NHS
Yorkshire and the Humber
Clinical Senate

Clinical Senate Review of Services at the Friarage Hospital on behalf of Hambleton, Richmond and Whitby CCG

Final Report Version 1.0

July 2019

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

Version Control

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1. Chair's Foreword

1.1 Friarage Hospital, part of South Tees Hospitals NHS Foundation Trust, provides acute and community services for a population of c. 144,000 across Hambleton and Richmondshire. However, as a small District General Hospital (DGH) it faces many challenges, particularly workforce shortages, which are driving non-compliance with clinical standards and guidelines.

1.2 We very much welcomed the opportunity to work with the Trust and the Clinical Commissioning Group (CCG) with whom we have worked for over a year now, considering how the Trust may provide sustainable acute services for its local population. Our work with you commenced in December 2017 culminating in our informal early advice to you in February 2019. We hope that this report, on your final proposals for consultation, challenges your thinking and interrogates the proposed clinical model to help you to move forward to a long-term workable and sustainable solution.

1.3 We thank colleagues in the CCG and the Trust for their hospitality during our 1 day site visit back in February 2018. Meeting the hospital and primary care staff, and visiting the departments, gave us the opportunity to better understand the geography, the challenges and the proposed solutions and to talk to clinicians delivering the services.

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

Chris Welsh, Senate Chair

2. Summary of Key Recommendations

2.1 The Senate is supportive of the proposed clinical model which we agree is a step in the right direction towards providing a sustainable future for the Friarage Hospital. We very much commend the innovation in this model which looks to sustain an acute hospital model that does not rely on 24/7 resident anaesthetic cover.

2.2 The main risk to your proposal remains the workforce or rather the lack of it, particularly in anaesthesia, critical care and the need to maintain the medical and nursing workforce required for the selected acute hospital model. Primary care staffing also remains challenging. The workforce challenges remain a significant concern to the Senate.

Our key recommendations are:

1. To provide assurance that James Cook University Hospital and Darlington Memorial Hospital can staff the increase in critical care patients and to be clear on your contingency if you are unable to recruit.

2. To provide greater clarity on how you will secure the primary care workforce to staff the Urgent Treatment Centre at the Friarage Hospital with skilled and experienced practitioners.

3. To ensure you have approval from Health Education England (HEE) for your proposals for Hospital at Night, out of hours supervision of staff and your non-invasive ventilation model.

4. To provide further assurance on the staff training and protocols that will underpin your proposal to extend the paediatric service to minor illness.

5. To develop a comprehensive consultation process with staff to develop broad organisational engagement on your proposals.

3. Background

Clinical Area

3.1 The Friarage Hospital is one of the smallest district general hospitals (DGHs) in the country serving a rural population of around 144,000 people across Hambleton and Richmondshire. The hospital has 95 adult inpatient beds (as at August 2018) and a 24-hour urgent and emergency care service with acute medical and surgical admissions. Theatre specialties include general surgery, thoracic, colorectal, breast, urology, gynaecology, orthopaedics, ophthalmology, ENT, oral, plastics and endoscopic procedures.

3.2 Current services provided from the Friarage Hospital include accident and emergency (A&E), intensive care/high dependency, diabetes, respiratory medicine, endoscopy, chemotherapy, rheumatology, elective orthopaedics and plastic surgery, pathology, surgery (including lung cancer, urology, colorectal), a midwifery-led unit and short-stay paediatric assessment unit, urology, pain services and a wide range of diagnostics and support functions.

3.3 As a small DGH the Trust faces the challenges of maintaining the range of services it currently offers, recruiting and retaining its workforce and maintaining their skills to meet clinical standards and guidelines. Concerns have specifically related to anaesthetics, critical care and accident and emergency services.

Role of the Senate

3.4 In December 2017 the Senate was approached by Hambleton, Richmond and Whitby CCG to work with them in reviewing the sustainability of acute services at the Friarage Hospital site. Initial documentation was shared in preparation for a site visit to the hospital in February 2018 but work halted thereafter whilst we awaited the clinical models on which to comment and advise. The Senate wrote to the CCG in May 2018 expressing concerns with the delay in progress. Work commenced again with the CCG in December 2018. The objectives of the early advice were to provide you with independent clinical oversight of the proposed clinical model to help shape its development prior to the model being finalised for inclusion in a Full Business Case. Our early advice was provided to you in February 2019 and is attached to this report at Appendix 3.

3.5 In March 2019 the Trust was required to implement urgent temporary changes to critical care services at the Friarage Hospital on the grounds of risks to patient safety. In May 2019 the Senate was asked to re-engage with this work to advise on whether the final proposals for public consultation will provide a sustainable future for the Friarage Hospital. The specific question the Senate was asked to address is:

Assessing the proposed clinical model against the core tenets of clinical effectiveness, patient safety and patient experience – does the panel think that our proposals will provide a sustainable future for the Friarage Hospital?

Process of the Review

3.6 In May 2019 the expert clinical panel who had previously worked with the Friarage were approached to see if they would continue to advise on these proposals. Most panel members agreed to this request and the gaps were filled with clinicians from the Senate Council. The draft consultation document (without appendices) was received on 13th May and distributed to the panel thereafter. The updated draft consultation document, including appendices, was received on 20th May and distributed to the panel and Senate Council. In order to ensure some fresh clinical perspectives on the model, the CGG and Trust representatives were asked to present to the Senate Council on 21st May to give opportunity to debate the model with a wide cross section of experienced clinicians who had not previously been involved in this review. The Council received a detailed presentation that included activity data on the temporary operation of the model. The presentation and the comments from this debate were fed into the deliberations of the expert clinical panel and discussions took place with all panel members during the weeks in June.

3.7 As there was little change between the draft model considered in our informal advice and the final draft model on which the Senate was now being asked to comment, we agreed to structure this report around the questions we had initially raised on the model in February 2019, and our assessment of how these issues had been addressed in the final proposed model. The report was provided to the commissioners for comment on 28th June 2019. The Senate based their recommendations on the evidence received, their previous site visit, discussions with commissioners and the presentation to the Council. The full list of evidence is included at Appendix 5.

4. Recommendations

Assessing the proposed clinical model against the core tenets of clinical effectiveness, patient safety and patient experience – does the panel think that our proposals will provide a sustainable future for the Friarage Hospital?

4.1 The Senate is supportive of the proposed clinical model which we agree is a step in the right direction towards providing a sustainable future for services at the Friarage Hospital. We very much commend the innovation in this model which looks to sustain an acute hospital model that does not rely on 24/7 resident anaesthetic cover. Whilst we support the decision to move critical care from the Friarage site and to replace the Accident & Emergency department with an Urgent Treatment Centre, not all our concerns regarding the implications of this move have been met. Further

comment on these points and other clinical areas are included within the specific sections below.

4.2 The main risk to the sustainability of your proposal remains the workforce challenges, particularly in anaesthesia, critical care and the ability to maintain the medical and nursing workforce needed for the selected acute hospital model. Primary care staffing also remains challenging. This model, although reducing some of these pressures, does not solve the workforce issues and this remains a key concern.

4.3 We have structured this report around the questions we raised in our early advice, assessing how these have been addressed in this final proposed model.

Critical Care and Wider Implications

4.4 Before introducing the temporary measure there was a critical care unit at the Friarage Hospital of up to 6 level 2 (high dependency) or up to 3 level 3 (intensive care) beds, a senior anaesthetist resident on site 24/7 and a daily critical care ward round by Consultant Intensivist/Anaesthetist. It was the workforce gaps in anaesthetics and critical care that were the key factor in driving the proposed service change. Your proposed model will remove the critical care unit at the Friarage Hospital and instead increase the critical care capacity at James Cook University Hospital (JCUH). There will be a consultant or other senior grade anaesthetist on site at the Friarage Hospital from 8am to 9pm 7 days per week, providing a response to any emergencies requiring airway support to stabilise the patient and prepare them for transfer to a site with full critical care capability, if required. There will also be an extended recovery service providing a high-level recovery environment on elective operating days until 9pm, overseen by an anaesthetist together with an anaesthetist-led retrieval team for emergency transfer supported by nurses/practitioners with the appropriate skills.

4.5 In our early advice we questioned whether JCUH had the ability to absorb the intensive care activity and recruit more anaesthetists to provide the anaesthetic cover. You have confirmed that the High Dependency Unit (HDU) at JCUH will have an increase in 1 bed, making a total of 17 beds and that from the start of the new model the HDU will become a flexible High Dependency Unit/Intensive Therapy Unit (ITU). You are working on the basis that there will be no more than 6 ITU patients in the flexible unit at any one time which results in a net increase of 6 ITU beds at JCUH. You have also confirmed that to mitigate the loss of HDU capacity you will implement an interim Post Anaesthetic Care Unit (PACU) in theatres at JCUH and will have five PACU beds available in the theatre complex for elective patients. We agree with you that the added benefit of the new model is that it provides a dedicated PACU for elective patients (predominantly cancer patients), which will aid the delivery of the elective programme.

4.6 The capacity increase (in terms of physical space) at JCUH has been met which addresses one of our concerns. We remain unclear on the following points:

a) Whether JCUH has adequate staffing to cover the increase in critical care patients. You acknowledge that anaesthetic and intensivist shortfalls continue and therefore this solution remains very dependent on your ability to recruit. What is the contingency if you are unable to do so?

b) You have referenced that the critical care changes will increase demand at Darlington Memorial Hospital (DMH) by 0.75 critical care beds but there is no further detail on whether this hospital has the physical space to expand by 1 critical care bed or can increase its medical and nursing workforce to staff this bed.

c) Although you have stated that you have not used your critical care network to help you map the implications of this change due to the confidentiality issues, our view is that this is a missed opportunity. We advise that you should be using your network to help calculate the impact of this model, certainly once the public consultation has commenced.

Recommendation: to provide assurance that JCUH and DMH can staff the increase in critical care patients and to be clear on your contingency if you are unable to recruit.

4.7 In our previous advice we questioned how the Friarage Hospital proposals fitted within the wider Integrated Care System (ICS) context. We understand that sustainability pressures upon the current Friarage Hospital services are driving change ahead of wider Tees Valley strategic reconfiguration, but you have confirmed that the proposed model is in line with the strategic aims of the wider ICS. You have also confirmed that you have considered the impact of the proposals on the Yorkshire and the Humber geography and that you have modelled a minimal impact on York and Harrogate Hospitals (totalling 5% of current A&E attendances and acute admissions at the Friarage Hospital). You have not confirmed that those hospitals are able to manage the increase in workload which may arise as a consequence of the proposals.

4.8 Our previous advice to you also questioned whether the Consultant Anaesthetist on site at the Friarage Hospital will be providing anaesthetics in the theatre suite or whether they will be available to provide anaesthetic cover for emergencies. You have confirmed that they will be providing anaesthesia but staffing within the theatre suite will be available to allow their immediate release. It would be helpful to further understand where that cover is coming from.

4.9 You have also confirmed that there will not be a separate dedicated on-call anaesthetist rota at JCUH for the Friarage Hospital, but a “senior” anaesthetist can be released without delay from JCUH to the Friarage Hospital due to the implementation of a two person Anaesthetic Consultant on call roster. This addresses our comments on this point.

Emergency Medicine

4.10 The model you are proposing changes the current A&E department to an Urgent Treatment Centre (UTC) model. Currently the A&E department is open 24/7 with separate but co-located GP out of hours service and the A&E department does not treat illness in children. A&E bypass protocols are already in place for a number of specialist services. In your proposed model the service in the UTC would be delivered by Nurse Practitioners, supported by a service integrated with the GP out of hours service. The proposed service will follow the national service specification for a UTC and will be accessible for NHS 111 referrals and direct booking, walk-ins and pre-selected ambulance take based on ambulance at scene triage and prior agreement with a clinician. The UTC will be able to refer for admission in line with the acute medicine model. The proposal for the UTC to treat minor illness and minor injury in children is discussed in paragraphs 4.27 – 4.29. Currently there is no final decision on whether the service will open 24 hours a day or 12 hours a day.

4.11 In our earlier advice our main concern was the availability of staff to run the UTC and although we very much support the proposal to replace the A&E with a UTC, the ability to staff the unit and maintain the staff skills, remains our key concern. You do acknowledge that this proposal is entirely dependent upon securing a sustainable primary care workforce, particularly influencing whether the UTC is led by an on-site GP, but we do not have a sense of how achievable the UTC model is both now and in the longer term. It would be helpful to understand whether there have been problems with local GPs staffing the new extended access hubs where required, in the same way as the GP Out of Hours (OOH), and if there are regular/long-term unfilled vacancies in practices. We are also not clear if local GPs have been sounded out as part of the consultation prior to and since the implementation of the temporary change to the service in March.

4.12 Given the staffing constraints it may not be achievable to deliver a 24-hour service and we agree that the UTC would be more resilient when other clinicians and services are available on site to call upon for support or advice. You may also wish to consider that if the UTC is open 24 hours a day but only has some primary care workforce input during the GP OOH period, then this is likely to cause confusion for patients and for primary and community care services who are signposting patients. It is important to try and keep things consistent in terms of conditions managed and those redirected. This confusion may be further exacerbated by the extended access hubs if there is further inconsistency.

4.13 We welcome that you are looking at innovative approaches to develop and grow your primary care workforce but there is little discussion about the non-GP primary care workforce, apart from when talking about the extended access hubs. Opportunities for a blended model including Advanced Nurse Practitioners, Clinical Pharmacists or other Advanced Clinical Practitioners or Physician Associates with specific primary care training and experience, might be being missed by focussing only on Emergency Nurse Practitioners and GPs. For example, Yorkshire Ambulance Service NHS Trust (YAS) plays a role beyond transport in terms of their paramedics contributing to the clinical care to avoid unnecessary hospital attendances or

admissions. There is a small team in Northallerton who undertake home visits on behalf of the 2 GP surgeries in the town, during the day and on behalf of GP Out of Hours at night. There is potentially more scope for the development of these practitioners into the ACP roles that can integrate more with the community and/or hospital workforce to provide some innovative solutions. It is also important to note that the newly emerging Primary Care Networks (PCNs) offer exciting new opportunities around integration with primary care but with the new roles they bring this also creates risks of increased competition for the same existing workforce.

Recommendation: To provide greater clarity on how you will secure the primary care workforce to staff the UTC with skilled and experienced practitioners.

4.14 We welcome the confirmation that you have commissioned additional ambulance resource 24/7 to compensate for the potential that ambulances will be more likely to be out of area with patients at neighbouring A&Es. This will ensure the continued ability of the ambulance service to respond to 999 calls.

Acute Medicine

4.15 Prior to your temporary changes, acute medicine admissions were accepted at the Friarage Hospital from A&E, via GP urgent referral to the Clinical Decisions Unit (CDU) or ward or via ambulance conveyance to the CDU between 8am to 9pm or in agreement with the medical registrar between 9pm and 8am. Patients who became unwell could be escalated to critical care and surgical emergencies accepted and handed over to the on call surgical team.

4.16 The model you are proposing is that admissions would be accepted in the following circumstances:

In Hours:

- 8.30am -6.30pm Weekdays
- 8.30am -4.30pm Weekends and Bank Holidays
- All admissions will be triaged by a senior clinician prior to conveyance and will be accepted to Ambulatory Care or Clinical Decisions Unit. The Friarage Hospital inpatients that become unwell unexpectedly will be transferred to JCUH by ambulance. The pathway for all patients requiring emergency surgery or critical care will be to JCUH 24/7

Out of Hours:

- 6.30pm-8.30am Weekdays
- 4.30pm -8.30am Weekends and Bank Holidays
- The pathway for all patients requiring admission during these hours is to JCUH. The Friarage Hospital inpatients that become unwell unexpectedly will be transferred to JCUH. Patients will be repatriated from JCUH at the earliest opportunity (if unable to go directly home) with community support. There will be a consultant-delivered service to ensure that all patients admitted or staying on the Friarage Hospital site overnight can be safely managed

4.17 We previously questioned the level of "safe" medical admissions, considering the facilities and staff to care for the patient safely out of hours after 9pm. We understand that your service model is designed to give senior decision-making early in the patient pathway and you have confirmed that there will be daily Consultant review (early evening) of all patients on site to ensure that all are safe and appropriate to continue to receive their care and treatment at the Friarage Hospital. All elective surgical patients will have been risk stratified based on the procedure and any potential co-morbidities and deemed low-risk. For acute admissions the consultant-led decision-making will consider the clinical assessment using NEWS2, the initial differential diagnoses and likely prognosis.

4.18 With this model, however, there is always the risk that a patient may deteriorate and need urgent airway protection and ventilation which is not going to be available on site after 9pm. Commissioners need to acknowledge that the risk of a patient deteriorating out of hours will remain whatever mitigating measures are put in place. You have confirmed that Standard Operating Procedures (SOPs), staffing and training will be put in place to manage these circumstances, regardless of the expected low frequency of occurrence. Within the detail you have provided, we note that you will have SOPs to detail the procedure for emergency transfer for patients requiring critical care. We also note that the Friarage Hospital will maintain a Cardiac Arrest Response Team compliant with Resuscitation Council Standards for an acute hospital, including Advanced Life Support skills and the ability to deploy an airway. This will be followed up with a Priority 1 response by the ambulance service to transfer the patient.

4.19 We are considerably more assured on your acute medical service model, but queries remain on the following two points:

a) We note that there is a difference between the opening hours of the Urgent Treatment Centre and the acceptance of emergency medical admissions and we question what happens with patients who require emergency medical admission between 6.30pm and 8pm (in your 12-hour UTC model) and we advise further thought on whether the UTC hours should be synchronised with the hours of emergency medical admissions. (Please also note that there is an overlap between the hours of operation of your weekday in hours and weekday out of hours service which we assume to be a mistake (p31))
b) You have stated that the overnight team will all be Advanced Life Support (ALS) trained but the proposals do not describe the out of hours team in more detail. As you propose a selected acute medical model their skills and competencies are essential to mitigating the risks to the patients overnight. The composition of that team needs to be clarified in your proposals. In paragraph 4.25 we recommend that you work with Health Education England (HEE) on the development of this team.

Surgical Services

4.20 The current model of service at the Friarage Hospital provides planned surgery including major colorectal surgery, unplanned admissions (following planned surgery) to critical care or HDU can be accommodated, and emergency surgery is undertaken on site 24/7 with support from critical care and HDU as clinically necessary. A three-tier surgical staffing model is in place with on-call registrar and on-call consultant 24/7.

4.21 In your proposed model you will provide a planned elective day case and short-stay inpatient surgery programme including orthopaedics. Patients undergoing surgery at JCUH will be repatriated to the Friarage Hospital when clinically appropriate in line with the principle of care closer to home. No emergency surgery will take place at the Friarage Hospital (patients will be referred to JCUH or other receiving hospital). Patients with a high anaesthetic risk and those undergoing higher-risk surgical procedures will not be suitable for the proposed service at the Friarage Hospital. Patients who present as medical admissions who may require surgery will be reviewed daily by the attending Consultant Surgeon and transferred to JCUH for surgery if needed.

4.22 With the early proposals, we questioned the complexity of surgical procedures which you propose continuing at the Friarage Hospital, a non-emergency site. We are assured by your response however, regarding the individual selection of ASA grade 3 patients and that at the outset no inpatients will be accepted for surgery if they are ASA3 until all protocols are fully tested. We are pleased with your confirmation that major colorectal surgery, and some other procedures such as some aspects of thoracic surgery, will not be undertaken at the Friarage Hospital (regardless of ASA status of the patient) due to the nature and risks of the surgery.

4.23 We note that the theatre capacity released would be utilised by bringing theatre lists from JCUH, which are within the clinical scope of the new model, resulting in no net loss of theatre capacity.

4.24 In our previous report we questioned how you will provide the specialist consultant input to the Friarage Hospital site and you have confirmed that specialty opinion is accessed via the on-call system, and some specialities will have a presence during weekday working hours e.g. gastroenterology, and when there is elective activity ongoing e.g. urology, ophthalmology, orthopaedics. We have no further comment on this.

4.25 We also previously questioned how you will ensure that trainee doctors on the Friarage Hospital site have explicit supervision and clear pathways to escalate care 24/7. We welcome that you are working with colleagues in HEE on the model and the Senate assurance of the trainee doctor model will be dependent upon HEEs endorsement of your proposals. We recommend that you clearly describe your Standard Operating Procedures with the HEE regional office and the Postgraduate Dean, particularly with regard to Hospital at Night, out of hours supervision and your non-invasive ventilation proposals (the latter discussed in paragraph 4.36- 4.37)

4.26 With regards to repatriation, you have confirmed that patients will be repatriated to the Friarage Hospital if their total length of stay is expected to be more than 48 hours. This will both enable care closer to home and enable the patient to be 'pulled' into locality care pathways for discharge and frailty services. Our concerns related to the assessment of the appropriateness of the repatriation to ensure the right balance between offering care closer to home and the clinical risk to the patient. You have confirmed that the patient will be reviewed by a consultant before they are deemed suitable for ward level care at the Friarage Hospital and we have no further comment on this issue.

Recommendation: To ensure you have approval from HEE for your proposals for Hospital at Night, out of hours supervision and your non-invasive ventilation model

Paediatric Services

4.27 You state in your consultation document that Maternity and Children's Services are out of scope of this change programme, but we consider this to be a misleading statement as there is a significant change to paediatric services. Under these proposals your new model will offer a Minor Illness Service for children (under 18) at the Friarage Hospital site and this will be a core service provided by the Urgent Treatment Centre. Currently, paediatric minor illness patients travel to either Darlington or James Cook hospitals for their treatment. Your statement about children's services being out of scope therefore needs to be amended in your document.

4.28 With regards to this extension to the service, you state that the Short Stay Paediatric Assessment Unit (SSPAU) will remain and that the Urgent Treatment Centre (UTC) will offer an additional option for the public to access for paediatric illnesses and paediatric primary care ailments. The National Directory of Services Profile will apply to direct patients to the most appropriate service. You state that the minimum standards for paediatric clinical skills and training will be met.

4.29 These proposals remain a concern to the Senate. Extending the service to minor illness does bring risks especially those associated with children presenting with what appears to be and is considered initially to be a minor illness but in fact is the early stage of a major illness (e.g. the child presenting with meningitis). As yet we are not assured that those risks have been adequately mitigated. With this model, parents will find it difficult to know when to access the SSPAU or the UTC or to assess what fits into a minor illness category and is appropriate for the Friarage Hospital site. This will inevitably result in children with more severe illnesses presenting at the Friarage. The standards that you have stated that you will meet are only the minimum recommended standards and we would like to have more assurance about the ability of staff to recognise and manage the sick child. Protocols need to be fully established to manage the presentation of the severely ill child at the Friarage Hospital and ensure their immediate assessment and transfer to JCUH.

Recommendation: To provide further assurance on the staff training and protocols that will underpin your proposal to extend the paediatric service to minor illness.

4.30 With regards to ensuring an appropriate environment for children, you have stated that you will ensure that environments are fit for purpose and meet the Royal College of Paediatrics and Child Health standards 2018. We note that the dedicated paediatric area of the current Emergency Department will become part of the UTC footprint.

Elderly Care

4.31 Our earlier advice raised questions about how you will provide a Comprehensive Geriatric Assessment (CGA) to patients at the Friarage Hospital. A CGA is essentially provided by a geriatrician (or occasionally another healthcare professional which could include a physician or GP with the skills for caring for older people) supported by a team which includes physiotherapy, occupational therapy, nursing staff, social work support, mental health support, dieticians and speech and language therapy. We are not clear if these are available at the Friarage Hospital.

4.32 The Senate was also concerned that arbitrary decisions based on patient's age would ultimately ration patient care. For example, those 85+ or those with a DNACPR would automatically not be considered for transfer to JCUH. However, in discussion, you have described how all acute admissions will be discussed with a Consultant and an individual holistic decision would be made as to whether the patient would best be cared for at the Friarage Hospital or JCUH. Whilst this approach offers assurance, we would stress that there should not be a protocol which would risk any arbitrary decisions pertaining to the care of those 85+ or with a DNACPR and that the individualised holistic approach is maintained.

4.33 We note that improved forward planning of elderly care is an issue that you are trying to address in conjunction with primary and community care colleagues and we welcome the information you have included in section 2 of your document. There are many good initiatives within your community transformation programme including the development of your integrated multi professional teams, Step Up/Step Down beds, your care plans for severely frail patients, the Integrated Care Homes initiative and the Discharge to Assess model. Whilst we welcome confirmation that you are developing a new pathway for people approaching end of life, a description of the local palliative care structure and your strategy would be helpful.

4.34 We also previously raised questions about whether there is adequate capacity in care homes locally to accommodate patients. Care services in patients' homes and care home capacity are vital to ensuring patient flow from A&E and through the wards to discharge. Whilst every Trust should monitor this; given the current change in configuration your services are now at increased vulnerability to downstream flow constraints. This heightens the need to ensure that there is resilience in the system. This issue remains a concern and you acknowledge in discussion that frailty and social care resources remains challenging. Strengthening services to provide care closer to home is integral to the success of your acute model and this community model needs to be developed in partnership with your proposed hospital services.

Mental Health

4.35 Mental health services receive very little mention within your proposals and our earlier advice questioned how you will work with your mental health provider and how patients attending the UTC will be linked into mental health services, if required. You have confirmed that crisis resolution and acute liaison services are present on site and will respond as required and that the UTC will work closely with the social care emergency duty team.

Non-Invasive Ventilation

4.36 Your model proposes that clinical assessment using NEWS 2 scores will be used to triage patients as part of the decision whether to admit to or bypass the Friarage Hospital; a score of 6 or more for patients in general will lead to bypass of the Friarage Hospital, except for chronic obstructive pulmonary disease (COPD) where the threshold for bypass will be 9 or more. The documentation makes no specific mention of the provision for acute non-invasive ventilation (NIV) for acute exacerbations of COPD, or facilities to deliver this. In discussion, you have confirmed that NIV will be delivered at the Friarage Hospital for COPD patients cared for at ward level. This issue was raised in our previous advice and remains a concern to the Senate. We have provided to you a separate paper on this which provides much greater detail on this important issue.

4.37 In summary, our concerns are that the NEWS2 threshold for decision making is arbitrary and that your proposals for the delivery of NIV are not in accordance with the national guidelines, that NIV is delivered in a designated area with enhanced staff training and staff ratios, with adequate equipment and specialist supervision. We are also clear that for those patients who have the presence of a DNACPR this should not result in them being withheld efficacious and potentially life prolonging treatment. Your proposals in this area need further discussion. Please also reference our recommendation (paragraph 4.25) that you clearly describe your Standard Operating Procedures on NIV with the HEE Regional office and the Postgraduate Dean.

Maintaining Staff Skills and Engaging with Staff

4.38 Thank you for your response to our questions regarding how staff will be able to maintain their skills and training and how you will keep the Friarage Hospital as an attractive place to work. You have confirmed that many staff already rotate or have job plans spanning the Friarage Hospital and JCUH, including the future UTC workforce, Consultant Physicians and surgeons, Critical Care Nurses and theatre staff. In the future workforce model, there will be a specific programme of rotation to JCUH for Emergency Nurse Practitioners and that education opportunities such as the Masters level apprenticeship in Advanced Clinical Practice will continue to be accessed by Friarage Hospital staff. Partnerships with Hull & York Medical School and Imperial College London Medical School have also recently been announced.

4.39 You have also confirmed that research, teaching and learning are an important part of the strategy for the Friarage Hospital. This includes the development of the academic centre. We understand that one of the strategic aims of the Sir Robert Ogden Macmillan Centre is to promote research and clinical trials in cancer services, and this is already beginning to be delivered.

4.40 We also questioned the staff feelings and attitudes towards the change and how you will work with the staff to address their concerns. We agree that a confirmed model will make staff feel more secure. We note that a significant number of clinical personnel were involved in the development of the model. Since February 2019 when the need to make an urgent temporary change was agreed, the preferred clinical model has been briefed to all staff in various forums and media, including feedback and learning from its implementation. It is vital to ensure that staff feel engaged and involved and have the opportunity to discuss the model with you. A thin slice of committed staff will not be enough to carry through this level of change and you need broad organisational engagement. We encourage the Trust to look at how they can support and engage with staff comprehensively.

Recommendation: to develop a comprehensive consultation process with staff to develop broad organisational engagement on your proposals.

Consultation with the Public

4.41 With regard to the consultation document, it presents the story of the consultation to date and how it has influenced the proposal very well. Commissioners may wish to think about how to focus with the public on the key messages about the changing demographic, increasing life expectancy and how much medicine has changed, against the increasing specialisation of staff and the backdrop of national staff shortages across many clinical areas. There is a very coherent message to give on the pressures that have led to this proposed change and these messages can be provided alongside the reassurance that for most patients their local care will remain unchanged.

5. Summary and Conclusions

5.1 The Senate is supportive of the proposed clinical model which we agree is a step in the right direction towards providing a sustainable future for services at the Friarage Hospital. We very much commend the innovation in this model which looks to sustain an acute hospital model that does not rely on 24/7 resident anaesthetic cover. Whilst we support the decision to move critical care from the Friarage Hospital site and to replace the A&E with a UTC, not all of our concerns regarding the implications of this move have been met.

5.2 Whilst this model alleviates some of the staffing pressures, your ability to recruit and maintain the workforce remains the key concern to the Senate and is the key risk to the sustainability of your proposal. The workforce challenges remain particularly in

anaesthesia, critical care, for the selected acute hospital model and in primary care staffing.

5.3 Our other recommendations are regarding the out of hours staffing model, your Hospital at Night Team and your non-invasive ventilation model which we recommend need to be approved by Health Education England. We also recommend further work on the staff training and protocols that will underpin your proposal to extend the paediatric service to minor illness and to be clear with the public that this extension of the paediatric service is a significant change. Finally, we wish you well in developing a comprehensive consultation process with staff to ensure you secure broad organisational support for your proposals.

APPENDICES

Appendix 1

LIST OF INDEPENDENT CLINICAL REVIEW PANEL MEMBERS

Name	Job Title
Chris Welsh	Yorkshire and the Humber Senate Chair
Sewa Singh	Medical Director, Doncaster and Bassetlaw NHS Foundation Trust
Jeff Perring	Senate Vice Chair, Consultant Intensivist and Deputy Medical Director, Sheffield Children's Hospital NHS FT
Nabeel Alsindi	GP and Clinical Lead Doncaster CCG
Rob Ghosh	Consultant Physician & Clinical Director - Geriatric & Stroke Medicine, Sheffield Teaching Hospitals NHS FT
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
Sue Cash	Lay Member

No declarations of interest were made by panel members.

Appendix 2

ITINERARY FOR THE SITE VISIT ON 8TH FEBRUARY 2018

NHS
Hambleton, Richmondshire and Whitby
Clinical Commissioning Group

Agenda

Session to run from 10am -4pm at the Friarage Hospital, Northallerton:

- 9.30am – Panel to be collected from Northallerton train station / arrive at CCG offices & be conveyed to the Friarage Hospital
- 9.30am – 10am – Introductions, tea & coffee
- 10am – 10:45am – Panel discussion with Adrian Clements – Medical Director for Urgent and Emergency Care, South Tees Hospitals NHS Foundation Trust and management team
- 10:45am – 12pm – Panel site tour with Adrian Clements and discussion with clinical teams (Emergency Dept; Clinical Decisions Unit/Acute Medicine; Theatres/Anaesthesia & Critical Care)
- 12pm – 12.45pm – Panel discussion with North Yorkshire County Council representative/s
- 12.45pm -1.45pm – Lunch break & informal discussion with senior representatives of partner organisations
- 1.45pm – 2.30pm – Panel discussion with CCG lay members – Linda Lloyd and Jane Ritchie
- 2.30pm – 3.15pm - Panel discussion with GPs – Drs Jacquie Moon, Gina Jackson, Duncan Rogers
- 3.15pm – 4pm – Panel discussion & wrap up with CCG senior management team – Dr Charles Parker – Clinical Chair, Dr George Campbell – GP member, Lisa Pope - Deputy Chief Operating Officer
- 4pm – Panel to be conveyed back to CCG offices / Northallerton train station

Appendix 3

EARLY ADVICE ISSUED 1ST FEBRUARY 2019

Our Ref:
Your Ref:

Oak House
Moorhead Way
Bramley
Rotherham
S66 1YY
Chris.welsh@nhs.net

Via email to:

1st February 2019

Amanda Bloor
Accountable Officer
Hambleton, Richmond and Whitby CCG

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)?

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.

1.

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.

2.

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

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

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.

4. 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.

5. 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.

6. What is not clear from the model is whether the Consultant Anaesthetist on site at the Friarage is providing anaesthetics 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.

7. 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

8. 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.

9. 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.

10. 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

11. 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

12. 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.

13. 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.

14. 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.

15. 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.

16. 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

17. 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.

18. 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.

19. 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

20. 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.

21. 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.

22. 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.

23. 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

24. 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

25. 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

26. 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.

27. 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.

28. 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)

Cc: Gill Collinson, Chief Nurse
Lisa Pope, Deputy Chief Operating Officer

Appendix 4

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: Lisa Pope, Deputy Chief Operating Officer at Hambleton, Richmond and Whitby CCG and Joanne Poole. Senate Manager for Yorkshire and the Humber Clinical Senate

Date: 11th June 2019

1. CLINICAL REVIEW TEAM MEMBERS

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

Citizen Representative: Sue Cash

Clinical Senate Review Team Members:

Name	Job Title
Chris Welsh	Yorkshire and the Humber Senate Chair
Sewa Singh	Medical Director, Doncaster and Bassetlaw NHS Foundation Trust
Jeff Perring	Senate Vice Chair, Consultant Intensivist and Deputy Medical Director, Sheffield Children's Hospital NHS FT
Nabeel Alsindi	GP and Clinical Lead Doncaster CCG
Rob Ghosh	Consultant Physician & Clinical Director - Geriatric & Stroke Medicine, Sheffield Teaching Hospitals NHS FT
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
Sue Cash	Lay Member

2. AIMS AND OBJECTIVES OF THE REVIEW

Question: Assessing the proposed clinical model against the core tenants of clinical effectiveness, patient safety and patient experience – does the panel think that our proposals will provide a sustainable future for the Friarage Hospital?

Objectives of the clinical review (from the information provided by the commissioning sponsor): To assess the clinical effectiveness of the proposed clinical model as part of the formal assurance of the clinical model prior to the public consultation.

Scope of the review: The Clinical Senate will focus their review on the above question considering the information provided in the documentation supplied by the CCG and supplemented with information provided during the informal advisory stage including our previous site visit and subsequent discussions.

3. TIMELINE AND KEY PROCESSES

Agree the Terms of Reference: mid-June 2019

Receive the evidence and distribute to review team:

Following evidence received 20th May and distributed 5th June 2019.

- The Friarage Hospital Consultation Document and appendices

(Note that the draft consultation document (without appendices) was received on 13th May and distributed on 15th May). A full list of the evidence is in section 5.

Teleconferences: scheduled to be held between the 12th and 21st June 2019

Presentation to Senate Council: 21st May. Draft consultation document (without appendices) was distributed to the Council on 14th May 2019.

Draft report submitted to commissioners: end June 2019

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

Senate Council ratification; Ratify at 17th July 2019 meeting or by email if required earlier

Final report agreed: following ratification at the Senate Council meeting on 17th July 2019

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

- The Friarage Hospital Consultation Document 200519 and appendices
- The presentation to the Senate Council 21st May 2019
- The response to the YH Senate letter 13th May 2019

The review team will review the evidence within these documents and supplement their understanding with a clinical discussion and also take into account:

- their knowledge gained from the site visit to the Friarage Hospital in February 2018
- the discussions and evidence provided for the informal advice finalised in February 2019
- the presentation to the Senate Council by the CCG in May 2019
- the responses to the questions raised in the Senate letter of February 2019. This response was received 15th May 2019.

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. provide feedback to the Senate on the impact of their advice
iv. undertake not to attempt to unduly influence any members of the clinical review team during the review.
v. submit the final report to NHS England for inclusion in its formal service change assurance process if applicable

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 review considered the following key evidence

- The Friarage Hospital Consultation Document 200519 and appendices
- The presentation to the Senate Council 21st May 2019
- The response to the YH Senate letter 13th May 2019

The clinical review panel supplemented their understanding with:

- Their knowledge gained from the site visit to the Friarage Hospital in February 2018
- The discussions and evidence provided for the informal advice finalised in February 2019