NHS
Yorkshire and the Humber
Clinical Senate

Free and full independent and impartial clinical advice

Clinical Senate Review

Of the Bassetlaw Children's Urgent and Emergency Services at Doncaster and Bassetlaw Teaching Hospitals NHS Trust on behalf of Bassetlaw CCG

VERSION 1.0

March 2022

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

Document Version	Date	Comments	Drafted by
Draft Summary	December 2021	Initial draft report incorporating Expert Panel comments	J Unwin
Draft Summary v0.2	December 2021	Revision of draft report following feedback from panel members	J Unwin
Draft Summary v0.3	December 2021	Revision of draft report following feedback from panel members	J Unwin
Final Draft 0.1	January 2022	Inclusion of Chair's foreword comments	J Unwin
Version 1.0	March 2022	Report ratified by Y&H Senate Council	J Unwin

1. Chair's Foreword

In September 2021, the Yorkshire and Humber Clinical Senate was approached by members of the senior leadership team of Doncaster and Bassetlaw Teaching Hospitals NHS Trust (with the support of its local clinical commissioning group) who sought independent clinical advice and support as part of the development of their Bassetlaw Emergency Village programme.

The Clinical Senate was asked to review the options for delivering children's emergency care from the Bassetlaw hospital site in light of financial support for a capital development. The Trust believes that the capital development affords it an opportunity to revisit the current models of care for children requiring overnight observation and care that had been put in place in 2017, due to challenges with nursing staff availability overnight.

To provide the best support to the programme team we identified clinical experts across the range of paediatric services who could provide advice and challenge to each of the service options being developed, to provide reassurance that the models were evidenced based, best practice, safe and sustainable and fit for the communities that the Trust serves. Importantly, we could then also give a view on the likely ability of these individual options to improve health inequalities in the local area.

This report summarises our findings following a review of the plans and discussions with local clinicians and other health professionals both within Doncaster and Bassetlaw Teaching Hospitals NHS Trust and from some of the commissioners that they work with.

In reaching our conclusions and recommendations the Senate's main considerations were in relation to the increasing population of children due to house building for families in the locality and thus an increasing demand for paediatric services from the local population. We also considered the geographical distance between Bassetlaw and other hospitals especially in the context of low car ownership amongst the local population.

The proposed and preferred plan offers safe care closer to home and allows for closer ties to primary care and social care services to be developed, which we would encourage. We did however have some concerns around workforce planning, especially in relation to medical and nursing staff recruitment and retention. The Trust is urged to consider implementing advanced nurse practitioner and physician associate roles to address any potential shortfalls in workforce in the future.

I would like to sincerely thank the programme team and clinical staff for their work and contributions which culminated in the virtual review on 16 December 2021. The Clinical Senate appreciated the opportunity to review the models of care in development at the Bassetlaw site, to virtually visit the current and future footprint of the paediatric emergency department and assessment unit and to speak with dedicated and engaged clinicians. We wish you well with the next steps in the Bassetlaw Emergency Village programme.

Mr Kirtik Patel

2. Introduction

The Yorkshire and Humber Senate was approached in September 2021 by Doncaster and Bassetlaw Teaching Hospitals NHS Trust and Bassetlaw CCG, to review the options for delivering urgent and emergency care to the children of Bassetlaw and surrounding areas in light of a capital investment to develop a Bassetlaw Emergency Village.

Specifically, the Clinical Senate was asked to:

1. To assess the appropriateness of the clinical evidence base and national guidance used to develop the proposed models of care (and rule out those deemed not to be suitable for implementation)
2. To give an independent view on the extent to which the proposed models (and preferred model) are likely to be:
    - sustainable
    - in line with the drivers for change
    - able to meet demand for the emergency and urgent paediatric services
    - appropriately resourced in the context of current workforce challenges
    - appropriately resourced in the context of likely future workforce availability
3. To assess the proposed models of care and the alignment of other interdependent services required to make the model effective and safe
4. To test the robustness of the risk assessment associated with the proposed models and the appropriateness of any mitigations identified
5. To provide any additional information or suggestions that the programme may find helpful in improving the quality of the proposed models or would aid effective implementation once a decision is made.
6. To assess the ability of the new models of care to reduce the health inequalities of the population.

2.1 Process of the Review

To carry out this review, the Senate formed an independent expert clinical panel from the Yorkshire and Humber and North of England Clinical Senate Council and Assemblies as well as known subject matter experts.

The supporting information (outlined in Appendix 5) was provided by the CCG on the 01 December 2021 and a pre-panel meeting was organised for 07 December 2021. All panel members were invited to attend to contribute early thoughts on the information that had been received. A request for additional information arose from the pre-panel meeting and this was provided to the panel members on 10 and 13 December 2021.

The full review session took place virtually via Microsoft Teams on 16 December 2021. A virtual review was conducted in view of the current COVID infection rates and national guidance.

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 December 2021 where the panel discussed the findings and gave draft recommendations.

The report was drafted during the final weeks of December and early January 2022 and was provided to the Senate panel for additional comments and factual accuracy on 14 January 2022.

3. Overview of the in-scope services

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTH) serves a population of more than 420,000 across South Yorkshire, North Nottinghamshire and the surrounding areas from 3 main sites, Doncaster Royal Infirmary (Doncaster), Bassetlaw Hospital (Worksop) and Montague Hospital (Mexborough). The Trust employs over 6000 members of staff overall.

Bassetlaw Hospital is an acute hospital with over 170 beds, a 24-hour Emergency Department (ED) for adults and children and a full range of hospital services.
The provision of children's urgent and emergency care at Bassetlaw Hospital includes a paediatric area within the ED, a ten bedded Children's Assessment Unit (CAU) which accepts referrals from primary and secondary care until 7pm and remains open until 9pm.

All children requiring overnight care (including observation) are transferred to Doncaster Royal Infirmary.

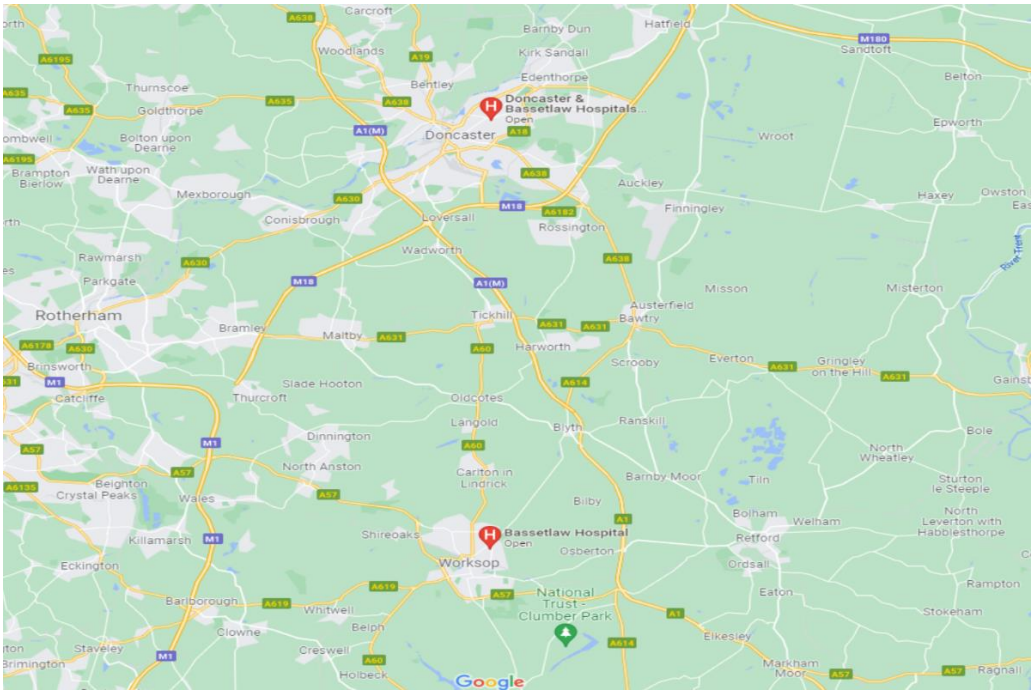
Demand for services is as follows:

Bassetlaw	2015	2016	2017	2018	2019	2020	2021*	Total
Paediatric ED attendances	9206	9913	8858	9082	10091	6834	7207	61191

*data are from 1 April 2021 to 30 September 2021.

Children's Assessment Unit (CAU)	Non Elective	Day case	Elective
Monthly demand prior to 2017	204	13	6
Monthly demand post 2017	126	8	7

The main CCG commissioners are Bassetlaw CCG.



4. Temporary Changes to Service Provision at Bassetlaw Hospital 2017 – current.

In January 2017, temporary changes were made to the inpatient (ward) provision for children at Bassetlaw Hospital. The changes meant that the overnight children's inpatient service was temporarily transferred to Doncaster Royal Infirmary (DRI) because there weren't enough nurses with the specialist skills in children's nursing to cover both the ED and to provide care on the ward (which is not located near the ED).

The number of paediatric nurses available within the A&E department (as required by Royal College of Paediatrics and Child Health Recommendations (April 2018)) was specifically highlighted in the December 2018 Care Quality Commission (CQC) inspection which rated DBTH as 'Requires Improvement' overall.

The temporary model meant that the ward changed from a 14 bedded inpatient and day case ward with ambulatory area, to a 10 bedded CAU, open until 9pm and only accepting referrals until 7pm. All children requiring overnight care (including observation) are transferred to DRI, a 20-mile journey which on average is a 35–40 minute drive. If patients are assessed as being well enough, they can travel in the family's own transport if available, if not, transport is provided.

After overnight services were temporarily transferred to DRI a subsequent CQC inspection in February 2020 rated the overall assessment as "Good".

5. Bassetlaw Emergency Village Development

DBTH has received support to create an 'emergency village' at Bassetlaw Hospital. The development will increase the size of the ED which the Trust believe will provide it with an opportunity to confirm the future model of urgent and emergency children's services at Bassetlaw Hospital since the temporary closure of overnight children's inpatient services.

The Senate was asked to give an independent view on the plans for the 'emergency village' to ensure that they are underpinned by clear clinical evidence and align with clinical guidance and best practice, in line with NHS England's guidance on service change[1].

The Senate was presented with three possible models of future service delivery to review within the parameters of the terms of reference:

- **Option 1**- Confirm current temporary arrangement as permanent. The existing CAU stays where it is (not near the Emergency Department) and opens at 8am and closes at 9pm each evening with no further admissions from 7pm and patients requiring overnight stay are transferred to the Doncaster Royal Infirmary site from 4pm.
- **Option 2** – A dedicated CAU is built next to the Emergency Department but still operates the same opening and closing hours as option 1. This allows for better use of specialist children's nurses.
- **Option 3** – A dedicated CAU is built next to the Emergency Department, which will open at 8am and allow children to remain on Bassetlaw Hospital site when they require a short stay for observation, which can be overnight. Children needing more specialist care or surgery who require a longer length of stay will continue to be transferred to the Doncaster Royal Infirmary site. This allows for better use of specialist children's nurses and means children who require a short stay would be cared for at Bassetlaw overnight.

6. Clinical Senate Review - Findings

On the review of the information provided by the Trust and in the discussion with staff in the panel session, the Clinical Senate sets out the following observations in regard to the options.

6.1 Option 1 - confirm current temporary arrangement as permanent

The panel found that Option 1 is not in line with the drivers for change in relation to the intention to be able to provide care closer to home for the local population nor in relation to being able to meet the demand for anticipated increases in paediatric urgent services.

[1] https://www.england.nhs.uk/wp-content/uploads/2018/03/planning-assuring-delivering-service-change-v6-1.pdf

The panel heard how there have been occasions where children have experienced lengthier stays in ED while waiting transfers to DRI due to the lack of capacity/resources in the CAU. This provides a lesser quality experience for the patients and families now which would be exacerbated over time as demand increases.

The Senate panel also heard information about the low level (40%) of private car ownership in the local population and, in the context of the distance patients and families need to travel to DRI for an extended or overnight stay, it was felt that this option would not reduce the local health inequalities.

Option 1 maintains additional cost to the health care system associated with patient transfers to DRI for short stays, which is funding that could be reinvested into local healthcare provision. As such it calls into question the sustainability of this way of working.

The Senate panel heard about the difficulties the Trust encounters when trying to recruit paediatric nursing staff, which many units of a similar size face, and Option 1 would not address those difficulties which would lead, in time, to an unsustainable position when current staff members retire.

The panel were unsure about the sustainability of paediatric middle grade staffing. The panel wondered if the middle grades would be able to maintain their paediatric expertise in ED if they are not getting sufficient or broad enough paediatric experience.

The panel were concerned to hear that whilst there is currently a dedicated ambulance transfer service for patient transfers from Bassetlaw to DRI, changes to this were possible from next year, making this option unsustainable and potentially unsafe.

6.2 Option 2 - Dedicated CAU on limited hours co-located to ED

The Senate panel agreed that a new build which allowed co-location of the Paediatric ED and CAU, with the same opening and closing times as currently, could provide an operational benefit by being able to use the paediatric staff across the full urgent and emergency care footprint.

However, this option would not address the requirement to reduce health inequalities as patients would still need to be transferred to DRI for short stays. This option would neither address the need to increase capacity to be able to respond to increasing demand for urgent care services or deliver a sustainable service.

The Senate heard from the Trust that having a new build and co-located paediatric services would offer an attractive working environment and encourage recruitment and retention of medical and nursing staff. The panel members acknowledged the potential positive impact of a new build but they were unsure to what extent the physical working environment would sufficiently enhance recruitment opportunities across the nursing and medical workforce.

6.3 Option 3 - Dedicated CAU co-located to ED with short stay facilities

The Senate panel members felt that the vision and ambition described in the option to have a new build which allows co-location of paediatric ED and CAU and overnight stays for children that require them, was a good one and the Bassetlaw Emergency Village team is to be commended for it.

Option 3 offers the best solution for the local population. This agreement was arrived at in view of the deprivation of the local population and the health inequalities experienced because of this.

The panel members felt that this model, which would involve primarily dealing with one Children's Services team as opposed to two, would improve the management of non-accidental injury in children.

Option 3 ensures a more comprehensive local health provision for the increasing population of the area and the increasing demands for children's urgent and emergency care which is fully aligned to the case for change.

There are risks associated with this option in relation to the availability of the workforce to ensure safe staffing across the longer opening times and, as per Option 2, the panel were not sufficiently reassured that a new build would offer enough recruitment and retention opportunities. Additional mitigations will be required to ensure there is sufficiently skilled and available workforce to provide the service delivery described in Option 3.

7. Recommendations

It is very clear to the Senate that the Bassetlaw Emergency Village programme team has ambition to provide comprehensive health services to the local population that it serves. This is a notable ambition and the Trust and CCG are to be commended for it. The panel felt that new paediatric facilities adjacent to the ED are essential for the Bassetlaw Hospital site but at this stage it did not hear enough information about plans for workforce development, recruitment and retention in order to be satisfied that the perpetual staffing issues will be resolved.

The panel was concerned about medical staffing, especially the availability of senior experienced clinical decision makers in ED and nurse staffing. We therefore offer up several recommendations relating to this:

- The Senate recommends that the team revisits the development and implementation of new roles within the Trust. Whilst the panel acknowledged the previous difficulties with the introduction of Nurse Practitioners in the Trust, it is encouraged to consider the development of those roles as well as physicians associates in paediatrics which can provide stability and consistency in service provision.

- The Senate members were reassured that there was currently adequate and safe provision of middle grade clinicians on site 24hrs. These included Tier 4 medical staff in ED (APLS, ALS and ATLS trained) and ST4 and above in paediatrics (APLS/EPLS trained) and experienced anaesthetic middle grades (speciality doctors) to cover the wide range of obstetric/neonatal and paediatric emergencies, such as caesarean section and ED attendances of children with meningococcal septicaemia. However, the Senate felt that it would be important if a consultant paediatrician were designated to represent children in the ED, providing onsite support and clinical leadership and decision making to help develop skills in the paediatric urgent care workforce.

- Similarly, the Senate felt that it would be important that a lead for paediatrics be identified from the ED. The two leads would be encouraged to work closely together to develop a common culture, training and governance processes for the paediatric urgent care staff.

- The panel members advise of the need to ensure that there is a rotation of paediatric, ED and anaesthetic middle grade staff between Bassetlaw and DRI for training and team development purposes and for governance purposes.

- There will be a requirement for robust clinical pathways with the development of standard operating procedures to allow clinical governance oversight. Appointing a lead for Bassetlaw paediatrics could allow better leadership to develop these pathways and develop closer links with colleagues in primary care, community paediatrics and social care.

- The annual job planning process would allow an increased commitment to the paediatric urgent care team for learning purposes across all ranks in the nursing workforce and to ensure care of children at a weekend is the same as during the week.

- Alongside the plans for overseas recruitment of nurses the Trust is advised to start building stronger relationships with the local universities that provide medical and nursing training, in particular Lincoln University with its new medical school and school of nursing.

- The team is additionally encouraged to consider the option of a primary care advanced nurse practitioner to work alongside secondary care colleagues within the ED. This would allow skills development and knowledge sharing as well as additional nurse staffing within the department.

- The Senate observed that there will be a need to proactively engage with the staff over the plans for Option 3. Nursing staff leadership will be required to bring the staff on the journey to providing the changing needs of the service especially since they have experienced the impact of a contraction in the service provided previously.

The Senate recommends greater integration with primary care in order to address the high levels of low acuity ED attendances. The panel heard about the proximity of a primary care centre to the ED and this affords an excellent opportunity to develop an effective streaming service (with appropriate IT infra-structure), which would be encouraged.

The paediatric service and ED are also encouraged to work with the wider urgent and emergency care system, so as to adopt appropriate streaming pathways and also develop fully the local directory of services (DOS) profile so that the alternatives to paediatric ED are promoted (where clinically suitable) and before patients arrive at ED.

8. Conclusion

In conclusion the Senate review panel members feel that Option 3 gives DBTH the most sustainable and high quality service model for the future in line with current national standards and guidance. The programme has considered the main clinical interdependencies associated with this model and identified the main risks to implementation and delivery (in particular regards to workforce). The Senate would encourage continued workforce planning to mitigate these risks in line with recommendations set out in section 6. Should the mitigations prove inadequate, and in due course the risks around workforce remain, then the Trust may need to modify the hours of operation of the CAU to reflect the ability to deliver extended opening hours with the workforce available at the time.

Finally, the panel members wish the programme team the best of luck with their plans to develop the Bassetlaw Emergency Village.

APPENDICES

Appendix 1

LIST OF INDEPENDENT CLINICAL REVIEW PANEL MEMBERS

Mr Kirtik Patel – Consultant Upper GI Surgeon & Clinical Senate Vice Chair

Mr Kirtik Patel graduated from the University of Manchester Medical School in 1993, which was followed by early postgraduate basic surgical training in the North West and Yorkshire. This was followed by a period of research culminating in the award of MD from the University of Sheffield. Higher surgical training was completed in South Yorkshire, with entry onto the Specialist Register in 2007. Further training and surgical experience was obtained as a Locum Consultant General Surgeon in Cork, Ireland and Hull, with appointment as Consultant Upper GI and Bariatric Surgeon at Sheffield Teaching Hospitals NHS Foundation Trust in January 2009. Current additional roles include those of Upper GI Cancer MDT Lead and Clinical Lead of Upper GI and Endocrine Surgery. He completed an MSc in Medical Leadership at Sheffield Hallam University and was also a Clinical Lead within the Seamless Surgery service improvement team. He is a Specialist Advisor for CQC and a member of the South Yorkshire and North Derbyshire Cancer Alliance.

Mr Andrew Simpson - Consultant in Emergency and Paediatric Emergency Medicine

I have been a consultant in Emergency and Paediatric Emergency Medicine at North Tees and Hartlepool NHS Foundation Trust for twenty years. I was Clinical Director of Emergency Care between 2006 and 2916 during which time we had a major reconfiguration of service which included the closure of an Accident and Emergency Department. I am a member of the Northern Clinical Senate and a Care Quality Commission Speciality Adviser for Urgent and Emergency Care.

Dr 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.

Dr Rum Thomas – Consultant in Paediatric Intensive Care Medicine

I have been a Consultant in Paediatric Intensive Care at Sheffield Children's NHS Foundation Trust since 2009. My clinical interests include transition from paediatrics to adult critical care and diabetic ketoacidosis and have co-authored national guidelines for both areas of practice.

Am passionate about developing people - all members of the multi-disciplinary team and was Training Programme Director in Paediatrics for many years. I enjoy watching people grow.

I am keen to ensure that children and young people have equitable access to health care in my role as Clinical Lead of the Paediatric Critical Care Operational Delivery Network Yorkshire and the Humber (South).

I was Clinical Lead of the Critical Care Unit at Sheffield Children's in 2020 and was appointed Deputy Medical Director in 2021 and am working on progressing the Trust's Patient Safety and Quality agenda.

I want all our children and young people, their families and our colleagues to have the best possible experiences and opportunities and believe kindness and patience (am working on the latter) is key to happiness and success in the workplace.

Dr Raj Khanna – GP & Emergency Department Consultant

- Consultant Emergency Medicine / Paediatric Emergency Medicine (STSFT)
- GP - Urgent Care Lead (STSFT)
- Regional Clinical Advisor Urgent and Emergency Care NHSE/I (NE&Y)
- Clinical Senate Member – Northern Clinical Senate
- Independent Reconfiguration Panel Member (DHSC)

Helga Charters – Associate Director of Nursing

I started my career in Leeds as an adult trained nurse and then completed further training to qualify as a sick children's nurse. I spent my initial years in nursing as Staff Nurse and then Sister in Leeds before returning home to the North East and the Newcastle upon Tyne Foundation Hospitals Trust

I worked for several years as Patient Services Co-ordinator (bed and site manager) before becoming Matron in Children's Services. During this time, I was fortunate enough to have been very much involved in the commissioning and planning of the Great North Children's Hospital. I held this post for 17years before my current role, Associate Director of Nursing (CYP). Within my current portfolio I oversee the Safeguarding and learning Disability Teams

I have always been passionate about the rights of children and young people and feel very privileged to be in this post which will allow me to support, reinforce and influence positive change to better support, understand and care for children and young people.

Dr Santhi Bethapudi – GP

Dr Geoff Lawson

I qualified from Dundee in 1977 and completed paediatric training in Newcastle and Birmingham before becoming one of three consultants at Sunderland Royal Hospital in 1991, retiring in May 2021. I was Clinical Director of paediatric and neonatal services for 25 years. Over that time, I was able to appoint a total of 26 high quality consultants to provide a comprehensive paediatric service. As a vital part of this I developed a Paediatric Emergency Department from three cubicles to one with a dedicated resuscitation room, high dependency rooms and a short stay assessment unit, staffed by a blend of adult and paediatric emergency medicine consultants, junior medical staff and paediatric emergency nursing staff. It is the only unit in the North East qualified to accept grid trainees in Paediatric Emergency Medicine.

Dr Tim Haywood – Consultant PICU & Anaesthesia

- I am a consultant in Paediatric ICU and Anaesthesia
- ICU service lead for 15 years, with involvement across the region
- Have been involved in major external review process by NHSE and internal remodelling of services and the children's hospital
- Involved in commissioning of new services such as Embrace
- Involved in consultant support and retraining

Appendix 2

PANEL MEMBERS' DECLARATION OF INTERESTS

Dr Rum Thomas, Consultant in Paediatric Intensive Care Medicine, Sheffield Children's NHS Foundation Trust, declared an interest given her role as Clinical Lead for the Paediatric Critical Care Operational Delivery Network in Yorkshire and Humber. The chair of the Senate review panel discussed this with Dr Thomas and the panel and it was agreed that there was no conflict of interest. The review chair felt that it was important that the panel recognise and explore all potential effects of any proposed changes on the network as a whole and any potential beneficial/adverse implications it may have.

The chair of the Yorkshire and Humber Clinical Senate also supported Dr Thomas' involvement with the Senate review.

Appendix 3

ITINERARY FOR THE VIRTUAL VISIT

NHS
Doncaster and Bassetlaw
Teaching Hospitals
NHS Foundation Trust

Clinical Senate Review
Thursday 16th December 2021
Bassetlaw Hospital Site / Microsoft Teams

(Due to COVID restrictions only 15 people are allowed within The Bassetlaw Board Room, this will consist of panel members and SROs/invited participants, all other attendance will be via MS Teams invite)

AGENDA

Item		Time
Welcome and Introductions (Refreshments and Breakfast savouries available)		9:30am
Bassetlaw Emergency Village Overview Presentation	Marie Purdue, Director of Strategy and Improvement	9:40am
Engagement/Consultation plans explained	Emma Shaheen, Head of Communications and Engagement and Clare Ainsley, Strategic Programmes Manager	10:00am
Children's Urgent and Emergency Services Clinical Model Options and Scenarios - Case for Change and Questions and Answers	David Purdue, Chief Nurse and Deputy Chief Executive, Nigel Brooke, Consultant and Andrea Bliss, Divisional Director of Nursing	10:15am
Comfort break		11:15am
Walk round of estate BDGH (current CAU and ED) and Panel Discussion	David Purdue, Chief Nurse and Deputy Chief Executive, Andrea Bliss, Divisional Director of Nursing and Karen Parrott, Senior ED Nurse	11:30am
Panel Discussion/Lunch		1:00 pm
Questions and Answers Session – SROs/Clinical Leads and Senate Panel	All stakeholders via MS Teams and SROs/DBTH Team/Panel	1:45 pm
Comfort break/Panel reflections		2:15 pm
Panel Feedback	Chair of Panel	2:45pm
Thanks and Close	Marie Purdue, Director of Strategy and Improvement	3:00pm

Appendix 4

NHS
Yorkshire and the Humber
Clinical Senate

CLINICAL REVIEW

TERMS OF REFERENCE

Sponsoring Organisation: Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust and Bassetlaw Clinical Commissioning Group.

Terms of reference agreed by: Chris Welsh on behalf of Yorkshire and the Humber Clinical Senate and Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Date: Visit 16.12.21

1. CLINICAL REVIEW TEAM MEMBERS

Clinical Senate Review Chair:
Mr Kirtik Patel

Clinical Senate Review Team Members:
Dr Raj Khanna
Dr Alexandra Hardisty
Dr Andrew Simpson
Dr Tim Haywood
Ms Helga Charters
Dr Rum Thomas
Dr Geoff Lawson
Dr Santhi Bethapudi

2. AIMS AND OBJECTIVES OF THE REVIEW

Aims of the review

Bassetlaw CCG and have developed three options for a sustainable model of care for Urgent and Emergency Paediatric Services at Bassetlaw hospital which includes a provisional preferred option of a dedicated Children's Assessment Unit (CAU) built next to the ED.

Bassetlaw CCG and Doncaster and Bassetlaw Trust believe that the preferred option of a co-located unit will better support children to remain on site at Bassetlaw Hospital for overnight short stay for observation because staffing capacity can be better managed. Children who require a longer length of stay due to their more complex needs will continue to be transferred to the Doncaster Royal Infirmary site.

The Yorkshire & Humber Clinical Senate are therefore asked to consider the suitability of the proposed clinical model to inform the development of the outline business case for the Bassetlaw Emergency Village and confirm that this approach represents a sustainable model for Bassetlaw patients into the future.

Objectives for the clinical review by the Clinical Senate (based on the information provided by the commissioning sponsor)

In order to assess the suitability of the potential options for the new model of care (including in particular the preferred option) the Senate will undertake an independent clinical review with the following objectives:

1. To assess the appropriateness of the clinical evidence base and national guidance used to develop the proposed models of care (and rule out those deemed not to be suitable for implementation)
2. To give an independent view on the extent to which the proposed models (and preferred model) are likely to be:
    a) sustainable
    b) in line with the drivers for change
    c) able to meet demand for the emergency and urgent paediatric services
    d) appropriately resourced in the context of current workforce challenges
    e) appropriately resourced in the context of likely future workforce availability
3. To assess the proposed models of care and the alignment of other interdependent services required to make the model effective and safe
4. To test the robustness of the risk assessment associated with the proposed models and the appropriateness of any mitigations identified
5. To provide any additional information or suggestions that the programme may find helpful in improving the quality of the proposed models or would aid effective implementation once a decision is made.
6. To assess that the new models of care reduce the health inequalities of the population.

Scope of the review

The three options that the senate have been asked to review are:

- **Option 1 (continue current temporary model but recognising this would be on a permanent basis)** – The existing Children's Assessment Unit (CAU) stays where it is (not near the Emergency Department) and closes at 9pm each evening with no further admissions from 7pm and patients requiring overnight stay are transferred to the Doncaster Royal Infirmary site from 4pm.
- **Option 2** – A dedicated Children's Assessment Unit (CAU) is built next to the Emergency Department but still closes at 9pm each evening with no further admissions from 7pm and patients requiring overnight stay are transferred to the Doncaster Royal Infirmary site from 4pm. This allows for better use of specialist children's nurses.
- **Option 3** – A dedicated Children's Assessment Unit (CAU) is built next to the Emergency Department, which will allow children to remain on Bassetlaw Hospital site when they require a short stay for observation, which can be overnight. Children needing more specialist care or surgery who require a longer length of stay will

continue to be transferred to the Doncaster Royal Infirmary site. This allows for better use of specialist children's nurses and means children who require a short stay would be cared for at Bassetlaw overnight.

With each of these options the Children's outpatient department remains on site at Bassetlaw and the outpatient services provided will remain unchanged.
The small number of children's orthopaedic theatre lists (approximately 3 children per week) will also remain.

As such, the following services are **in-scope** of the review:

- Children's Urgent and Emergency Services at Bassetlaw Hospital

The following services are **out-of-scope** of the review:

- Children's services in primary care and the out-of-hours service
- Children's Urgent and Emergency Services at Doncaster Hospital

3. TIMELINE AND KEY PROCESSES

The key steps in the review timeline are as follows:

- Receive the Topic Request form: 01 November 2021
- Agree the Terms of Reference: Mid-November 2021
- Receive the evidence and distribute to review team: Last week in November 2021
- Teleconferences: TBC
- Review visit booked for 16th December 2021.
- 48hr high-level interim initial findings report: 20 December 2021
- Draft report submitted to commissioners: Early January 2022
- Senate Council ratification; Mid-January 2022
- Final report agreed: Mid-January 2022
- Publication of the report on the website: End February 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 organisation 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 case for change and options development

- Activity data
- Relevant Standard Operating Procedures
- Recruitment details
- Availability of the clinical and leadership teams - site visit recommended to view locations
- Workforce models and rotas
- Capital development plans (only Strategic case where clinical model is being assessed)
- Health Inequalities assessments

The review team will review the evidence within these documents 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 sponsoring organisation who will be able to use it as part of NHS England and NHS Improvement assurance processes and made available on the Senate website. Publication will be agreed with the commissioning sponsor.

The publication date will be agreed with the sponsoring organisation during the development of these terms of reference. It is expected that the report will be published soon after its agreement and at the latest 8 weeks followings its sign off by the Council (ie by the next Council meeting following its ratification)

8. EVALUATION

The Senate will ask the sponsoring organisation to contribute to a Case Study to help summarise the work undertaken and assess the impact of the Senate advice. This will be emailed to the named organisational lead following the publication of the report with a request for an evaluation of our impact, a testimonial and suggestions as to how we may improve our processes.

9. 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.

10. 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.

The review report may be used by NHS England and NHS Improvement in their formal service change assurance process.

11. 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 and NHS Improvement for inclusion in its formal service change assurance process if applicable
v. complete the Case Study and request for evaluation issued by the Senate after the publication of the Senate report.

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

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 the draft report
iii. ensure that the report accurately represents the consensus of opinion of the clinical review team
iv. comply with a confidentiality agreement and not discuss the scope of the review nor the content of the draft or final report with anyone not immediately involved in it. Additionally, they will declare, to the chair or lead member of the clinical review team and the clinical senate manager, any conflict of interest prior to the start of the review and /or materialise during the review.

END

Appendix 5

EVIDENCE PROVIDED FOR THE REVIEW

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

Case for Change
CAU Activity data pre 2017 and post 2017
ED activity figures 2015 - 2021
Patient feedback on current service
Engagement and Consultation plan
Equality and Health Inequalities assessment for each option
Patient pathways:

- Attending ED – 0800-1900
- Presenting via ED
- GP and Community referrals

CAU Operational Guidance
Current staffing levels
Workforce models and proposed rotas
Recruitment plans for nursing and medical staff
Data on patient transfers
Video 'walkabout' of current and potential ED and CAU footprint and location