NHS
Yorkshire and the Humber
Clinical Senate

Clinical Senate Review

of

Humber Acute Services

on behalf of

Humber Coast and Vale Health and Care Partnership

Final Version
November 2020

Clinical Senate Reviews are designed to ensure that proposals for large scale change and reconfiguration are sound and evidence-based, in the best interest of patients and will improve the quality, safety and sustainability of care. The recommendations are designed to aid the commissioner to understand the clinical impact of large scale change and reconfiguration and to fulfil their obligation to commission healthcare for their population that meets the 5 domains of the NHS Outcomes Framework.

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1. Chair's Foreword

1.1 Hull University Teaching Hospitals Trust serves a population of 600,000 living in Hull and the East Riding of Yorkshire and the Northern Lincolnshire and Goole Hospitals NHS Foundation Trust serve 450,000 people living across Northern Lincolnshire and the East Riding of Yorkshire. With a population that is older and more deprived than the national average, with 40 minute travel times on average between the main hospital locations and severe workforce challenges across both trusts, there are complex issues to address. What is clear is that quality of care and patient experience needs improvement and that the current range of services delivered across multiple sites is not sustainable in the long term.

1.2 We very much welcomed the opportunity to work with the Humber Coast & Vale Health and Care Partnership, considering how the trusts may provide sustainable acute services and improved outcomes for their local population. I congratulate you on the excellent work you have done in presenting your compelling case for change and developing the range of options to address this. It is evident that you have worked very hard to get to this point and we hope that our early advice to you helps to narrow these options to a workable shortlist. We urge you to keep up the momentum with this work as keeping too many options on the table will paralyse their development.

1.3 We thank colleagues in the Humber Coast & Vale Health and Care Partnership and the trusts for their hospitality during our 1 day site visit in January 2020. Meeting members of the hospital staff and talking to clinicians delivering the services, gave us the opportunity to better understand the geography, the challenges and the proposed solutions.

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

Our key recommendations are:

General Comments

i. To reduce the number of options under consideration as rapidly as possible in order to maintain momentum and allow the development of detailed proposals.

ii. To further consider the challenges of patient movement and choice in this geography and ensure you design services to meet those natural patient flows. This work will need to include discussion with neighbouring services to understand the impact of any restructure.

iii. To work closely with local medical schools to promote more local people to train in medicine.

iv. To prioritise the frailty pathway within your clinical models.

v. To look at solutions as a whole system and focus more on care in the non-hospital settings to support your acute services proposals.

vi. To improve compatibility of IT between the 2 trusts and prioritise digital solutions to support patient care in non-hospital settings.

Urgent and Emergency Care

i. To focus your option development in Northern Lincolnshire to the options of exploring a 2 site model of an acute site and a less acute site.

Maternity Care and Paediatric Care

i. Any proposals to redesign the services which retain either 2 Obstetric Led Units, or a Local Neonatal Unit, in Northern Lincolnshire must include actions that mitigate the concerns highlighted with workforce availability, critically interdependent services and levels of activity.

ii. Any proposals which include a freestanding Midwifery Led Unit in Northern Lincolnshire must demonstrate that the activity will be sufficient to ensure the sustainability of both the MLU and the Northern Lincolnshire neonatal service.

iii. To fully consider the workforce, resuscitation, stabilisation and transfer skills needed to support the paediatric model which will be required for an inpatient paediatric service at one Northern Lincolnshire site.

iv. To develop the community paediatric services to support the hospital-based service

Planned Care

i. To take action ahead of the wider reconfiguration, particularly in ophthalmic surgery, urology and ENT to develop clinical networks working across Hull and East Riding and Northern Lincolnshire to change the way that the workforce delivers care.

3. Background

3.1 The Humber Acute Services Review (HASR) will determine the long-term future of acute hospital services at the five hospitals in the Humber area (Scunthorpe General Hospital (SGH), Grimsby's Diana Princess of Wales Hospital, (DPoW), Hull Royal Infirmary (HRI), Castle Hill Hospital in Cottingham (CH) and Goole and District Hospital (GH). The key driver for changing the hospital services across the Humber are the shortages of specialist staff across a number of services, who are particularly stretched in the current model of trying to run similar services across multiple sites 24 hours a day and seven days a week. There are also the issues of:

- The low volume of patients for many services across this rural and coastal geography leading to the difficulty of specialists maintaining their skills;
- The inability to meet many core NHS standards;
- The high death rates compared to national figures;
- The limitations of the estate and the lack of access to the latest IT and equipment

3.2 This review builds on the joint working in place between the trusts of Hull University Teaching Hospitals NHS Trust (HUTH) and Northern Lincolnshire and Goole Hospitals NHS Foundation Trust (NLaG) and the emerging Integrated Care Partnerships (ICP) which bring health, social care and other public service providers together around the needs of people and communities across the Humber (Hull, East Riding, North Lincolnshire and North East Lincolnshire).

3.3 This phase of the review is looking at the fundamental building blocks of acute hospital provision:

- Urgent and emergency care (UEC)
- Acute assessment
- Inpatient and critical care
- Maternity and paediatrics
- Planned care

3.4 Tertiary services delivered by HUTH such as cancer, cardiac and major trauma are central to the trust's long-term strategy for specialised services and are not in the scope for this review, although interdependencies are being identified and managed alongside this review.

3.5 The high-level service options have been developed through discussion in Clinical Design Groups, speciality project groups, a citizens' panel, and workshops for members of the public. Analyses have been explored in a series of workshops with wide clinical and operational representation across key stakeholders.

Role of the Senate

3.6 The Senate was invited early in the development of the proposals to advise on the clinical models across the acute hospital provision. The Senate was asked to provide the advice by the end of January 2020 to be used by the Clinical Commissioning Groups (CCGs) and hospital trusts participating in this review. The advice will inform the development of the options from the 18 high-level options presented to a final range of options which may include a preferred final option. The advice from the Clinical Senate will be received by the Clinical Design Group and directly influence the recommended options. The advice will be cited in subsequent decision-making fora and influence planning.

3.7 The Senate was asked to consider the following question:

Can the Clinical Senate provide an independent clinical assessment of whether the options currently under consideration are clinically feasible and sustainable given the volumes of activity, case mix, local health needs and constraints presented in the case for change?

Please indicate whether there are other options, or combinations thereof which we should be actively considering.

Process of the Review

3.8 The Terms of Reference for this review were agreed in mid-October and are available at Appendix 4 to this report. The supporting documentation was received by the Senate and distributed to the clinical panel in mid-November. The Senate expert panel shared comments on the documents through discussions by teleconference and email and as a result of these discussions the panel requested further information from the Humber Coast and Vale Partnership. The information was received promptly and distributed to the panel in late December. The panel discussed this information further in a teleconference on 15th January prior to a site visit which was arranged with commissioners and clinical representatives on 17th January 2020. This site visit provided opportunity for a robust clinical discussion and to further improve our understanding of the proposals. The agenda for the meeting can be found at Appendix 3. During the day we discussed the specialties of paediatrics, maternity services, emergency medicine, acute medicine and planned care including critical support in terms of services and clinical alignments with other specialties. Once consensus was reached by the panel on the draft report it was sent to the commissioner for comment on 31st January.

3.9 The commissioners and hospital Trusts are given 10 working days to respond with any comments on the accuracy of the report. The report is to be ratified by the Senate Council at their March meeting and published within 8 weeks of ratification unless there are reasons to delay this to tie in with planned public engagement.

4. Recommendations

General Comments

4.1 The Senate was asked to comment on the clinical feasibility and sustainability of the options presented. We would like to make the following general comments in relation to all of the clinical models presented before discussing in more detail the individual service areas.

4.2 Your case for change is very well made and you are to be congratulated on the very thorough appraisal of options. It is evident that the clinical engagement and commitment is positive, and we are pleased to hear that there is clinical consensus that services need to change, although there is no growing consensus on a preferred model. We advise that you learn from service re-organisation undertaken elsewhere (for example the Friarage Hospital in Northallerton and Whitehaven Hospital in Cumbria) and work quickly to further narrow down your options to maximum of 5 to ensure this complexity of choice doesn't paralyse decision making.

Recommendation: To reduce the number of options under consideration as rapidly as possible in order to maintain momentum and allow the development of detailed proposals.

4.3 Whilst both sides of the river have issues in terms of buildings and staffing, services in Northern Lincolnshire are in a much more difficult position than those in Hull and East Riding. For that reason, our discussions and our recommendations focus on Northern Lincolnshire. Whilst this configuration spans the ICS footprint across Hull and East Riding and Northern Lincolnshire, the reality is that this population does not act as a single health economy. The decisions on the configuration of services are therefore complicated by the fluid boundaries. In general, the population in Northern Lincolnshire looks west to Doncaster and Sheffield for their shopping, entertainment and health care and not north to Hull. In addition, public transport across the Humber Bridge is very limited. There are also the patient flows from the Lincolnshire area with at times one third of beds at Grimsby occupied by such patients and 15-20% of NLaG emergency admissions from out of area. We recognise that if some services are centralised on the Grimsby site that a large proportion of patients from the Scunthorpe area may choose to access those services at Doncaster. Patient movement therefore is a real challenge to any of the clinical models presented and your solutions need to consider those natural patient flows and design services accordingly. You also need to ensure that you work with services across the boundaries to discuss how your potential restructure will impact on those services. We advise that you commission work to fully understand patient preferences, particularly from out of area, as this may help you to develop a solution that best addresses those flows.

Recommendation: To further consider the challenges of patient movement and choice in this geography and ensure you design services to meet those natural patient flows.

This work will need to include discussion with neighbouring services to understand the impact of any restructure.

4.4 Services are at risk of collapse due primarily to difficulties in recruitment and retention, particularly of specialist staff. This is largely driven by the lack of new trainees wishing to settle in the area and our advice is that longer term this can only be resolved by getting more local school leavers to consider applying for medical school as a career option. We advise the trusts to work strongly with, and independently of, local universities to ensure young people in the area are given every opportunity to pursue a career in the health service in all professions. Closer working with the local medical schools could help to encourage more local people to train in medicine who are then more likely to return to the area. We welcome the news that Hull Medical School is set to double in size and will be applying weighting to support local applicants. We also recognise that your aspiration to become a research hub will help to attract staff to the area.

Recommendation: To work closely with local medical schools to promote more local people to train in medicine.

4.5 We question whether the clinical models presented are looking hard enough at demographic planning across a longer time frame to influence decisions in service provision, particularly considering elderly care. We advise that you give more priority to developing the frailty pathway as your population analysis clearly reflects that the older age population is predicted to grow at a faster rate than younger age groups. There are opportunities with new services which could provide a state of the art frailty centre designed to accommodate an academic centre for elderly care medicine with all appropriate healthcare professions involved. Whatever option is pursued the frailty pathway will be an essential part of the model.

Recommendation: To prioritise the frailty pathway within your clinical models.

4.6 We recognise that we were asked to review the acute services model and that the primary and community care workstreams are being developed in parallel. These services however are very stretched and cannot expand to support the acute models without investment. We advise that more focus is needed on the non-hospital setting to better support the options proposed and there is opportunity for you to be bold and creative with your primary and community workforce and the services they offer. Social services and voluntary services also need to be included in these discussions to help design services to support patients in their homes. Thought also needs to be given to developing roles, for example in community pharmacy, to improve discharge pathways.

Recommendation: To look at solutions as a whole system and focus more on care in the non-hospital settings to support your acute services proposals.

4.7 Digital improvement is a fundamental building block of these clinical options and greater priority needs to be given to improving compatibility of Information Technology (IT) across HUTH and NLaG and investing in digital solutions to support patient care in a non-hospital setting. Whilst it should not be assumed that all

patients can embrace digital engagement there is so much innovation in virtual consultations and health apps that can be trialled as part of your proposals. You may also wish to consider working with a health technologist who can bring their knowledge and skills to bring the latest innovations into your solutions. The advice in the Topol Review[1] also needs to be considered and the appointment of a digital champion may help you to drive forward the implementation of IT solutions.

Recommendation: To improve compatibility of IT between the 2 trusts and prioritise digital solutions to support patient care in non-hospital settings.

4.8 Within the options, you have quite rightly presented the option of a new build single hospital for Northern Lincolnshire. This longer-term solution to hospital provision, most likely on a site between Scunthorpe and Grimsby, has the support of the panel and has opportunity to be innovative in meeting the needs of your population and attracting new staff. Whilst this would resolve most of the short-term problems you have presented, it would take a minimum of 5-10 years to achieve, and more likely 15 – 20 years, given the complexities, lead in time and cost. If this is to be pursued as an option, interim solutions will still need to be achieved within a very much shorter timescale to support the current struggling services. There was unanimous agreement that whatever configuration you decide, the resultant clinical service changes must be safe and sustainable whilst meeting the needs of the local populations.

4.9 We recognise that there is a tension between Royal College guidance and the challenges of the local geography. The Senate acknowledges the Nuffield report on "Rethinking Acute Medical Care in Smaller Hospitals" [2] and the need to allow smaller hospitals more flexibility in designing models of care to meet the needs of their population.

4.10 At public consultation, the Humber Coast and Vale Partnership will need to present an easily understood narrative explaining the need for change and the options for future services, including the impossibility of a "do nothing" option. The language used in discussion with staff and the public is very important in ensuring an understanding that centralising the acute care is a small part of a pathway of services and that diagnostics, follow up and rehabilitation for example, will remain locally delivered.

4.11 We recognise that you have involved the public via a small citizens panel, which meets regularly (a membership of 20) and a series of open-invitation workshops to develop the options. In order for the public to inform the way forward, however, you will need enlargement of citizens engagement and a comprehensive plan to inform and prepare patients to engage positively in their healthcare and their expectations.

[1] "Preparing the Healthcare Workforce to Deliver the Digital Future" (Feb 2019), https://topol.hee.nhs.uk/wp-content/uploads/HEE-Topol-Review-2019.pdf;

[2] Rethinking acute medical care in smaller hospitals | The Nuffield Trust

Urgent and Emergency Care

4.12 Urgent and emergency care (UEC) is currently provided across the Humber region through a range of Emergency Departments (ED), Urgent Treatment Centres (UTCs) and Ambulatory Care Units (ACUs). In Hull and East Riding, HUTH provides the majority of its emergency care at Hull Royal Infirmary which is designated as a Major Trauma Centre (MTC) covering East and North Yorkshire and the Humber region. UTCs are provided at East Riding Community Hospital, Bridlington and Bransholme. In Northern Lincolnshire, NLaG provides 24-hour emergency care at Diana Princess of Wales Hospital (DPoW) in Grimsby and at Scunthorpe General Hospital (SGH). UTCs are also provided on these hospital sites with an additional UTC at Goole Hospital.

4.13 The options presented to us ranged from maintaining the current ED locations but with acute care hub models of care, to options which reduced the ED locations in Northern Lincolnshire to 1 site. The terminology of hot / cold sites and warmer and cooler sites is used in the options which we understand to refer to a fully functioning Emergency Department with supporting specialist inpatient beds, to reduced clinical specialities on site and different offers of care in terms of the acuity of the patient and the hours of service. Due to the difficulties in staffing and sustaining full emergency services, with all the clinical specialities and support services requiring them to function, we recognise that you cannot sustain 2 'hot' EDs on both sites in Northern Lincolnshire.

4.14 In considering emergency services, the Senate considered the following principles:

- That in modern health care, patients travel to hospitals that can provide the treatment and care that they require rather than simply to their nearest hospital. There are already a number of bypass protocols in place for cardiac, stroke and major trauma services for example, in this geography.

- That if a hospital has an "Emergency Department" sign outside of its front door, it needs to have sustainable systems and services in place to ensure that it is always safe for all types of patient when it is open. Any department not providing 24/7 services must ensure that there are systems in place to provide a safe service when it is closed. There are a variety of models across the UK that should be considered remembering that each reconfiguration of service presents its own unique issues.

- Frailty and care of the elderly is a fundamentally important service for this population

4.15 We advise that amongst the options presented, you focus your thinking on a more acute site and a less acute site. Careful consideration is required in determining the optimal number and type of ED(s) required along with the variation in allied services present on site. This could range from an ED supported by the full breadth of

secondary care services to an ED supported by some acute specialities but predominantly integrated with community based services. Whichever model is agreed upon frailty services need to form an essential component of any configuration of emergency care.

4.16 In this more acute site/ less acute site model travelling to one "hot" site would be clinically unnecessary for the majority of urgent and emergency cases. The less acute site could have a fully functioning ED able to safely manage patients not deemed to be critically ill, but nonetheless requiring hospital assessment and potentially admission. The majority of walk in patients would fall into this category. Ambulances would need robust triage protocols in place to ensure that they take patients to the right hospital depending on assessment. Those patients deemed to be critically ill (or at least worryingly sick) must be transported by ambulance to the more acute site where facilities include level 3 critical care. In some cases bypass protocols are already in place for conditions such as trauma, stroke and cardiac care and patients would be transported directly to the identified hospital as they are currently.

4.17 Therefore the more acute hospital would take patients directly if they were thought to require (or potentially require):

- Access to a level 3 ICU and Critical Care consultants (not just ventilator support).
- Urgent brain CT for stroke requiring thrombolytic therapy
- Gastrointestinal (upper GI) haemorrhage where emergency gastroscopy (and endoscopic therapy) is available 24/7. (see NICE/BSG guidelines).
- Care at the more acute site based on paramedic assessment

4.18 Both hospital sites would take the majority of all other urgent/emergency cases based on locality. The less acute unit would have an ED capable of dealing with:

- All acute medical and surgical emergencies with a "low-risk" assessment
- Children managed in a paediatric day unit (this is heavily dependent on other options you are still considering)
- Obstetric and Gynaecology cases with a "low risk assessment"

4.19 Stabilisation and ventilation overnight and level 2 critical care would be required on the less acute site with protocols in place to ensure the safe transfer of patients requiring level 3 care.

4.20 Urgent Care/ED should be co-located in each hospital, utilising both GPs and Advanced Care Practitioners (ACPs) in order that walk-in patients can be referred to acute assessment and then either admitted or discharged. This should be supported by wrap around community based care. Senior decision makers, especially in Geriatrics and Elderly Care must be on the front line to avoid unnecessary admissions (even to a short stay unit).

4.21 To ensure patient safety is paramount at all times this more acute site/ less acute site model would need to be underpinned by:

- comprehensive pathways and protocols agreed with ambulance services to ensure they know which patient presentation is appropriate for the less acute site and which requires blue light transfer and diversion to the more acute hospital with intensive care facilities on site. This will require agreed protocols with 2 different ambulance services – East Midlands Ambulance Service (EMAS) and Yorkshire Ambulance Service (YAS)
- the ability to stabilise and transfer any seriously ill walk in patients or in-patients of any age from the less acute site to an emergency department or a critical care level 3 facility and
- comprehensive local communication of the service offer

Recommendation: To focus your option development in Northern Lincolnshire to the option of exploring a 2 site model of an acute site and a less acute site.

4.22 In considering these models, we advise that you consider the following issues:

- The need for the models to support sustainable staffing from the anaesthetic and critical care perspective. Our understanding is that with your current model one consultant anaesthetist covers critical care, obstetrics and out of hours anaesthetic emergencies in each of the acute units south of the Humber. This results in a struggle to meet both the Obstetrics Anaesthetists' Association (OAA) and the Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidance in the General Provision of Anaesthetic Services[3] and the Intensive Care Society (ICS) and Faculty of Intensive Care Medicine (FICM) General Provision of Intensive Care Services[4] for a consultant led and delivered critical care service. Concentrating the acute services in 2 sites, one north and one south of the river would have definite workforce advantages for anaesthesia and critical care and provide a better quality and sustainable service. Using a digitally driven augmented telemedicine advice service for critical care may provide some relief for the workforce pressures in critical care rotas but this does not match the quality of a service staffed to national standards.

- Given the demographics of your population all sites need to offer a "front of house" frailty service to allow frail elderly patients to be seen and assessed immediately with the aim of not admitting hospital patients who can be managed at home or in a more appropriate setting. We welcome the development in Hull of an integrated care pathway with a shared record for elderly care. There is less development in Northern Lincolnshire and whilst we acknowledge that

[3] https://www.rcoa.ac.uk/safety-standards-quality/guidance-resources/guidelines-provision-anaesthetic-services

[4] https://ics.ac.uk/ICS/GuidelinesAndStandards/GPICS_2nd_Edition.aspx

recruitment is difficult, focus needs to be given to the creation of a 7 day a week frailty unit with extended hours into the evening.

- To appraise the options with primary care and social care across the Integrated Care System (ICS) footprint. It is clear that whatever decision is made on acute and emergency care, that primary care and social care needs to be integrated into the system. We understand that the situation is complicated by the fact that there are different community provider structures in North East Lincolnshire and North Lincolnshire CCGs. The lack of a coherent out of hospital urgent response across the ICS is a real gap in your consideration of the acute service provision.

- There are alternative roles that can be further considered particularly in terms of avoiding admissions and unnecessary attendance at ED. The role of the paramedic is evolving to include rotation through primary care, UTCs and EDs and could be considered as part of this service redesign, including within the Advanced Care Practitioner framework. This current lack of whole systems approach in the service design may result in paramedics, nurses and other healthcare professionals not being used to their potential in contributing to the solutions to the system challenges.

- For the ED to function effectively the issues with patient flow need to be addressed by ensuring greater support and responsiveness to the ED from specialities and with social care to aid the discharge of patients.

- There are developing models where ED care can be run by an interdisciplinary medical team with support from specialists when needed. This would help to manage the workforce gaps and we agree that there is learning that you can bring from the Cramlington model, for example. We advise you to consider however, the differing consequences that this type of model brings, with difficulties in repatriation and its heavy reliance on ED consultants.

- We understand why, at this early point in the option development, that mental health services are not discussed, however, you need to ensure that the final acute and emergency model is supported by liaison psychiatry services.

Paediatrics and Maternity Services

4.23 Both trusts provide a comprehensive range of maternity services across their sites. In Hull and East Riding at HUTH maternity services are provided at HRI. HRI has a large obstetric led unit delivering approximately 4400 births a year and a co-located midwifery led unit that caters to low risk women (approximately 500 births a year). The trust has recently updated their neonatology unit to level 3 which now allows them to deliver higher risk births. In Northern Lincolnshire NLaG runs two obstetric led units, in DPoW and in SGH. DPoW has approximately 2500 births a year and SGH approximately 1600 births a year. Neither site has dedicated midwifery led units. Both DPoW and SGH have level 2 neonatal units. DPoW operates a continuity

of care model, with a single room for labour, delivery, recovery and postnatal care. At Goole District Hospital a home from home unit exists with approximately 10 births a year.

4.24 Both trusts provide a comprehensive range of paediatric services across their sites. In Hull and East Riding HRI is a tertiary centre and provides general acute medical and surgical paediatric care, as well as specialist services to its patients. Paediatric intensive care is not provided at HUTH but can be accessed in Leeds and Sheffield. In Northern Lincolnshire NLaG provides the majority of its paediatric services from DPoW and SGH. Paediatricians at NLaG also provide level 2 neonatology care for the consultant led obstetrics service at both sites. Whilst some tertiary referrals are made to HRI, much of the specialist paediatric patient activity from NLaG flows out of the Humber area.

Maternity Services

4.25 The options presented for the maternity services range from maintaining 2 obstetric led units (OLUs) in Northern Lincolnshire with variations in the level of neonatal unit, reducing the OLUs in Northern Lincolnshire to one of the existing sites, a new build option in Northern Lincolnshire or a new Humber wide maternity service on one site for both north and south of the river. Taking each of these options in turn we have the following comments:

Option 2 (an OLU with a level 1 Neonatal Intensive Care Unit (NICU) and an OLU with a level 2 NICU in Northern Lincolnshire)

4.26 Women of childbearing age in the Humber region have a greater degree of co-morbidity and deprivation and the proportion of teenage mothers and premature births is above the national average across the Humber region. Given this population profile and the travel distances, we understand the attraction of maintaining 2 OLUs in Northern Lincolnshire in the short term. This option is clinically feasible and involves relatively little clinical change from the current situation, acknowledging that a number of mothers (and babies) will require transfer from the unit that will become a Special Care Nursery (SCN) (or level 1 centre) rather than a Local Neonatal Unit (LNU) (or level 2 unit). However, the numbers of women in the affected catchment area who give birth between 27 and 32 weeks or are born weighing 800-1000g (i.e. the differences in admission criteria between SCNs and LNUs (or level 2 units), will be relatively small.

4.27 The geographic configuration of neonatal (and maternity) services within option 2 is clinically acceptable, and in line with many other neonatal Operational Delivery Networks (ODNs) within the UK.

4.28 There are longer term challenges, however, to the availability of the maternity workforce (obstetricians and midwives), that will need to be addressed if this option is to be sustainable well into the future. These include the following factors:

- national difficulties with recruitment to some of the allied professions (e.g. ultrasonographers)
- potential difficulties over the next few years with the age profile (and imminent retirement) of midwives

- the general uncertainties around workforce planning

4.29 However, there is a general perception nationally that the problems experienced by many services with regards to the recruitment of junior and senior obstetric medical staff are starting to improve following national changes to admission criteria for training posts.

4.30 Where the panel has more concerns on this option is in relation to the sustainability of critically interdependent services. These potential difficulties relate to workforce availabilities, as well as the levels of workload and activity for the neonatal units and are detailed below.

Sustainability of critically interdependent services- paediatrics / neonates

4.31 Both units in Northern Lincolnshire appear to be experiencing problems with recruitment to paediatric posts. These recruitment difficulties and levels of staffing mean that the retention of two neonatal units (even with one being an SCN) might be associated with longer-term difficulties in meeting national standards, such as:

'*There must be 24-hour availability in obstetric units of a consultant paediatrician or neonatologist (or equivalent SAS grade) trained and assessed as competent in neonatal advanced life support who are able to attend within 30 minutes*'[5]

'*Junior medical staff (obstetricians, anaesthetists and paediatricians) of appropriate competencies, as determined by College curricula, and the type of maternity unit, should be immediately available on the labour ward' (RCOG 2016)*

4.32 It might be that these difficulties can (to an extent) be mitigated by the development of neonatal nurse advanced practitioner (NNAPs), but many areas have struggled to recruit, train and retain such staff – meaning that a model of care based on NNAPs might not be sustainable in the longer term.

Sustainability of critically interdependent services - anaesthetics

4.33 There also appear to be similar difficulties within anaesthetics services, including the current need for on-call staff to cover clinical areas other than obstetrics when on call, meaning that it might be difficult for two units to meet national standards such as:

'*A duty anaesthetist must be immediately available for emergency work on the delivery suite 24 hours a day and there should be a clear line of communication from the duty anaesthetist to the supervising consultant at all times.' (RCOG 2016)*

'Anaesthetic staffing levels should ensure that the duty anaesthetist for labour ward is not primarily responsible for elective obstetric work or solely responsible for the ICU or cardiac arrests' (RCOG 2016)

Availability of adjacent services

4.34 If, due to the pressures in emergency care, the decision is made to consolidate acute services on one site then the non-acute site will struggle to maintain a 24-hour

[5] 'Providing Quality Care for Women – a Framework for Maternity Service Standards, the Royal College of Gynaecologists (RCOG), 2016

obstetric led service due to the reduction in on site services to support maternity care. This is particularly with regard to the following standards:

'*Access to level 3 critical care must be available for all obstetric patients and preferably available on site. Portable monitoring with the facility for invasive monitoring must be available to facilitate safe transfer of obstetric patients to the ICU*' (*RCOG, 2016)*

'There should be clear local guidance for transfer to high dependency units (HDUs) or to intensive care units (ICUs) and easy access to these units for all women in labour' (RCOG, 2016)

Levels of workload and activity for the neonatal units

4.35 The potential difficulties associated with the re-designation of a local neonatal unit (or level 2 unit) to a special care nursery (or level 1 unit) include the possibility that this might be perceived by the local population as a more significant alteration to services than is actually the case. Such a misperception might result in women choosing to give birth in services away from the area. If this were to happen, it might be difficult for the LNU at one of the sites to sustain acceptable levels of activity as recommended within the recently published national review of neonatal care (Implementing the Recommendations of the Neonatal Critical Care Transformation Review, 2019) [6]. This report suggests that LNUs should aim to undertake a minimum of 500 days of combined intensive and high dependency care per year. In addition, the report suggests that services providing on-going high dependency care should be expected to have higher levels of activity and all should work towards becoming services that provide at least 1000 combined intensive care/high dependency days. This brings into question whether there is sufficient overall activity in Northern Lincolnshire to support two neonatal units and their long term sustainability needs to be fully considered.

Mitigations

4.36 There are actions that can be taken to mitigate the difficulties described above with option 2:

- There are examples of maternity and paediatric services elsewhere in the country that have overcome workforce difficulties by taking innovative approaches to recruitment – using the principles we heard during the visit such as the creation of training opportunities and links (or even joint posts) with specialist centres

- In addition, steps can be taken to enhance an accurate and balanced portrayal of redesign proposals within the local media, politicians and activist groups – thereby reducing the numbers of women who might choose to give birth in another area. Members of the panel would be happy to put the HCV Partnership in touch with colleagues in the North East who have led on the redesign of maternity services

[6] https://www.england.nhs.uk/publication/implementing-the-recommendations-of-the-neonatal-critical-care-transformation-review/;

- As regards the sustainability of an LNU, another option might be to have two SCNs rather than an SCN and an LNU (see below)

4.37 Hence, the description of the difficulties described above is not meant as a suggestion that option 2 is unequivocally unsustainable, but we recommend that any proposals to redesign the services as based on this option must include actions that mitigate these concerns.

Options 3, (One OLU and standalone midwifery led unit (MLU) in Northern Lincolnshire), option 3+ (one OLU with level 2 NICU and one MLU in Northern Lincolnshire co located on one site), option 4 (a new Northern Lincolnshire maternity unit built in between Scunthorpe and Grimsby) and option 5 (a new Humber wide maternity service on one site for both Hull and East Riding and Northern Lincolnshire)

4.38 The panel agrees that the configurations of service within options 3 and 3+ (as well as 4 & 5) are all clinically acceptable. These options are characterised by the development of either freestanding and / or co-located midwife-led units, meaning that any conclusions about the clinical acceptability of these options must include comments in relation to both the outcomes of women giving birth in MLUs, and the transferability of the evidence base regarding the safety of MLUs to the Humberside area.

4.39 The Birthplace Cohort Study (2016)[7] was designed to answer questions about the risks and benefits of giving birth in different settings. The study collected data on care in labour, delivery and birth outcomes for over 64,000 'low risk' births. The results confirmed that the outcomes for 'low risk' women who chose to give birth in either a freestanding or co-located MLU are at least equivalent to women of a similar level of risk who choose an obstetric unit. There were benefits to choosing a midwife-led unit – such as a reduced chance of having an intrapartum caesarean section, instrumental delivery and / or episiotomy. There was no suggestion that the outcomes for women choosing a freestanding MLU were any different to those choosing a co-located unit, meaning that the development of a freestanding MLU (as described in option 3 – and presumably options 4 & 5) is clinically appropriate.

4.40 It is reasonable to conclude that the findings of the Birthplace Study are transferrable to the Humberside area. The population of the area is relatively disadvantaged. Moreover, the geography of the area is very rural and characterised by relatively large distances between neighbouring units, but the Birthplace Study collated outcomes from all areas across the country – including those with disadvantaged services and rural locations.

4.41 Option 3+ might be perceived as reducing the choices of birthplace available to women (i.e. there is no offer of a freestanding MLU), but the choice offer – as described in 'Better Births', the report from the National Maternity Review 2016[8] – is more generally taken to mean options of either a home birth, birth in an obstetric led unit, or birth in a midwife-led unit, be that freestanding or co-located.

[7] https://www.npeu.ox.ac.uk/birthplace
[8] https://www.england.nhs.uk/publication/better-births-improving-outcomes-of-maternity-services-in-england-a-five-year-forward-view-for-maternity-care/

4.42 The panel agrees that options 3 and 3+ are more likely to be clinically sustainable than option 2 due to the issues highlighted in option 2 with the workforce and the critically interdependent services. What needs to be considered in these options particularly, is the potential problems in levels of activity, particularly with regard to the freestanding MLU in option 3 and the LNU (in options 3 & 3+)

Sustainability of freestanding midwife-led units

4.43 A co-located midwife-led unit is often perceived as being more popular with women – and the numbers of women choosing to give birth in such units is generally more than is the case for freestanding units. There are numerous examples within the UK of freestanding MLUs experiencing problems in relation to sustainability as a result of critically low levels of women choosing to give birth in such services. Nonetheless, there are also examples of units that have been highly successful – with actions to enhance the probability of success including the development of such centres as vibrant maternity community hubs, as well as the passionate advocacy of the local workforce in promoting the merits of such a unit to local women.

Sustainability of a local neonatal unit

4.44 As mentioned above in paragraph 4.30, the recent national review of neonatal services suggests that local neonatal units should aim to undertake a minimum of 500 days of combined intensive and high dependency care per year – and services providing ongoing high dependency care should work towards providing at least 1000 combined intensive care / high dependency days.

4.45 It is possible that the development of a site in Northern Lincolnshire as a freestanding midwife-led unit rather than an obstetric unit, might be associated with some of the local population choosing to give birth out of the area – and thereby reducing the potential for the local neonatal unit to meet the national standards described above – especially when the current levels of activity are not comfortably in excess of these levels. It might be that such a difficulty could be countered by passionate advocacy of the freestanding MLU, but another option might be to have a single site with a SCN rather than an LNU.

Alternative options

4.46 The panel concluded that there are no major options that the group should be actively considering that have not been presented, but there might be variations that merit further thought in relation to midwife-led units, as well as the level of neonatal units.

4.47 The benefits associated with giving birth in a midwife-led unit – be it freestanding and / or co-located – are such that it might be worth considering a greater role for such facilities with several of the options. For example:

- With option 2, it might be reasonable to consider the creation of co-located MLUs at one or both sites hosting the OLUs
- With option 3, it might be reasonable to consider the development of a co-located MLU at the OLU site

4.48 The issues discussed above in relation to the preferred levels of activity for an LNU suggest that it might be worth considering:

- With option 2, designating both sites as a SCN
- With option 3, having a SCN at the single site rather than an LNU

4.49 Targeted stakeholder involvement will be required to understand patient preferences for maternity services and where they may choose to access care should local services change.

Recommendation: Any proposals to redesign the services which retain either 2 OLUs, or a Local Neonatal Unit, in Northern Lincolnshire must include actions that mitigate the concerns highlighted with workforce availability, critically interdependent services and levels of activity.

Recommendation: Any proposals which include a freestanding MLU in Northern Lincolnshire must demonstrate that the activity will be sufficient to ensure the sustainability of both the MLU and the Northern Lincolnshire neonatal service.

Paediatrics

4.50 The options presented for paediatric services focus on maintaining a full acutely ill 24/7 paediatric service with inpatient beds and some emergency surgical work at one Northern Lincolnshire site and limiting paediatrics at the other site to a short stay paediatric assessment unit (SSPAU) and no inpatient beds, to fully consolidating paediatric services on one Northern Lincolnshire site.

4.51 There are currently 2 paediatric departments at each hospital site in Northern Lincolnshire providing both acute and out-patient care to the local populations. There is the need for significant expansion of the medical workforce and locums are very difficult to obtain as there are few available. The same issue applies to newly qualified trainees who will generally opt for less onerous rotas widely advertised of between 1 in 7 to 1 in 10. We therefore advise that consolidating paediatric services on one site would achieve a much more manageable rota for the majority of the year. It would also allow for more subspecialisation within the specialty. Locating to one site would still allow all out-patient paediatrics to continue as they are currently provided.

4.52 The consolidation of paediatric services on one Northern Lincolnshire site would help to alleviate the workforce issues more so than the option to only limit the range of paediatric services at one Northern Lincolnshire site. In your consideration of the latter model however, we advise that you explore the following issues further:

- The ability to staff a paediatric day unit. This limited paediatric offer on one Northern Lincolnshire site would not solve the current staffing issues as you would still require enough paediatricians to oversee the care at the day unit, for transfers and to support care out of hours.
- The potential for a significant number of inter hospital transfers which will need to be estimated and discussed with transfer services. You will need to think through the impact of increased transfers in terms of pressures on staffing, the skills staff will need and what service you will use to carry these out. The Embrace service is a limited resource and usually commissioned to move a child from a ward environment to intensive care, so this proposed model is outside of their normal pathway and their ability to support this needs to be discussed with them.

Ambulance services can struggle to transfer children in timely manner from what is considered to be a safe place.

- ED and critical care anaesthetic staff will need to have the skills to stabilise a child until the transfer service or support arrives. These resuscitation, stabilisation and transfer skills are a key part of the safety of this model.
- Further discussion will be needed with ED on the skills required on site to enable them to support this model. To meet Paediatric Intensive Care Society standards[9] you will require one person available at all times who is an advanced life support provider (Advanced Paediatric Life Support/European Paediatric Advanced Life Support). Clear escalation and decision-making criteria are paramount.
- Consolidation of paediatric services on one site would facilitate development and retention of subspecialist skills in paediatric anaesthesia.

Recommendation: To fully consider the workforce, resuscitation, stabilisation and transfer skills needed to support the paediatric model which will be required for an inpatient paediatric service at one Northern Lincolnshire site.

4.53 The panel also questioned whether Northern Lincolnshire should look more to Sheffield, where it receives its paediatric intensive care, which may help to make services in Northern Lincolnshire more sustainable, but it is unclear what impact this may have on paediatric services at Hull.

4.54 One final important point is the investment needed in paediatric community services. The population of the Humber has high levels of deprivation with significant health needs of children. We advise that you give greater thought to what care can be provided outside of hospital-based practice in developing community models, and in upskilling primary care, to help support the inpatient unit.

Recommendation: to develop the community paediatric services to support the hospital-based service

Planned Care

4.55 The discussions on planned care focussed on the specialties of Ear Nose and Throat (ENT), gastroenterology, general surgery, ophthalmology, orthopaedics and urology. The configuration of these services across Hull and East Riding and in Northern Lincolnshire differs across the specialties but includes out patient clinics at East Riding Hospital and Goole Hospital as well as inpatient wards and day case wards at HRI, Castle Hill, DPoW Hospital and SGH. Interventional radiology is provided at HRI. Data looking at outcomes from planned care specialties such as RTT (referral to treatment) and day surgery rates, generally falls below the national average and there are insufficient staff at all grades and staff groups within both Trusts to meet the demand for services.

4.56 The options proposed include establishing a hot/cold split in Northern Lincolnshire as already present in Hull and East Riding, a warmer/ cooler split in Northern

[9] https://PIC society standards 2015

Lincolnshire and developing discrete elective services appropriate to each site. Whilst each specialty has its particular challenges we recognised that the recurrent theme is the difficulty in stretching the workforce across multiple sites, particularly in delivering out of hours care.

4.57 Carrying through our earlier discussions about emergency care, the panel agreed that this model of a more acute/less acute configuration in Northern Lincolnshire would allow the less acute hospital site in Northern Lincolnshire to develop into a major elective surgical site employing the very latest technology to enhance surgical outcomes. In this acute/less acute model day case surgery will become more efficient as less non-elective work will be undertaken at this site, reducing the incidence of last minute cancellations due to emergency work. This could apply to all surgical specialties. Patients requiring a higher level of care can be treated at an appropriate hospital either within the NLaG footprint or elsewhere. When the decisions have been made on the reconfiguration, the elective provision will need to be designed with robust protocols for patient and procedure selection, transfer and aftercare.

4.58 There are however a number of actions that can be initiated ahead of the reconfiguration, particularly in ophthalmic surgery, urology and ENT through developing a network approach to change the way the workforce delivers care. We are all agreed that there is a need for increased integration and collaboration across the trusts, centralising the workforce, supported by regional multi-disciplinary teams (MDTs) for specialties and standardised pathways of care.

4.59 Within this discussion we considered the following points:

Network model and pathways of care

- In the future you could look to appoint personnel to a network position, developing one specialty team, with one lead organisation for employment with the expectation for this team to work across the 2 trusts north and south of the Humber. We recognise that there are challenges in selling the idea of a joint workforce across the Humber to the medical workforce but this is the way forward to alleviate those workforce pressures. The South Yorkshire and Bassetlaw ICS is further forward on many of these network models and would be able to provide advice to you on taking this forward.
- Within these discussions the whole pathway of care needs to be modelled to ensure seamless care for the patient.
- There is more opportunity to centralise some activity in HUTH but then for other activity to be shifted to Northern Lincolnshire in a reciprocal arrangement. Clinical comment was that currently this reciprocity to maximise resources is not in place.
- Robust activity modelling is required to ensure these elective pathways are supported by the right bed base.
- We understand that there are risks with a consultant on call model based in Hull and East Riding, but these are not insurmountable risks and you must guard against trying to build a service around exceptional airway emergencies. You do, however, need to ensure that your pathways and protocols are in place to manage those emergencies.

Digital support

- For this networked model of care to work you need compatibility of IT systems across the 2 trusts.
- You can explore opportunities to improve the patient pathway by co-ordinating outpatient appointments to accommodate tests and procedures and consultant appointments on one visit. In designing new pathways of care there is also the opportunity to consider virtual consultations.

Primary and social care

- Our earlier discussions about needing to increase the support for the patient in the services provided by primary and social care applies equally to these elective pathways. Working across services, you need to consider how your pathways support typical presentations, especially the frail elderly, to ensure their needs are met.

Patient flows

- Discussion with neighbouring CCGs is needed to understand the complications of patient flows across boundaries and how different options will impact on their services.
- There is currently a lot of planned care activity taken by private providers in this area which we understand complicates what changes to patient care you feel able to make. This is an opportunity however to become a centre of excellence for high volume procedures.

4.60 Our only point specific to a speciality is with regards to ophthalmology services. We discussed the potential to develop a combined out of hours rota across the 3 eye casualties and noted that there are examples from South Yorkshire which could be helpful to you. We can share these contacts with you.

Recommendation: To take action ahead of the wider reconfiguration, particularly in ophthalmic surgery, urology and ENT to develop clinical networks working across the Hull and East Riding and Northern Lincolnshire to change the way that the workforce delivers care.

5. Summary and Conclusions

5.1 The Senate thanks the Humber Coast and Vale Partnership for the opportunity to work with you on the development of your options across urgent and emergency care, maternity, paediatrics and planned care. It was a pleasure to meet your enthusiastic and committed clinicians.

5.2 In urgent and emergency services we agree that in Northern Lincolnshire, due to the difficulties in staffing and sustaining urgent and emergency services across 2 sites, it is not possible to maintain 2 'hot' EDs on both sites in Northern Lincolnshire. In modern health care the model of patients travelling to the hospital that can provide

the treatment and care they need rather than their nearest hospital is well established and we advise that you focus your option development in Northern Lincolnshire to the options which explore one acute site in Northern Lincolnshire or a two site model of an acute site and less acute site.

5.3 All the options you present for maternity services are clinically feasible but our concerns for this service focus on the clinical sustainability of the options. The option which retains 2 obstetric led units in Northern Lincolnshire leads to concerns regarding the sustainability of the workforce and critically interdependent services of paediatrics and anaesthesia. The proposals which include a freestanding MLU in Northern Lincolnshire raise concerns as to whether the activity will be sufficient to ensure the sustainability of both the MLU and the Northern Lincolnshire neonatal service. Options 2, 3, 3+ and 4 include a Local Neonatal Unit, but there are concerns about whether there is sufficient activity to maintain the clinical skills of the workforce for such a unit.

5.4 In paediatric services the model which limits paediatric services at one site in Northern Lincolnshire will need full consideration of the workforce, resuscitation, stabilisation and transfer skills needed to support this. All options will need the development of the community paediatric services to support the hospital-based service

5.5 When the decisions have been made on the reconfiguration, the elective provision will need to be designed with robust protocols for patient and procedure selection, transfer and aftercare. We advise that there are actions that can be taken ahead of the wider reconfiguration, particularly in ophthalmic surgery, urology and ENT to develop clinical networks working across Hull and East Riding and Northern Lincolnshire to change the way that the workforce delivers care.

5.6 More broadly, we recommend that you consider further the challenges of patient movement and choice in this geography and ensure that you design services to meet those natural patient flows. Close working with local medical schools is also recommended to address the issues you have with recruitment and retention. Finally, we advise of the need to improve compatibility of IT between the 2 trusts, to give greater priority to elderly medicine and the frailty pathway within your proposals, and to present whole system solutions with primary care and social care services integrated into the service proposals. Whatever configuration you decide, the resultant clinical service changes must be safe and sustainable whilst meeting the needs of the local populations.

5.7 We hope these comments are helpful to you in your further discussions and we are very happy to work with you again when your options are further refined.

APPENDICES

Appendix 1

LIST OF INDEPENDENT CLINICAL REVIEW PANEL MEMBERS

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

Margaret Wilkinson, Senate Assembly Lay Member

Sue Cash, Senate Assembly Lay Member

Amarvir Bilkhu, Fellow to Future Leaders Programme, Health Education England

Dr Patrick MacDowall, Consultant Nephrologist, Lancashire Teaching Hospitals NHS Foundation Trust

Dr Jeremy Groves, Consultant in Anaesthesia & Intensive Care, Chesterfield Royal Hospital

Dr Andy Simpson, ED Consultant, North Tees & Hartlepool NHS Foundation Trust

Dr Stephen Sturgiss, Consultant Obstetrician, Newcastle Upon Tyne Hospitals NHS Foundation Trust

Dr Raj Khanna, ED & Paediatric ED Consultant, South Tyneside & Sunderland Hospitals NHS Foundation Trust

Prof. Mike Bramble, Senior Fellow in Gastroenterology, South Tees Hospitals NHS Foundation Trust

Fiona McEvoy, Head of Nursing Quality, North Tees & Hartlepool NHS Foundation Trust

Andrew Hodge, Consultant Paramedic Urgent Care, Yorkshire Ambulance Service NHS Trust

Dr Mark Anderson, Consultant Paediatrician, Newcastle Upon Tyne Hospitals NHS Foundation Trust

Mr Jon Ausobsky, Consultant General Surgeon, Bradford Teaching Hospitals NHS Foundation Trust (Retd)

No declarations of interest were made by the panel members.

Appendix 2

ITINERARY FOR THE SITE VISIT ON 17th JANUARY 2020

Humber, Coast and Vale Health and Care Partnership
Humber Acute Service Review
Clinical Senate Panel

Friday 17th January 2020

Scunthorpe General Hospital – Boardroom
Cliff Gardens, Scunthorpe DN15 7BH

PROGRAMME

Registration, tea and coffee available from 9.30

	Item	Led by	Delivery	Time
1	Welcome and introductions	Chris Welsh	Verbal	10.00-10.15
2	Opening presentations	Makani Purva Kate Wood	Presentation	10.15-10.30
3	Service model combinations	Jacquie Smithson Anwer Qureshi Kate Wood Colin Vize Kishore Sasapu Anantha Ananthasayanam	Presentation	10.30-12.00
	Lunch Provided 12.00-12.30			
4	Informal 1-1 discussions with HASR representatives	Various	Discussion	12.30-13.15
5	Protec ted panel time	Chris Welsh	Discussion	13.15-14.15
	Comfort break			
6	Panel feedback	Chris Welsh	Verbal	14.30-15.30
7	Close	Chris Welsh		

Presenters

Anantha Ananthasayanam, Medical Director, Surgery, HUTH

Makani Purva, Chief Medical Officer, Hull University Teaching Hospitals NHS Trust (HUTH)

Anwer Qureshi, Consultant Acute Care Physician, NLaG

Mr Kishore Sasapu, Divisional Clinical Director for Surgery, NLaG

Jacquie Smithson, Medical Director Medicine, HUTH

Colin Vize, Family and Women's Health Group, HUTH

Chris Welsh, Yorkshire and the Humber Clinical Senate Chair

Kate Wood, Chief Medical Officer, Northern Lincolnshire and Goole NHS FT (NLaG)

Invited Colleagues

Peter Ashley, Humber Acute Services Review, Citizen's Panel member

Sue Barnett, Strategy and Planning Consultant, NLaG

Linsay Cunningham, Strategic Lead, Humber Coast and Vale STP

Ekta Elston, Medical Director, North East Lincolnshire CCG

Beverley Geary, Chief Nurse, HUTH

Jane Halpin, Humber Acute Services Review, Project Director Deloitte LLP

Chris Long, CEO, HUTH

Sarah Lovell, Director of Collaborative Acute Commissioning, NHS Hull, East Riding of Yorkshire, North Lincolnshire and North East Lincolnshire CCGs

Peter Melton, Clinical Chief Officer, North East Lincolnshire CCG and Chair - Humber Coast and Vale STP Clinical Advisory Group

Ellie Monkhouse, Chief Nurse, NLaG

Jacqueline Myers, Director of Strategy, HUTH

Peter Reading, CEO, NLaG

Andy Rhodes, Independent Clinical Lead, Humber Acute Services Review, St George's University Hospitals NHS Foundation Trust

Appendix 3

EVIDENCE PROVIDED FOR THE REVIEW

The review considered the following evidence provided by HCV Health and Care Partnership:

Received Mid November:

- Briefing for the Clinical Senate: Humber Acute Services review
- Final HASR Long Case for Change
- Final HASR Case for Change Summary
- Service Model Development

Received 20th December

- Clinical Senate Panel Information Requests Response
- HASR Citizens Panel Feedback Report
- Revised Service Model Development

Appendix 4

NHS
Yorkshire and the Humber
Clinical Senate

CLINICAL REVIEW

TERMS OF REFERENCE

TITLE: Humber Acute Services Review

Sponsoring Organisation: NHS Hull Clinical Commissioning Group

Other organisations requesting this advice: North Lincolnshire and Goole NHS FT (NLaG), Hull University Teaching Hospitals NHS Trust (HUTH), NHS East Riding CCG, NHS North Lincolnshire CCG, NHS North East Lincolnshire CCG.

Terms of reference agreed by: Sarah Lovell, Director of Collaborative Acute Commissioning and Joanne Poole, Senate Manager, Yorkshire and the Humber Clinical Senate

Date: 14th October 2019

1. CLINICAL REVIEW TEAM MEMBERS

Chair	Chris Welsh	Senate Chair	Yorkshire and the Humber Clinical Senate
Primary Care	Nabeel Alsindi	GP and Clinical Lead	Doncaster CCG
Emergency Medicine	Andy Simpson	ED Consultant	North Tees and Hartlepool NHS FT
	Raj Khanna	ED and Paediatric ED Consultant	South Tyneside and Sunderland Hospitals NHS FT
Critical Care	Jeremy Groves	Consultant in Anaesthesia and Intensive Care	Chesterfield Royal Hospital NHS FT
General Surgery	Jon Ausobsky	Consultant General Surgeon (retired)	Bradford Teaching Hospitals NHS FT
	Amarvir Bilkhu	Fellow to Futures Leaders Programme (surgery)	Health Education England
Obstetrics	Stephen Sturgiss	Consultant Obstetrician and Clinical Lead for Maternity Network	Newcastle upon Tyne Hospitals NHS FT
Paediatrics	Mark Anderson	Consultant Paediatrician	Newcastle upon Tyne Hospitals NHS FT
Nursing	Fiona McEvoy	Head of Nursing Quality	North Tees and Hartlepool NHS FT
Ambulance Service	Andrew Hodge	Consultant Paramedic Urgent Care	Yorkshire Ambulance Service
Acute medicine	Patrick MacDowell	Consultant Nephrologist	Lancashire Teaching Hospitals NHS FT
	Mike Bramble	Senior Fellow Gastroenterologist.	South Tees Hospitals NHS FT
Lay members	Margaret Wilkinson		YH Senate Assembly member
	Sue Cash		YH Senate Assembly member

2. AIMS AND OBJECTIVES OF THE REVIEW

Question:

Can the Clinical Senate provide an independent clinical assessment of whether the options currently under consideration are clinically feasible and sustainable given the volumes of activity, case mix, local health needs and constraints presented in the case for change?

Please indicate whether there are other options, or combinations thereof which we should be actively considering.

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

To provide independent clinical advice to the CCGs and hospital Trusts participating in this review to inform the development of the options from the high-level options presented to a final range of options which may include a preferred final option. The advice from the Clinical Senate will be received by the Clinical Design Group and directly influence the recommended options. The advice will be cited in subsequent decision-making fora and influence planning.

Scope of the review:

The Humber Acute Services review will determine the long-term future of acute hospital provision across the Humber. This phase of the review is looking at the fundamental building blocks of acute hospital provision for urgent and emergency care, acute assessment, inpatient and critical care, maternity and paediatrics and planned care. Options for each of these will be designed through a process of clinical design, patient involvement and modelling.

The Senate will answer the above questions based on the information provided in the documentation and through information received at the panel visit on 17th January 2020 and discussion with clinical and commissioning leads at that visit.

3. TIMELINE AND KEY PROCESSES

Receive the Topic Request form: 17th July 2019

Agree the Terms of Reference: by end October 2019

Receive the evidence and distribute to review team:

- By mid-November the case for change and long list of emerging potential options

Meetings and Teleconferences:

- **Clinical Panel teleconference** on 12th December 2019 and 15th January 2020
- **Chair's feedback from the Clinical Panel teleconference to HASR leads:** 12th December
- **Clinical Panel visit** on Friday 17th January 2020

Draft report submitted to Humber Acute Services Review Executive Oversight Group: 3rd February 2020

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

Senate Council ratification; at the March 2020 Council meeting or ratification by email if earlier ratification required

Final report agreed: following Council ratification

Publication of the report on the website: by end March 2020 or by a date agreed with HCV Partnership due to local elections and public engagement/ consultation timeline

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:

- Case for Change report
- long list of emerging potential options

The review team will review the evidence within this documentation and supplement their understanding with a clinical discussion and information shared with the panel at the visit on 17th January 2020.

6. REPORT

The draft clinical senate report will be made available to the sponsoring organisation for fact checking prior to publication. Comments/ correction must be received within 10 working days.

The report will not be amended if further evidence is submitted at a later date. Submission of later evidence will result in a second report being published by the Senate rather than the amendment of the original report.

The draft final report will require formal ratification by the Senate Council prior to publication.

7. COMMUNICATION AND MEDIA HANDLING

The final report will be disseminated to the commissioning sponsor and NHS England and NHS Intelligence (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. organise their clinical and commissioning input into the Senate clinical review panel and fund the travel costs of the visiting panel
iii. respond within the agreed timescale to the draft report on matter of factual inaccuracy.
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
vi. provide feedback to the Clinical Senate on the impact of their advice when requested through contribution to a case study.

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