2021 by Southport and Formby CCG, to further review progress on the models of care that had been developed via the Shaping Care Together programme; a collaborative between the CCG and Southport and Ormskirk Hospitals NHS Trust.

The specific questions the Senate was asked to address were:

- Do the models of care describe sustainable solutions to the clinical case for change?
- Can the Senate offer any advice about strengthening the clinical and care leadership/clinical and care participation?
- What evidence would you expect to see within plans to improve patient outcomes?
- Do the options, for each of the services reflect clinical guidelines and best practice?
- Have innovations and improvements that would improve quality and outcomes been considered?
- Are there unintended consequences/interdependencies of the options that need to be taken into account? (e.g. adult social care, medically unexplained, primary care)

2.1 Process of the Review

To carry out this review, the Senate formed an independent expert clinical panel which included many of the panel members from the previous Senate review of 2018 for continuity purposes.

The supporting information (outlined in Appendix 5) was provided by the CCG on the 14 August 2021 and a pre-panel meeting was organised for 8 September 2021. All panel members were invited to attend to contribute early thoughts on the information that had been received.

The full review session took place virtually via Microsoft Teams on 15 September 2021. The agenda for the day is included at Appendix 3. The details and short biographies of the full panel can be found in Appendix 1. The clinical panel followed up the virtual review with a teleconference discussion on 17 September 2021 where the panel discussed the findings and gave draft recommendations.

The report was drafted during the final weeks of September and early October and was provided to the Senate panel for additional comments and factual accuracy on 14 October 2021.

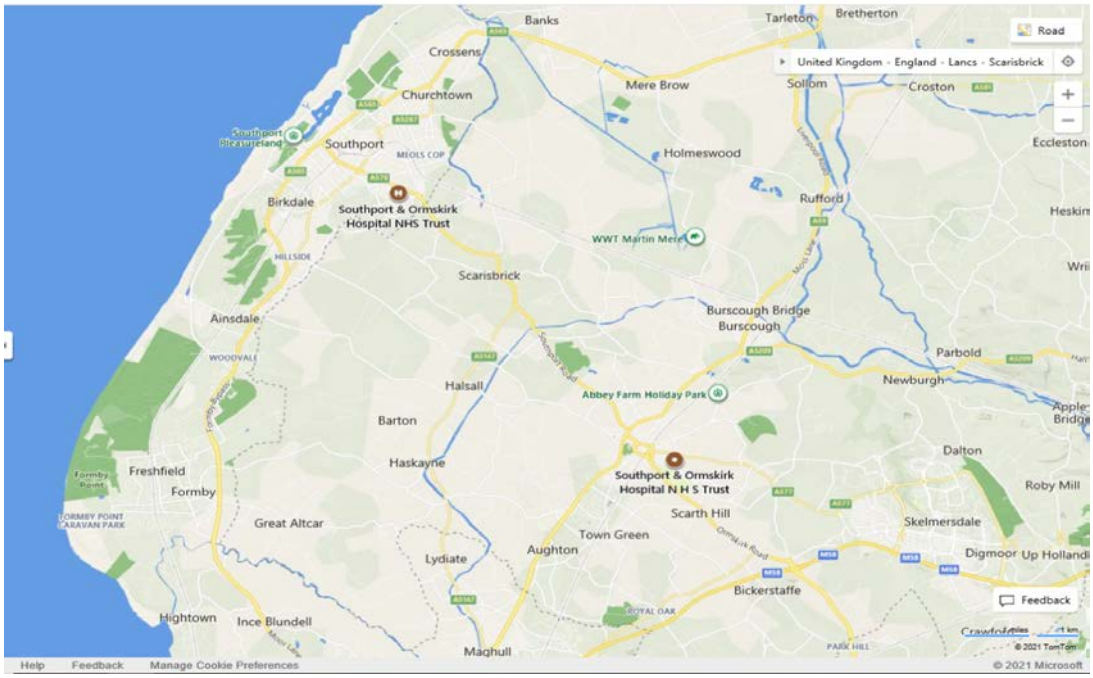
The Senate took the information received from the clinicians during the visit at face value and based their recommendations on the evidence received, which is listed at Appendix 5.

3. Overview of the in-scope services

Southport and Ormskirk Hospital NHS Trust provides acute and community services for a population of approximately 258,000 and employs 3,495 whole time equivalent staff. Despite its small size it offers a range of acute services including urgent and emergency care for adults and children including an A&E, urgent care centre, acute medicine, emergency surgery and critical care. It also offers the full range of women and children's services including obstetrics, gynaecology, paediatrics and neonatology, planned care and surgery. The average weekly demand is:

Population Needs	Average Weekly Demand
Adult A&E attendances	1065/week
Paediatric A&E attendances	478/week
Deliveries	43/week
Day case and Elective Inpatient General Surgery Spells	69/week
Day case and Elective Inpatient Orthopaedic Spells	20/week

Services are split across the Southport and Ormskirk sites with Southport providing a Type 1 24/7 A&E for adults, and Ormskirk the equivalent for children. Medical specialties, including urology and orthopaedics are provided at Southport. Obstetrics, gynaecology, neonatology and paediatric inpatient services are provided at Ormskirk. The three main CCG commissioners are Southport and Formby CCG, South Sefton CCG and West Lancashire CCG.



4. Previous clinical senate review recommendations

This latest Clinical Senate review follows on from a previous review that took place in October 2018[1]. The key recommendations that came out of that piece of work were as follows:

- Reconfiguring the services across the two sites is a necessity. The agreed best option would be a new build located between the two existing sites which would still require clinical partnerships with neighbouring Trusts to ensure the sustainability of some of the services. The interim solution to a new build would include moving to a hot and cold site model on the two existing sites.
- The small size of the obstetric unit may make this service difficult to sustain long term even if the workforce shortages can be addressed. The sustainability of both neonatal and obstetric services depends on the final location of the hot site. A small obstetric unit and a neonatal unit could be sustainable at Ormskirk.
- Paediatric A&E needs to be in the same place as the adult A&E. We advise that the Trust needs to develop proposals for paediatric partnership working with other providers regardless of whether the obstetric service remains on site.
- There are gaps in the urgent and emergency care model and we question whether enough focus is given to the crowding and flow through the hospital.
- There are still too many direct lines to the A&E department in the proposed model and the sustainability of the critical care unit is also not adequately considered here. The sustainability of the critical care service is integral to the viability of most of the scenarios.
- The vision for developing Ormskirk into a sub-regional elective care centre is well received but the detail behind this and the fit with emergency surgery needs further development.
- A key concern for the Senate is the lack of joined up thinking between community and Trust services, and the inconsistency of provision in community services, which are resulting in the failure to present a single view of care for the whole population.
- 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 ICS view.
- There are outstanding individual clinicians working in the Trust but broader staff engagement is needed to achieve the commitment to the scale of change required.

This latest Senate review used these previous recommendations as a frame of reference to determine, in either the circumstances or context that the Shaping Care Together programme is now operating in, mean that these recommendations no longer stand, or if the updated and revised models of care provide sustainable solutions to the issues found by the YH Senate in 2018.

1 http://www.yhsenate.nhs.uk/modules/reports/protected/files/YH%20Senate%20Report%20-%20SOAcute%20Services%20January%202019.pdf

5. 2021 Senate Review - Findings

On the review of the information provided by the Shaping Care Together team and in the discussion with staff in the panel session, the Clinical Senate set out the following observations in regards to the programme and the individual plans for the in-scope services.

5.1 Urgent and Emergency Care

The plans for an Urgent and Emergency Care (UEC) Village were well received by the Senate, as was the working principle of a 'no wrong door' access to care. There has clearly been significant engagement work for the UEC models and this would benefit from clinical integration/sense-check across all presented programme models due to clinical interdependencies. This is especially given that deliverables will be impacted by efficient patient flow and demand across the system. Full clinical engagement with the proposed changes is critical, especially with clinical support services and critical care.

The Senate members think there is a requirement for emergency care for children to be co-located on the same site with an adult emergency department (ED), and ideally, alongside a children's short stay ward. In this scenario it would need to be clear where the paediatric inpatient beds would be situated. The Senate advises that the inpatient facility should be on the same site as paediatric ED to avoid stretching the paediatric staff across two hospitals and to avoid the need to transfer paediatric patients by ambulance from an ED on one site to an inpatient bed on the other, when required.

The Shaping Care Together programme team is encouraged to continue to work with families and primary care to develop an integrated and seamless care approach to prevent attendances to ED where the children can be safely looked after in the community. This approach would require the development of a hospital at home community nursing service to ensure children are safely looked after by the right person at the right time and by adopting this approach inequalities would be addressed as only those children who need to travel to hospital will do so.

The Senate agreed that the Urgent Treatment Centre (UTC) proposal would benefit from being developed further with a more detailed service specification. It will be critical to ensure that the plans for this service include consistent access across the patch and also that the directory of services is consistent and robust and that there is alignment with the national picture of promoting the 111 service first. The plans should also include how they will meet the requirements for the management and potential transfer to a place of definitive care for children.

5.2 Frailty

For the frailty pathway, the Senate was not clear on the depth that the plans are multidisciplinary and multi-professional across both health and social care, the local authorities and the private, voluntary and independent sector.

The Senate felt that the model of care had many positive features but would benefit from further detail on the underpinning workforce model which would need to reflect the lack of elderly care consultants employed by the Trust.

5.3 Planned Care

The Senate heard about the difficulties maintaining a full elective programme due to the demands of non-elective activity. There is a need therefore to establish effective emergency care pathways to enable provision of elective capacity.

The Senate finds that the planned care models of care did not reference the anaesthetic workforce which is an important omission. There was also limited information provided about the likely availability and capacity of critical care staff to provide the necessary support for operating in two hospital sites at the same time as supporting maternity care on the Ormskirk site where there is no local critical care service.

5.4 Gynaecology and Sexual Health

The Senate found the models of care for gynaecology were positive but would highlight that the plans to expand consultant-led services in the community could result in a drain on already challenged workforce capacity. With regards to sexual health, consideration should be given to ensure there is alignment with other services outside of S&O (contraception services in schools and colleges) to ensure the pathways are as effective as possible. Additionally, direct referral routes between sexual health and benign gynaecology clinics need to be considered to improve the patient pathway and reduce demand on GP services.

5.5 Maternity and Neonates

The Senate was pleased to see the aspirational community model for neonatal services and the Trust is to be congratulated for this. These plans could be further improved with the production of a detailed staffing model that would allow the development of a community service along with the requirement to staff the neonatal unit. The Senate would recommend that the Trust is realistic in the further development of this model however given the number of obstetric consultants, midwifery and neonatal outreach nursing staff required and that workforce plans and mitigations are prepared in this context.

The view of the Local Maternity System (LMS) on the Shaping Care Together proposals was not clear in the documentation and the Senate would recommend that the Trust engages with the LMS to ensure that there is an alignment of plans. Similarly the Senate also noted a lack of reference to the National Critical Care Review and the recommendations resulting from that for the local neonatal unit, which are an important consideration in the ongoing development of future service models, given the interdependency between these services with maternity provision.

The Senate believes that the plans for the development of a community birthing hub, and the support and expertise that would be available for the unexpectedly ill neonate, still contain unquantified risk which needs to be resolved.

Plans for transfers and transport also need to be developed alongside these models to ensure that, in situations where a clinically unforeseen and urgent event occurs that mother and baby can swiftly and safely access the hospital-based services.

5.6 Paediatrics

Currently paediatricians need to provide care to inpatient and outpatient paediatric patients, the neonatal unit and cover Paediatric ED. The Senate was pleased to see the ambition and aspirations for an integrated care approach with the development of community care for children and that the models focused in an area of deprivation. However, workforce risks remain in regard to any introduction of this model due to current low levels of availability which could be exacerbated to serve the many points of care described in the models of care.

There are many opportunities to develop paediatric care delivery further based on best practice from across the UK as well as working with other parts of the system such as mental health services, voluntary organisations, social care and schools. Ambitious plans are needed based on early years intervention and family voice, especially in areas of deprivation, to ensure equity is reached during childhood and into adult life.

The Senate did not see any plans about the need to develop new workforce models to deliver an integrated care agenda such as Physicians Associates and Advanced Care Practitioners which would be required to deliver the ambitions.

5.7 System leadership, engagement and collaboration

During the Clinical Senate review a number of observations were made on the leadership, and system wide challenges that present themselves for the Shaping Care Together programme team, clinicians and the S&O executive.

After multiple senior leadership changes over the recent past it seems that significant progress in resolving some of the complex challenges S&O faces has been difficult to achieve. However, the Senate was pleased to hear about the newly announced working arrangement with St Helens and Knowsley Teaching Hospital NHS Trust. It is hoped that this working arrangement will provide stable and consistent leadership to oversee the changes required for the local population.

To deliver large scale successful change there will be a need for wide engagement with staff at all levels in the organisation to engage and empower staff through the changes and to maintain staff morale. The development of a single culture for all staff across the sites will be an important enabler to effecting and sustaining change.

The models of care will require collaborative working with primary care, community services and other providers to support improved patient outcomes. The time and work required to collaborate effectively will be great and should not be underestimated.

6. Senate response to the Shaping Care Together programme's questions

Alongside these service-specific observations, the Senate has also set out a response to each of the questions asked of it as part of the agree Terms of Reference for this review.

6.1 Do the models of care describe sustainable solutions to the clinical case for change?

The models of care as described do potentially offer a sustainable solution however, they will need to be viewed in the local context of population health needs, likely patient flows and particularly a realistic assessment of future workforce availability.

There will be a requirement to model and understand patient flows in proposals that involve services being based on one site. In these situations, the unintended consequences of the proposals may result in patients opting to receive their care from elsewhere, thus impacting on sustainability.

Similarly, there will be a requirement to model and understand the needs and flows of patients following the development of a community birthing centre to ensure that the health needs of the local population can be met by such a development.

The current major challenge of recruiting clinical staff is not clearly addressed at this stage and might be exacerbated by some of the proposals. Solutions which improve staff recruitment and utilisation would be beneficial to the delivery of quality patient care.

The depth of support for the models from clinically interdependent staff groups is unclear and as such there remains some degree of risk in relation to the deliverability and therefore sustainability of the models.

6.2 Can the Senate offer any advice about strengthening the clinical and care leadership/clinical and care participation?

Generally, the view of the Senate was that the models did reflect some degree of engagement and clinical participation. However, it was difficult for the Senate to form a view on how widespread that was from the specialities that it didn't hear from on the day of the review, such as from acute medicine, critical care and radiology and pathology and from other staff groups including nursing, allied health professionals and administrative staff.

It would also be helpful for the Shaping Care Together programme team to be able to describe the participation of a multi-disciplinary and multi-professional team across both health and social care, the local authorities and the private, voluntary and independent sector in the development of the plans.

6.3 What evidence would you expect to see within plans to improve patient outcomes?

To reassure commissioners, stakeholders and the public the plans should incorporate evidence that would demonstrate improvements in clinical outcomes. However, at this stage the outcome measures are not evident within the models of care as they currently stand. It would be helpful to present the high-level generic metrics reproduced from national documents and adapted for the local population with respect to the Joint Strategic Needs Assessment (JSNA), population demographics, health inequalities and the preferences of the local population.

Additionally, it would be helpful to present baseline hospital and population outcomes and care delivery standards from NHSE, the regulators and Royal Colleges with an associated evaluation and monitoring plan for expected improvement in outcomes, unintended consequences and sustainability. These should be developed for all new individual pathways/models and for the whole system.

The Senate felt that it would be critically important that a clinical integration sense-check be carried out across all presented programme models to ensure all clinical interdependencies had been identified.

6.4 Do the options, for each of the services reflect clinical guidelines and best practice?

The options do, for the most part, reflect the current, recommended approaches to care delivery and they do reflect the quality standards indicated by the relevant Royal Colleges. However, the specifics of which advice and guidance is being reflected was not clear across the models of care and it would be helpful if this could be detailed.

The Senate is unclear whether the best practice guidelines have been applied to the models of care in the context of the needs of the local populations and as such these will require more thought.

The Senate noted that the NHS Cheshire and Merseyside Women's and Children's Partnership is a strong advocate of the community birthing centre model of care. The British Association of Perinatal Medicine (BAPM) provides guidance for such units with respect to ambulance services and neonatal transfer teams. https://hubble-live-assets.s3.amazonaws.com/bapm/file_asset/file/25/CMU_final_May2011.pdf
The National Institute for Health and Care Excellence (NICE) also provides clinical guidelines on intrapartum care for healthy women and babies including advice on place of birth. https://www.nice.org.uk/guidance/cg190/chapter/Recommendations#place-of-birth

6.5 Have innovations and improvements that would improve quality and outcomes been considered?

The Senate was pleased to hear that there has been consideration of innovations accelerated by the covid-19 pandemic, particularly with digital offerings and new patient pathways.
It was particularly pleased to hear of the UEC plans for a single site and this demonstrates an example of an innovation that would improve quality and outcomes for patients.

The Senate panel members felt that there wasn't enough information provided to it about innovations in staffing, IT solutions, patient flow, capital investment in estate and equipment, site of services and primary care ways of working in order to fully respond to this question.

The Senate offers the advice that it would be helpful to undertake impact assessments of digital enablers, remote assessments, ambulatory care pathways and other innovations before deployment and dissemination to ensure that they do not contribute to widening health inequalities.

6.6 Are there unintended consequences/interdependencies of the options that need to be taken into account? (e.g. adult social care, medically unexplained, primary care)

Having considered all of the models of care and supporting information it is the view of the Senate that there are risks that demand will be shifted to other parts of the health system if one or more delivery programmes do not consistently have capacity and are unsustainable. This unfortunately will result in new provider-induced demand that will be absorbed elsewhere, which is likely to be in primary care or EDs.

The Senate panel members found that the interdependencies between pathways and adult social care and support and the private, voluntary or independent (PVI) sector need to be more fully explored with any associated risks being identified and mitigated for.

It is suggested that it will be important to ensure that patient flow from community to acute trust and wider partner organisations is proactively monitored and managed.

7. Closing recommendations

It is very clear to the Senate that an immense amount of work has been done over the years and that you have worked hard at Shaping Care Together. Most of the relevant literature has been identified and you have considered the requirements necessary to transform services. The Senate acknowledges that the plans need to be further developed.
Having reviewed the information presented ahead of the review and during the review itself it was difficult for the Senate to see the depth of engagement with clinical teams. The contribution from critical care and acute medicine physicians was not evident. Although general practitioners representing the two CCGs contributed to the panel it was not clear whether this represented the views of the wider primary care community. There was no contribution from diagnostic services such as pathology, including laboratory medicine, or radiology. The programme should look to demonstrate the depth of contribution of clinicians in the development of these models so that commissioners, stakeholders and the public can have confidence that they will play an integral part in delivering a safe, integrated and comprehensive package of care to patients.The Senate observed that the potential benefits for the system, in relation to financial and administrative benefits, were clear in the Case for Change. The benefits to patients in terms of quality of service and improvement of clinical outcomes, which is essential in any Case for Change, could have been stronger in the document.

The Senate was pleased to see some reference to addressing health inequalities within the Frailty and Stroke pathways but the Case for Change needs to make clearer how health inequalities would be addressed more comprehensively, especially given the levels of deprivation in the local populations. Following the Senate review in 2018, there were recommendations made regarding the development of a hot / cold model which would have involved consolidating acute care on one of either of the S&O sites, at the same time as working in partnership with other providers in the geography. This was acknowledged as not being a perfect solution however, it was said at the time that it would have gone some way to mitigating the risks of maintaining local services for the population and would give the best chance for long-term clinical sustainability. The Senate is interested to understand why the recommendations made in 2018 were not considered as part of the models of care presented in 2021.The Senate panel were concerned that some of the models of care presented in September 2021 (for services that are already experiencing pressures from a workforce perspective such as paediatrics, emergency medicine, midwifery and critical care staff), could exacerbate the current staffing position by increasing the number of points of care rather than consolidating them. Whilst the Case for Change and the models of care that were presented set out a number of scenarios that may help strengthen the current range of more vulnerable services within the control of Southport & Ormskirk Hospitals NHS Trust, they do not greatly reference or reflect any feasible clinical partnerships with other providers outside of the organisation.

S&O is limited in what it can achieve in isolation given the workforce issues and patient flows described, yet the current state of the local health economy and the solutions presented referred to S&O only rather than being reflected in the new landscape of Integrated Care Systems (ICS) and provider collaboratives. The Senate acknowledges the early stages of partnership working with St Helens and Knowsley Teaching Hospitals NHS Trust and

encourages the programme to engage with other providers of clinical and education services.Finally, it was noted that the Shaping Care Together programme has carried out patient engagement activities which is positive. The Senate recommends that in sharing messages to the public in the context of changing models of care, there is a need to continue to explain modern clinical and treatment practices so that the local population can understand the benefits from any change in service delivery.

In summary, the Senate feels that the additional work undertaken since 2018 has improved the quality of the proposals and planned models of care. But even with this work, and that the new partnership with St Helens offers the potential for new solutions to some of the Trust's most long-standing problems, there are some difficult decisions that will likely need to be made as the future availability of some of the specialist clinical workforce will shape the configuration of services in order to ensure a high quality offer to the patients and residents of S&O.

APPENDICES

Appendix 1

LIST OF INDEPENDENT CLINICAL REVIEW PANEL MEMBERS

Council Members

Professor Chris Welsh (Chair), Yorkshire & the Humber Clinical Senate
Mr Eki Emovon, Consultant Obstetrician & Gynaecologist, Doncaster & Bassetlaw Teaching Hospitals NHS FT
Dr Nicola Jay, Consultant Paediatrician, Sheffield Children's Hospitals NHS Trust
Dr Chris Scott, Consultant Intensivist, Sheffield Teaching Hospitals NHS FT

Dr Eric Kelly, GP & Chair, Bassetlaw CCG

Assembly Members
Alexandra Hardisty, Paediatric Consultant, Harrogate District Hospital
Shammi Ramlakhan, Consultant General & Paediatric Emergency Physician, Sheffield Children's Hospital NHS Trust
Sharon English, Consultant Neonatologist, Leeds General Infirmary
Clare Vickers, Head of Nursing (Vascular Services), Calderdale & Huddersfield NHS FT

Clinicians from Other Senates
Andrew Simpson, Consultant Emergency Medicine, North Tees & Hartlepool NHS FT
Dr Ben Pearson, Executive Medical Director, Derbyshire Community Health Services NHS FT

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.

Ben Pearson – Consultant Geriatrician

I trained in London and the East Midlands and was appointed as a consultant in geriatrics, general and acute medicine in Derby in 2004. I set up the acute medicine and ambulatory care services while holding leadership and management roles both internal and external to the hospital. I have delivered a community geriatrics service focussing on care home medicine while maintaining acute admission and weekend on call duties. I was a CCG secondary care doctor gaining 7 years Board experience and a Clinical Senate Council member since they were established. I have a master's degree in medical education and have published on the subject of clinical governance. In 2019 I was appointed Executive Medical Director of Derbyshire Community Health Services and I chair various system groups.

Nicola Jay – Consultant Paediatrician

After qualifying as a doctor in London (Royal Free Hospital MBBS, St Mary's Hospital/Imperial BSc physiology) Nicola trained in general paediatrics across three regions (Nottingham, Sheffield and Birmingham) with post graduate qualifications in Health Care Leadership (MSc) as well as Ethics & Law (PgDip). Has worked at Sheffield Children's Hospital as a consultant in paediatric allergy/asthma for a decade with research interests being prevention of food allergy as part of the BEEP study, looking at minority population to

improve health, moving allergy services into the community to improve access and de-labelling of antibiotic allergy. Nicola sits on the paediatricians in medical management committee at the RCPCH which advises on national health policies and standards for young people and is a Council member for the Clinical Senate of Yorkshire & the Humber. Nicola's main additional role is as the clinical lead for the acutely unwell child managed clinical network (MCN) of South Yorkshire and Bassetlaw (Barnsley, Bassetlaw, Doncaster, Rotherham, Sheffield and Chesterfield/Mid Yorks NHS Trust). The MCN is a work stream of the Integrated Care System (ICS) aiming to improve equity of access, quality of care and subsequent reduction in inequalities of health for the children in our region by working closely together. Central to her vision is an NHS that unites across currently recognised boundaries to provide seamless care for all children that need health care.

Shammi Ramlakhan – Consultant General & Paediatric Emergency Physician

Trained in South Yorkshire in Emergency Medicine (with sub-speciality accreditation in paediatric emergency medicine). Deputy Clinical Lead for EM at Sheffield Teaching Hospitals and chaired the Trust Resuscitation Committee from 2009-2014. On NICE's expert advisory panel, the RCEM Safer Care Committee and co-lead the NIHR Y&H Clinical Research Network in Injuries & Emergency Care.

Chris Scott – Consultant Intensivist

Has been a Critical Care Consultant at Sheffield Teaching Hospitals for 19 years and during that time has been Clinical Director and Clinical Lead for the North Trent Critical Care Network. Chris has a particular interest in the design and build of new critical care facilities and has been the clinical lead for 2 new builds at Sheffield Teaching Hospitals and has just completed a chapter for the latest Guidelines for the Provision of Intensive Care Standards (GPICS) national framework document due out later this year.

Eki Emovon – Consultant Obstetrician and Gynaecologist

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

Andrew Simpson - Consultant in Emergency and Paediatric Emergency Medicine

I qualified in 1988 having trained at the Royal Free Hospital School of Medicine. My postgraduate training was in the Northern region and in Sheffield. My consultant appointment was in 1999 to North Tees and Hartlepool NHS Foundation Trust. I was Clinical Director of Emergency Medicine from 2006 to 2016 a period that included large-scale service change for the trust including the closure of an Accident and Emergency Department. I am currently the trust's Director of Undergraduate Emergency Medicine and

Hon Senior Lecturer at Newcastle University. I am a member of the Northern Clinical Senate Council and also a Care Quality Commission Specialty Adviser.

Alexandra Hardisty – Paediatric Consultant

I qualified from Glasgow and completed paediatric training in South and West Yorkshire. I have been a paediatric consultant at Harrogate District Hospital since 2015, where I have subspecialty interests in child development and neurodisability. I am departmental lead for transition of young people from paediatric to adult services, which involves close liaison with allied health professionals, education services and social care, in order to support young people and their families through the often challenging period of transition.

Sharon English – Consultant Neonatologist

Consultant in neonatal medicine at Leeds Children's Hospital since 2004 and perinatal team hospice doctor at Forget Me Not Children's Hospice since 2019. 17 years' experience providing tertiary and specialist neonatal care in one of the busiest neonatal units in the UK. Neonatal Clinical Lead for 7 years, with experience in leading team through major service reconfiguration. Postgraduate qualifications in Healthcare Management and Leadership (PGCert) and Paediatric Palliative Medicine (PGDip). Yorkshire and Humber Neonatal ODN locality lead for West Yorkshire and Harrogate. Member of the Yorkshire and Humber Clinical Senate since 2014. Member of NICE Expert Advisory Panel, NHS England QST peer reviewer.

Clare Vickers - Head of Nursing, West Yorkshire Vascular Service, WYAAT

Qualified as a nurse in September 2000 at the University of Huddersfield and secured a post at Calderdale and Huddersfield NHS Foundation Trust. Developed a specialist interest in Cardiology and held different nursing roles within the cardiology setting; coronary care nurse, cardiac rehabilitation nurse, acute coronary syndrome nurse, cardiac device nurse and as the trust lead nurse for arrhythmias.

Current post (May 2019) was established to design and shape the West Yorkshire Vascular Service (WYVaS); as a single service encompassing Calderdale & Huddersfield FT, Bradford Teaching Hospital FT, Airedale NHS FT, Leeds Teaching Hospitals Trust and Mid Yorkshire Hospitals Trust. Working as part of a Triumvirate (Clinical Director, Head of Nursing and General Manager) to design and deliver the service to meet the NHSE specification for vascular services.

Eric Kelly – GP and Chair of Bassetlaw CCG

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

Dr Kelly moved to Bassetlaw in August 2015 and joined the Bassetlaw CCG Governing Body in November 2016.

Appendix 2

PANEL MEMBERS' DECLARATION OF INTERESTS

No declarations of interest were made.

Appendix 3

ITINERARY FOR THE VIRTUAL VISIT

Yorkshire & Humber Clinical Senate Visit

Agenda Wednesday 15th September 2021	
Introduction session: Welcome by Neil Masom, Chair, Southport and Ormskirk Hospital NHS Trust	9am – 9.30am
Single Model of Care: led by Kate Clark, Executive Medical Director, Southport and Ormskirk Hospital NHS Trust	9.30am – 10.30am
Break	10.30am – 10.45am
Model of care focus session: Chaired by Kate Clark, Executive Medical Director, Southport and Ormskirk Hospital NHS Trust • Urgent & Emergency • Frailty • Planned	10.45am – 12.45pm
Lunch	12.45pm – 1.15pm
Model of care focus session: Chaired by Claire Heneghan, Chief Nurse, West Lancashire CCG • Gynaecology & Sexual Health • Maternity & Neonates • Paediatrics	1.15pm – 3.15pm
Break	3.15pm – 3.30pm
Yorkshire & Humber Clinical Senate Consideration	3.30pm – 4.15pm
Close Session	4.15pm – 5pm

Appendix 4

NHS
Yorkshire and the Humber
Clinical Senate

CLINICAL REVIEW

TERMS OF REFERENCE

Southport, Formby and West Lancashire Shaping Care Together Programme

Sponsoring Organisation: Southport & Formby CCG

Terms of reference agreed by: Chris Welsh on behalf of Yorkshire and the Humber Clinical Senate and Kate Clark on behalf of Shaping Care Together

Date: August 2021

1. CLINICAL REVIEW TEAM MEMBERS

Clinical Senate Review Chair: Prof Chris Welsh, Senate Chair

Citizen Representative:

Clinical Senate Review Team Members:

Eki Emovon	Consultant Obstetrician & Gynaecologist, Doncaster & Bassetlaw Teaching Hospitals NHS FT
Shammi Ramlakhan	Consultant General and Paediatric Emergency Physician, Sheffield Children's Hospital NHS Trust
Chris Scott	Consultant Intensivist, Sheffield Teaching Hospitals NHS FT
Ben Pearson	Consultant Geriatrician, University Hospital of Derby & Burton
Nicola Jay	Consultant Paediatrician, Sheffield Children's Hospital NHS Trust
Sharon English	Consultant Neonatologist, Leeds General Infirmary
Eric Kelly	GP & Chair of Bassetlaw CCG
Alexandra Hardisty	Paediatric Consultant, Harrogate District Hospital
Clare Vickers	Head of Nursing (Vascular Services), Calderdale & Huddersfield NHS FT
Andrew Simpson	Consultant Emergency Medicine, North Tees & Hartlepool NHS FT

2. AIMS AND OBJECTIVES OF THE REVIEW

Question:

Do the models of care describe sustainable solutions to the clinical case for change?

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

- Can the senate offer any advice about strengthening the clinical & care leadership/ clinical & care participation?
- What evidence would you expect to see within plans improve patient outcomes?
- Do the options reflect relevant clinical guidelines and best practice?
- Have innovations and improvements that would improve quality and outcomes been considered?
- Are there unintended consequences/interdependencies of the options that need to be taken into account? (e.g. adult social care, medically unexplained, primary care)
- Key interdependencies with place-based services, including primary care and mental health services

Scope of the review:

Acute services, excluding stroke services, delivered for the populations served by Southport & Formby and West Lancashire CCGs and those who access services at S&O.

3. TIMELINE AND KEY PROCESSES

Receive the Topic Request form: 13 August 2021

Agree the Terms of Reference: 26 August 2021

Receive the evidence and distribute to review team: 20 August 2021

Teleconferences: 8 September 2021

Virtual Site Visit: 15 September 2021

Draft report submitted to commissioners: 15 October 2021

Commissioner Comments Received: 12 November 2021

Senate Council ratification; 23 November 2021

Final report agreed: 23 November 2021

Publication of the report on the website: 04 January 2022

4. REPORTING ARRANGEMENTS

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

5. EVIDENCE TO BE CONSIDERED

The review will consider the following key evidence:

Model of Care summary documents

Model of Care documents

KPMG Case for Change

Draft outline PCBC

Core Acute Service Business Case

Baseline Modelling (Estates, Workforce, Finance, Travel, Activity, Digital)

The review team will review the evidence within this document and supplement their understanding with a clinical discussion.

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

Appendix 5

EVIDENCE PROVIDED FOR THE REVIEW

The CCG provided the following documentation to the Senate for consideration:

- Digital Case for Change
- Activity Baseline Modelling
    1. Southport and Formby CCG demographic profile 2019/20
    2. West Lancashire CCG demographic profile 2019/20
    3. Southport and Ormskirk NHS Trust demographic profile 2019/20
- Estates Baseline Modelling
    1. Community estate
    2. Hospital sites
- Models of Care
    1. Frailty
    2. Planned Care
    3. Urgent and Emergency Care
    4. Gynaecology and Sexual Health
    5. Maternity and Neonatal
    6. Paediatrics

- South Sefton CCG Travel and Transport assessment
- Shaping Care Together strategy
- Shaping Care Together Post Listening Equality Analysis
- Workforce baseline and 2025 staffing requirements report
- Case for Change
- Health Inequalities impact assessment
- Acute Sustainability Programme - Core Acute Services Position Paper
- Pre Consultation Business Case
- Equality Analysis