NHS
Yorkshire and the Humber
Clinical Senate

Clinical Senate Review of Acute Services at Scarborough Hospital on behalf of Humber Coast & Vale Health Partnership

Final Report

February 2020

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Chair's Foreword

1.1 Scarborough Hospital, part of York Teaching Hospitals NHS Foundation Trust, serves a population of 118,000 in Scarborough town, with surrounding rural and coastal areas. There is an average of 53 minutes drive in any direction to the next large hospitals which are in Hull, Middlesbrough or York and journey times are significant, even by emergency ambulance. This is due to poor road conditions as well as mileage. The remoteness of Scarborough hospital is a key issue in considering the services that need to remain on site.

1.2 We very much welcomed the opportunity to work with the Trust and the Humber Coast & Vale Health and Care Partnership, considering how the Trust may provide sustainable acute services and improved outcomes for its local population. Our work with you commenced in October 2019 culminating in our formal advice to you in November 2019. We hope that this report challenges your thinking on the proposed clinical models to help you to move forward to a long-term workable and sustainable solution.

1.3 We thank colleagues in the Humber Coast & Vale Health and Care Partnership and the Trust for their hospitality during our 1 day site visit in November 2019. 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

1. To develop a strategic plan to provide acute services to the population of East and North Yorkshire served by the York Teaching Hospitals NHS FT.
2. To encourage closer working between the Urgent Treatment Centre and Emergency Medicine.
3. To invest in training provision and ensure there is equity in opportunity for the York and Scarborough workforce.

Urology Services

1. To describe the long-term strategy for the urology service.
2. To consolidate urology services on the York and Scarborough sites. This will include developing a dedicated urology bed base in York which is of sufficient capacity to allow patients transferred from Scarborough in a reliable and timely fashion.
3. To discontinue the joint on call urology rota between York and Harrogate.
4. To deliver in patient elective operating in York and day case surgery at Scarborough hospital.
5. To discuss with Hull and Leeds the opportunity for York consultants to participate in tertiary service provision.
6. To consider the consultant of the week model and to consider the potential role of the Urology Specialist Nurses within the proposed model.
7. To explore options to offer surgery for testicular torsion at the Scarborough site.
8. To provide greater clarity on the responsibility for care of urological conditions between general surgery, acute medicine and the urology service.

Maternity and Paediatrics

1. To invest in training and support for neonatal staff in Scarborough and to develop a robust strategy for neonatal nursing care and development.
2. To consider the data on high risk deliveries in the future discussions on the obstetric service.
3. To develop your thinking on the criteria for admission and diversion for the paediatric low acuity model and utilise the audit of overnight paediatric presentations to inform this.
4. To develop your thinking on the training and education needed to support the staff in stabilising a sick child and to consider the implications of the increased numbers of transfers.
5. To consider a hybrid Tier 1/2 model of cover overnight consisting of ANP/ANNP, staff grade paediatrician or tier 2 trainees with skills to cover neonatal and paediatric emergencies.
6. To be ambitious in considering alternative staffing models for the paediatric service.
7. To develop the community paediatric services to support the hospital-based service.

3. Background

3.1 The Scarborough Acute Services Review (SASR) commenced in the summer of 2018 and is a collaborative review of acute hospital care for the people of Scarborough and the surrounding areas. Health services in the local area face a range of challenges which the commissioners are working to address. Those challenges include the changing health needs of the population, the significant staffing vacancies in the hospital and primary care services, and the low patient numbers for some specialist services. These challenges are more pronounced due to the rural and coastal location and the relatively small and dispersed populations. The review is seeking a sustainable, strategic approach to the provision of acute services for the Scarborough population.

3.2 In developing the Case for Change, a number of clinical areas were identified as priority areas. These areas are:

- Maternity and paediatrics
- Urgent and emergency care
- General surgery
- Care outside of the hospital

Due to staffing challenges which have since arisen in urology, this service has now also been added to the scope of the review.

3.3 Throughout the review process there was an agreed view that there is a need to maintain an emergency department at Scarborough Hospital to meet the urgent care needs of the population living in and around Scarborough. The Senate was asked to focus its attention on the priority areas of urology, maternity and paediatrics.

Role of the Senate

3.4 The Senate was invited in to advise on the developing clinical models for the key specialty areas of urology, maternity and paediatrics but with reference to the proposed ED/acute medicine and general surgery services. The Senate was asked to provide the advice by the end of November 2019 so that this could be included within the presentation to the North Yorkshire and East Riding Overview and Scrutiny Committee meetings in December 2019 and January 2020.

3.5 The Senate was asked:

Based on the submission of evidence, is the Senate supportive of the outlined configuration of Acute Urology and Paediatrics/Obstetrics to ensure sustainability and deliver improved outcomes for the population of Scarborough?

Can it advise on any clinical concerns or adverse impacts relating to this configuration and provide recommendations to mitigate these and ensure the safe and sustainable transition of services to the outlined configuration?

Process of the Review

3.6 The Terms of Reference for this review were agreed on 15th October and are available at Appendix 5 to this report. The supporting documentation was received by the Senate and distributed to the Clinical Panel in late October. During October the Senate expert panel shared comments on the documents through discussions by teleconference and email. A site visit was arranged with commissioners and clinical representatives on 13th November 2019 to provide 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. The meeting was held at Scarborough Hospital which gave opportunity for some of the panel members to view the facilities and estate. Once consensus was reached on the draft report it was sent to the commissioner for comment on 29th November.

3.7 Commissioners 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 January meeting and published within 8 weeks of ratification unless there are reasons to delay this to tie in with planned public consultation.

General Comments

3.8 The Senate wishes to make the following general points before considering the detail of the 3 service areas:

3.8.1 The Trust have a very motivated and enthusiastic workforce who are a real asset to the organisation. We recognise the significant challenge to recruit the workforce required for the acute services.

3.8.2 We congratulate you on the development of the recently implemented general surgery service. General surgery is now resilient overnight with the fully recruited twin rotas across York and Scarborough.

3.8.3 The Senate recognises the complexities of your situation including the limitations of the estate, the rurality and high levels of deprivation of much of the local population, and the distance from Scarborough to other hospital sites. We welcome that you have secured £40m investment for improvements to the Emergency Department and supporting infrastructure.

3.8.4 The Senate recognises and supports the retention of the Emergency Department within the clinical model and supports urology, paediatrics and obstetrics services remaining “on-site”. Commissioners may find the South East Coast Senate report on the colocation of services[1] helpful to

[1] South East Coast Clinical Senate: The Clinical Co-dependencies of Acute Hospital Services: A Clinical Senate Review

support their future discussions. Whether in the longer term two fully staffed 24/7/365 Emergency Departments for the Trust is a sustainable solution in practice is questioned by the Senate who note that other Trusts with similar challenges are developing different innovative strategies.

3.8.5 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. You may be able to learn from other small hospitals, for example, the Friarage Hospital in Northallerton, Whitehaven hospital, and The Faculty of Remote and Rural Healthcare in Scotland.

3.8.6 In view of all of the above it is essential that a strategic plan is developed to provide acute services to the population of East and North Yorkshire served by the York Teaching Hospitals NHS Foundation Trust. This would aid recruitment in that candidates would receive a clear picture of the future. Piecemeal planning has the opposite effect. There is more that can be done to manage the Scarborough and York sites as one Trust, to fundamentally consider York-Scarborough as a 'single Trust with two sites' model, to integrate the clinical teams, and to develop a positive culture about the merits of both sites. Clarity of the governance arrangements between services which are run across 2 sites is important.

3.8.7 A clear and well-articulated vision for Scarborough Hospital is required to both support recruitment and to communicate with the public. Scarborough Hospital does have a sustainable future and is important for the community, both as an employer and provider of care.

4. Recommendations

Urology

4.1 York Teaching Hospital NHS Foundation Trust currently provides a 24/7 consultant urology service to Scarborough Hospital. This is done on a rota basis, with duties shared between four consultants based at Scarborough. A review by the national Getting It Right First Time (GIRFT) team has suggested there should be a single rota working across the York and Scarborough sites. However, the geographical challenges make this difficult to achieve, particularly as the York rota is currently shared with Harrogate consultants who would practically struggle to get to Scarborough in any reasonable response time.

4.2 One of the four consultants currently providing services in Scarborough as part of the rota is a locum who has indicated they will be leaving at the end of November 2019. This will mean that from that date, the service in Scarborough would not be viable. In addition, two of the three remaining consultants are set to

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

retire next year and the likelihood of the Trust being able to recruit three new consultants to be based in Scarborough is low.

4.3 The model presented to the Senate is a single York-based on call service which will commence on 18th November. There would be a consultant urology presence in Scarborough between 8am and 6pm on weekdays.

4.4 The consultants will continue to see inpatient referrals from other specialties, provide acute assessment clinics and deliver some elective services. Outside of these hours, half of the approximately 400 emergency presentations per annum would be managed without inpatient admission through Same Day Emergency Care (SDEC) procedures, with the other half (approximately 200 patients) transferred to York Hospital. The average length of stay for acute admission cases is between two to four days. Patients requiring further care for non-urological conditions will receive rehabilitation at Scarborough or Bridlington Hospitals as appropriate.

4.5 The Senate panel agrees that there are strong drivers for a model whereby in-patients and emergency urological care is centred in York, given the practical difficulties of recruiting to and maintaining in-patient and on-call provision on two sites within the Trust. We are therefore supportive of the proposed acute urology configuration.

4.6 We are concerned, however, that the safety and quality questions remain inadequately addressed by the documentation for when the service change begins on 18th November. We realise that you have little choice on that date due to the departure of the locum. Based on our discussions we do have confidence in the dedicated "front door" emergency medicine service to work through the implementation successfully (with more inter-hospital transfers out of hours) despite the inadequacies in the proposed urology pathways at this time. Certainly, looking further ahead, the forthcoming retirement of two of the Scarborough consultants opens up an opportunity to recruit further consultants to York which would provide a sustainable eight consultant team, based on the York site.

4.7 Our clinical concerns with the proposed model and its full implementation are detailed below:

<u>The On Call Rota between York and Harrogate</u>

4.8 With the model proposed, our advice is that it would be unsatisfactory to continue to have a joint on-call rota between York and Harrogate, as this would leave on-call consultants covering Harrogate, York and Scarborough. We recommend that to make your proposed model workable you need to give notice to Harrogate, so that they can work in conjunction with the Urology Department in Leeds to develop a model for urology networking between Harrogate and Leeds. We recognise that there is a risk in cutting ties with Harrogate before consultant recruitment to York is assured. However, it is likely that a consultant

post in the Trust will only be attractive if there is real clarity about the long-term configuration of urological services.

Recommendation: To discontinue the joint on call rota between York and Harrogate

The Long-Term Strategy for the Service

4.9 From the information provided and the supporting discussion the impression given to the Senate is that an incremental approach to service-development is in place and that the final configuration for the urology service has not been agreed or described in crystal-clear detail. Is the preferred model a consultant presence with Scarborough offering a urology investigation unit and a day time service? If it is possible to put together a comprehensive long-term strategy for the service, the prospects for consultant recruitment would be greatly enhanced.

Recommendation: to describe the long-term strategy for the urology service

The Proposed Centralisation of In-patient Urology Care to York

4.10 The centralisation of the urology service to York would create a busy in-patient and emergency urology department in York Hospital. This would need to have access to an appropriate number of designated urology beds and out-patient investigation and treatment facilities (a urological investigation unit) in order to function efficiently. We note that you have estimated that an additional 3 urology beds are required in York to accommodate the acute patients who will be transferred but you have no proposals to increase the bed number and state that the extra capacity can be created through more effective management of acute patients through ambulatory pathways. We need assurance that these pathways are viable and will achieve the desired outcome.

4.11 With this model there would be a need to maintain a regular senior urological presence in Scarborough, in order to ensure that Scarborough Hospital receives reliable “office hour” urology support. Our understanding is that there will be a consultant urology presence in Scarborough between 8am and 6pm on weekdays. In order to achieve this, Scarborough would need to provide out-patient services, preferably using a urological investigation unit model and day case surgery. This led the panel to question the current model where urology sessions are provided in Malton and Bridlington and our advice is that consideration should be given to reducing or stopping urology sessions in one or both of these sites. We are aware that withdrawing urology activity from Malton would put into reverse a process which led to the development of specific urology facilities in Malton Hospital. However, with a fragile overnight service you need to focus your efforts and capacity. Our advice is that it will be very difficult to make this an attractive model if there is an 8-person rota and 4 sites to cover (York, Scarborough, Malton and Bridlington). We advise that it is

preferable to move towards a logical, sustainable service than to continue on the same basis with an inherently inefficient model.

Recommendation: to consolidate urology services on the York and Scarborough sites. This will include developing a dedicated urology bed base in York which is of sufficient capacity to allow patients transferred from Scarborough in a reliable and timely fashion.

Elective Urology Services

4.12 In general, the out-patient management of urology patients is moving towards a system whereby a visit to a unit with out-patient and investigation facilities on hand leads to most patients undergoing a clinical consultation and key investigations at a single visit. Patients are either then discharged from urology care or have a further definitive management plan in place. In order to provide this type of "one stop" service, it is likely that out-patient and investigative urology services would be provided on fewer sites i.e. York and Scarborough. This leaves some patients travelling further, but with the compensation that they should attend on significantly fewer occasions in order to pass along a clinical pathway. Out-patient follow up will increasingly be carried out using a non-face to face approach. The follow up of urology patients is generally well disposed to such an approach, as physical examination is not usually a key factor in urology follow up.

4.13 Urology services are increasingly being provided by a combination of consultants and Specialist Nurses. Our understanding is that the York Trust does not have a large number of urology middle grade medical staff but does have Surgical Care Practitioners on the Scarborough site. It will be important that this non-medical workforce is developed in a way which facilitates the working of the reconfigured urology service.

4.14 Operative urological care is increasingly carried out on a day case basis, although a move to a higher level of day surgery is, in some situations, dependent on investment in technology, such as surgical lasers for carrying out surgery for benign prostatic enlargement and stones. Given the lack of planned out of hours specialist urology cover in Scarborough following reconfiguration, it is questionable whether any urology in-patient activity should be taking place in that hospital. The continued use of Bridlington hospital for urological surgery appears therefore to be unsatisfactory in this proposed model where the department has its main base in York. Our advice therefore is that all in-patient elective operating, including short stay surgery, should be carried out in York. However, well-configured urology day surgery activity should be provided for increasing numbers of patients in Scarborough, in line with British Association of Day Surgery Guidelines[3].

[3] https://daysurgeryuk.net/en/home/

Recommendation: to deliver in patient elective operating in York and day case surgery at Scarborough hospital

Urology Area Network

4.15 The development of the Humber, Coast and Vale Urology Area Network is an important initiative. Future pathways for patients should be considered in the context of that network, as it is expected that patient pathways and protocols will be adopted on a network-wide basis. There will also be a continuing relationship with the Leeds Trust, as Leeds continues to provide some tertiary services for the York population.

4.16 We advise that it is important to open discussions with Hull and Leeds in relation to present and future York consultants being able to participate in tertiary service provision. In particular, York consultants should have the option of carrying out complex stone and urological oncological procedures, including robotic surgery, in Leeds or Hull, if service configuration meant that such surgery was not going to be offered in York.

Recommendation: to discuss with Hull and Leeds the opportunity for York consultants to participate in tertiary service provision

Arrangements for Acute Urological Care

4.17 Many Urology Departments are adopting a consultant of the week model as a way of providing continuity of consultant care to patients who are admitted with acute urological conditions. Such a model would seem to be desirable in the context of the reconfigured urology service, as that consultant would have a clear overview of, not only the acute urological activity in York, but any ongoing urological input into the care of patients in Scarborough. They would be involved in undertaking daily ward rounds in York and attending handover sessions.

4.18 It would be essential to have a senior urology presence in Scarborough during office hours (which your model proposes), which would mean at least one consultant being on site in Scarborough through the working week, undertaking out-patient clinics, investigation sessions and day case operating lists. They would also be available to see in-patient referrals and to liaise with the on-call consultant in York as necessary. This could be configured in a timetable as a "Scarborough week", possibly with accommodation being available to those consultants who did not want to undertake the York-Scarborough commute each day. If such an arrangement was adopted, then it would be apparent that the York on-call week and the Scarborough week would always need to be filled, with annual and other types of leave taken during the other six weeks of the eight-week consultant timetable.

4.19 A small number of departments around the country have adopted a model whereby acute urology patients are initially assessed by a Urology Specialist Nurse. That nurse is generally able to manage approximately one third of

patients without the need for medical input. For example, a specialist nurse will be able to deal with catheter problems and "routine" cases, i.e. emergencies that fit into standard protocols. Developing a physical facility for urological investigations and acute assessment work in Scarborough would allow for this type of model of care to develop and provide a clear point of contact for other clinicians to make contact with the Urology Team.

Recommendation: to consider the consultant of the week model and to consider the potential role of the Urology Specialist Nurses within the proposed model

Specific Acute Urology Conditions

4.20 Testicular Torsion: The Senate advises that the proposal for blue light transfers of patients with suspected testicular torsion is highly undesirable. It is difficult to justify transferring a boy or man, whose testis is ischaemic, from a hospital with available operating theatres and competent surgeons to a distant site with long or, possibly, very long transfer times. It is clear in our view that the General Surgical Team in Scarborough will need to take on this workload. This is a model which is successfully used in other parts of the country (in Barnstaple and Hereford). We understand that specific training may need to be provided to senior and middle grade general surgical staff in order to ensure that they are able to provide a well-governed service for the assessment of the acute scrotum.

4.21 We also acknowledge, however, that there is a need for the Trust to protect its new model for general surgery and not risk the collapse of those arrangements. Nevertheless, every effort should be made to explore options, other than transferring patients with acute scrotal pain.

4.22 One option would be to offer bespoke training to the middle grade tier of surgeons in Scarborough and to provide decision-making support remotely from the York on-call urologist (or a urologist who is on site at Scarborough, during office hours). That grade of surgeon would expect to be able to explore the scrotum without needing senior assistance. However, in the very rare situation when a more senior surgeon actually needs to attend the operating theatre in person, as opposed to providing further telephone/Skype advice, it is clear that that person would need to be the on-call Scarborough general surgeon.

4.23 We also advise that you widen this pathway to a Scrotal Pain Pathway and that this pathway should begin with pre-hospital triage by primary care and Yorkshire Ambulance Service (YAS) before hospital attendance.

Recommendation: to explore options to offer surgery for testicular torsion at the Scarborough site

4.24 Intraoperative Emergencies: The need to call a urologist to a general surgical or gynaecological operating theatre, in order to deal with an unexpected problem, does arise from time to time. Within urology it is increasingly recognised that not

all urology consultants have the necessary expertise to manage these emergencies by carrying out immediate reconstructive surgery if there is a complicated bladder or ureteric injury present. The issues have, belatedly, been recognised within urology and are referred to in both the GIRFT National Report[4] and the British Association of Urological Surgeons (BAUS) document on emergency care provision[5]. In time it may become accepted practice for patients sustaining intraoperative urinary tract trauma to have drains and packs inserted with a view to being transferred immediately post-operatively for definitive reconstructive urological surgery in a specialist centre. Our advice therefore is that the proposal within the Urology Services Reconfiguration October 2019 Document is appropriate but note paragraph 4.28 with regard to emergency medicine training.

4.25 Other Conditions: The paper setting out the management of acute urological conditions in Scarborough provides a set of outline protocols for the care of a number of different conditions. We agree that these conditions are suitable for management using such an approach. It will be extremely important that general surgical and general medical consultants sign up to protocols where any element of joint care is envisaged. It will also be important that the on-call urology consultant in York is contactable at all times for telephone discussion and has access at all times to any imaging investigations which have been carried out in Scarborough. This will include having facilities to view images while on-call at home.

Clarity of Responsibilities

4.26 Where a patient, who presents with a urological condition, is admitted to Scarborough, under the care of a general physician or surgeon, there needs to be absolute clarity as to who is taking responsibility for what aspects of care. Therefore, detailed written protocols need to be developed that provide clarity as to how patients are to be looked after. The appropriate efforts to limit transfers to York must not lead to a situation where patients are admitted to Scarborough but fall between two services and receive suboptimal care.

4.27 You have confirmed that CT scanning is available on a twenty four hour basis for all acute and emergency work at Scarborough Hospital. You have also confirmed that interventional radiology is available on a continuous basis in York. It is not available out of hours in Scarborough hospital and patients requiring interventional radiology will continue to be transferred to York as they are currently, supported by clear policy and protocol.

[4] https://gettingitrightfirsttime.co.uk/wp-content/uploads/2018/07/Urology-June18-M.pdf

[5] https://www.baus.org.uk/_userfiles/pages/files/publications/Provision%20of%20OOH%20emergency%20care%20FINAL.pdf

Recommendation: to provide greater clarity on the responsibility for care of urological conditions between general surgery, acute medicine and the urology service

The impact on Emergency Medicine

4.28 The Emergency Medicine (EM) service are committed to making the urology reforms work but we advise that commissioners consider the following points:

4.28.1 As there is no urology specialist nursing provision at present the EM team will call a urology consultant if there are problems with catheterisation and the need for either suprapubic or bladder aspiration. From the 18th November this arrangement will change out of hours as there will be no Consultant Urologist on site. This may result in it being necessary to transfer the patient to York for treatment until staff training has taken place to allow management of this in the ED in Scarborough. Inter-hospital transfers are therefore likely to increase in the short term. We advise that training will be needed to develop the skills to provide suprapubic catheter and bladder aspiration services which will not be reliably available in Scarborough out of hours from the 18th November

4.28.2 Communications between EM and urology should be informed by the relationships already developed with general surgery. It is more important that the contact to the specialty comes from an appropriately skilled clinician (including nurse practitioner) who has had direct contact with the patient and is completely familiar with the details of the case than through a more senior grade (a registrar grade was suggested in discussion) that may delay decisions when the limited resources of the registrar grades are needed to cover the whole EM service. The experience with general surgery suggests these relationships can develop well based on mutual trust and recognition of the clinician's skills

4.28.3 Trigger beds in York will be essential. If a patient has been assessed in Scarborough as fulfilling criteria for management by specialist in-patient urology services in York the patient should be admitted directly to a urology bed in York unless resuscitation is needed (by a change in condition during transfer). The patient should not therefore be transferred from Scarborough for assessment or management in the York EM service. To achieve this a 'trigger bed' arrangement would be needed in inpatient urology in York to allow 'direct to urology admissions'.

4.29 We have 3 further observations:

4.29.1 Necrotising fasciitis/Fournier's gangrene is mentioned in the documentation. In many hospitals, this is regarded as primarily a plastic surgical emergency, rather than a urological one and the view of the panel is that this is a correct approach. Therefore, we advise that any patient with a suspected necrotising fasciitis should primarily be discussed with a consultant in plastic surgery if possible, but any delay in treatment may threaten life and immediate access to surgical debridement as a critically

timed emergency surgical procedure needs to be described in a suitably governed pathway. Further exploration with the surgical service available 24/7 in Scarborough may be needed to underpin the governance of this pathway.

4.29.2 For patients with renal trauma, we agree that conservative management under the care of a General Surgeon would be reasonable for patients whose condition is stable. Transfer of patients with high grade trauma or circulatory instability would need to be carried out in liaison with a Trauma Centre which had access to interventional radiology, general surgery and urological consultant input.

4.29.3 The loin pain/stone pathway does not discriminate between younger recurrent presenters (e.g. having had a CT evaluation already within 3 months) and new presentations. There are examples elsewhere (e.g. Sunderland Royal Hospital) where pathways are agreed so that out of hours access to CTKUB (cross-sectional imaging to diagnose urological stones and disease) is timely and appropriate but unnecessary reimaging is avoided by the safe delay of imaging until the urology review (for example, with recurrently symptomatic young patients where CT imaging and reassuring blood investigations have recently been undertaken). Some development of the loin pain/stone pathway may help with efficient use of CTKUB imaging out of hours and ensure radiation exposure is timely and necessary.

Paediatrics and Obstetrics

4.30 Scarborough Hospital has one of the smallest obstetric led maternity units in the country with about 1300 births per year, the seventh smallest consultant led unit nationally, and your information suggests that this number will continue to decrease over time. The number of children admitted to hospital in an emergency is also very low compared to other hospitals locally and around the country. (pages 57 – 59 of your Case for Change).

Your Current Model

4.31 Scarborough sees around 3,400 paediatric patients a year with fewer than 3,000 admissions, and this includes patients up to 18 years. The Duke of Kent Children's ward has 10 beds including one high dependency unit (HDU) bed, although this is not formally commissioned, and a 4 bed children's assessment area (CAU) at the entrance to the ward. Since February 2019 this CAU is open from 8am-9pm to manage patients referred from ED, ambulances and GP referrals. When the CAU is closed there are 12 inpatient beds overnight. This can flex up to 14 beds if needed.

4.32 The neonatal unit at Scarborough has raised its admission threshold to 34 weeks and temporarily reduced to 4 cots with the agreement of the Network and Commissioners. You are moving to introduce transitional care, developing midwives and reducing pressure on neonatal nurses. There is limited capacity for

outpatient work as there are only two clinic rooms, although an additional room has been provided nearby on the main hospital corridor.

4.33 Consultant cover for Scarborough comprises those who live locally and are non-resident on-call and those living near York who cover on-call on a residential basis. There are 2 less than full time resident consultants, 1 full time resident consultant, 1 resident consultant currently on maternity leave (4 people in total) and 2 locums who will do resident on call. At Tiers 1 and 2 there are frequent gaps in the rota. Advanced Paediatric Nurse Practitioner (APNP) roles have not been developed. There are 19 graduate Physician Associates a year who would be welcomed to join this team to support Tier 1 and possibly Tier 2 but their current preference appears to be to work for GPs. Anaesthetics currently provide support for managing critically ill children with two consultants attending if intubation/ airway support is required.

4.34 The main challenges to the service on the Scarborough site is in:

- Recruiting and retaining a skilled paediatric medical workforce and neonatal nurses to maintain a high-quality service
- Maintaining the level of skills required due to the small size of both the paediatric and obstetric service

4.35 The Senate panel members wish to commend the clinicians with whom we met who are committed to working together to develop a sustainable model for this service. We note that you are still developing the options for the paediatric and maternity services and although you have an emerging model this is still very much a work in progress.

The Proposed Model

4.36 The preferred model at this point has been developed in conjunction with Royal College of Paediatrics and Child Health (RCPCH) following their visit to the Trust in March 2019. The proposed model is to:

- Develop a Paediatric assessment function from 8 a.m. until 10 p.m. (6 – 8 beds) with the onsite Paediatric ward accepting low acuity admissions between 9 am – 10 pm. Sicker patients presenting at Scarborough would be transferred to York. There would be no overnight admissions. We note, however, that there will be some paediatric inpatients kept overnight at Scarborough and children may still present in ED overnight and would need transfer to York.
- Provide a paediatric consultant on site at Scarborough Hospital until 11pm and on call overnight in Scarborough (within 30 minutes of the hospital site). Consultants will rotate between York and Scarborough covering acute work.
- Overnight in Scarborough will be a hybrid Tier1/2 cover consisting of ANP/ANNP/APNP, staff grade paediatrician or tier 2 trainee with skills to

cover neonatal and paediatric emergencies until the on call paediatric consultant arrives.

- Retain the current level of Obstetric care at Scarborough Hospital.
- Retain the neonatal unit as a Level 1 but increase its cots to 8. Support for Neonatal care cases will be provided by the new integrated Paediatric Consultant rota.

4.37 We fully support your discussions to provide an alternative model and understand how difficult these discussions are to move to cross site working. We agree that unless changes are made the service will not be sustainable. The Senate has a number of concerns however with your outlined configuration which are detailed below.

Obstetric and Neonatal Service

4.38 We understand and support your preference to retain a Consultant led obstetric service on site at Scarborough hospital due to the geographical distance to the neighbouring obstetric service. Moving this service to a midwife led unit would result in approximately 1000 women a year needing to transfer to have their baby. With the current transport links we agree that a full consultant unit is the preferred option. We note that you do not have any recruitment or retention issues with your obstetric or midwifery workforce. Your midwifery ratio is currently 1:22 which is better than nationally recommended levels but the opportunities for their development are limited.

4.39 The Senate is mindful that with 8 Consultants on a rota for 1300- 1400 births, when a similar size workforce would support more than double that activity, that the operation of the current model needs to be kept under review. We have no information on the volume of gynaecological workload alongside the obstetric service.

4.40 Our other main concern is the mismatch between the consultant obstetric service and the neonatal unit support to this. Currently, due to staffing vacancies, your neonatal unit has reduced its admission threshold to 34 weeks gestation and 4 beds. We note that your proposal is to expand this unit to 8 beds and lower the admission threshold back to 32 weeks. With capacity running at 59% we question whether a 6 bed unit would be more realistic.

4.41 The RCPCH report[6] details many concerns with the staffing vacancies on the neonatal unit and the challenges to recruit and retain staff in a unit which offers limited neonatal experience. We share their concerns with both recruitment and the risk of nursing and medical staff becoming deskilled and recommend that you give greater priority to ensuring the safety and stability of this unit. The Senate echoes the RCPCH recommendation to develop a robust strategy for neonatal nursing care and development across both the York and Scarborough site and

[6] Royal College of Paediatrics and Child Health (RCPCH) Service Review York and Scarborough Paediatric Service, Version No 3. Visit date March 2019.

invest in training and support for their neonatal staff. The panel questioned the sustainability of this neonatal unit in the long term, however, if birth rates reduce.

Recommendation: to invest in training and support for neonatal staff in Scarborough and to develop a robust strategy for neonatal nursing care and development

4.42 To support this expanded neonatal service overnight, without a paediatric consultant on site, you propose recruiting to a hybrid tier 1 / 2 model to support the paediatric service and the neonatal unit. During the panel visit, however, it was clear that staff were concerned that by only having one hybrid rota, with the next level being a consultant, that the consultant would be called often leading to excessive tiredness and an unwillingness for consultants to do this job. Given the low acuity and small size of the paediatric service and the neonatal unit, however, we question how attractive a separate Tier 1 and Tier 2 arrangement will be for recruitment and agree that a hybrid Tier1/2 model may be more achievable. The Trust needs to consider what they can offer to attract trainees to those rotas. We discuss the proposed staffing model in further detail in paragraph 4.49.

4.43 The other main concern of the Senate is the lack of data to support the argument that an obstetric led service is needed for the rural geography. We recommend that you support your proposal with data on the proportion of high-risk deliveries at Scarborough, the numbers of high-risk deliveries transferred to York and the outcomes of these. You may also benefit from examining the obstetric led service provided in Whitehaven.

Recommendation: to consider the data on high risk deliveries in the future discussions on the obstetric service

Paediatric Service

4.44 The Senate notes that the low acuity model has been developed from the options provided in the RCPCH report however we recommend that you consider the following points in your further discussions on this model.

<u>Low Acuity</u>

4.45 It is very difficult to define “low acuity” and to communicate this effectively to the local population, the summer visitors and primary care clinicians. We note that currently your thinking on the proposed criteria for admission/ diversion is not well developed and those tools that were referred to in discussion are not suitable assessment tools for this type of proposal. Our panel members were not aware of any other examples of where the low acuity model had been successfully introduced and have real doubts about how feasible this will be in reality, particularly with the added complexity of communicating the thresholds with high numbers of holidaymakers. We are also unclear of the arrangements that will be made for when a patient arrives shortly before the service closes. If

commissioners do want to explore this model it will be helpful for the clinicians to meet with the paediatric team in Northumbria and learn from their experiences.

4.46 We note that the RCPCH report recommended that a case note review was undertaken to understand the time, conditions and acuity of admissions over a period of time to inform the development of the model. We note that 6 months on from that report that the review has not commenced. Thank you for sharing the proposals for that audit and we recommend that you complete this soon to help develop your thinking on this model. The RCPCH also recommended that you convene a working group to understand how a low acuity model may operate and we note that your first meeting was held on 7th November 2019 and that this working group is now meeting monthly.

Recommendation: to develop your thinking on the criteria for admission and diversion for the low acuity model and utilise the audit of overnight paediatric presentations to inform this.

Management of the Deteriorating Child

4.47 Children with more acute needs will undoubtedly present at the hospital, particularly in the summer months with families on holiday who are unfamiliar with local arrangements. We also discussed how children can deteriorate rapidly and that those that appear to be low acuity could change to a higher acuity level quickly. Although you advise that you will transfer the child at an early stage it is essential that your team have the skills to stabilise a really sick child. These resuscitation, stabilisation and transfer skills are a key part of the safety of this model.

4.48 We discussed how the proposed model may result in a significant number of inter hospital transfers and the plans you are considering to manage this. We are not clear what estimation you have of the need for additional ambulance service journeys (for unexpected transfer requests from wards where the patient deteriorates or any additional pathways of care). Due to the long journey time to York or Hull or Middlesbrough the risk of the child deteriorating on route could increase and the teams involved in transferring these children will need some training and education on transport and stabilisation. We advise that you work with your Operational Delivery Network on this. The journey time will also mean that any staff involved in the transfer will be out of service for at least 3 hours which will need to be considered in terms of ongoing workforce issues. Currently you will not have enough nursing staff on a shift to manage this. We advise that more thought needs to be given to 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. It was also noted that helicopter transfer is

only possible in daylight hours due to the lack of lights at the helipad which should be a simple issue to resolve.

Recommendation: to develop your thinking on the training and education needed to support the staff in stabilising a sick child and to consider the implications of the increased numbers of transfers

Staffing

4.49 The proposal from the RCPCH is for a low acuity paediatric ward with no overnight admissions and cover by a hybrid tier 1/tier 2 with support from a non-resident on call consultant. The hybrid post and consultant would also need to be available to support the neonatal unit and the ED. There were concerns expressed by your clinical team during our visit that this model would mean that the consultant would be called frequently to support the team (which would not be a viable model and unattractive in persuading your team to work across sites). It was suggested by your clinical team that if you have a busier neonatal unit by opening to more beds you will need a separate group to cover this service i.e. two rotas. As we have stated in paragraph 4.42, given the low acuity and small size of the paediatric service and the neonatal unit, we question how attractive this will be for recruitment. You may wish to consider a hybrid tier 1/ 2 paediatrician to cover paediatrics with a consultant and the tier 1 and 2 doctors that you have for obstetrics to help support the neonatal service. This would result in an obstetric consultant with an obstetric tier 1, an obstetric tier 2, a paediatric consultant and a paediatric tier 1 / 2 hybrid (mainly to support paediatrics out of hours and not neonates). We recognise that having a well-staffed Tier 1/ Tier 2 rota is essential in supporting the Consultant Paediatrician on call and it will take time to achieve this model of neonatal and paediatric skills on site at Scarborough Hospital.

Recommendation: Consider a hybrid Tier 1/2 model of cover overnight consisting of ANP/ANNP, staff grade paediatrician or tier 2 trainees with skills to cover neonatal and paediatric emergencies

4.50 To ensure the success of your model there will need to be significant transfer of staff across hospital sites and it will be challenging to persuade the workforce to do that. Ideally you will need all twenty consultant paediatricians to do resident on call rotations through Scarborough (or to work out how many consultants you will need for this). A 1:10 on call rota in Scarborough and 1:10 on call rota in York would mean that the consultants will have three weekends and three Mon-Fri night shifts in Scarborough in the year (or if some consultants live in Scarborough they may be happy to do more of the shifts). Whatever model you agree it needs to be a planned bespoke arrangement for your population.

4.51 You also need to consider the staffing skills you require on site to enable ED to support this model. Staff with neonatal life support skills will be required at all times on the neonatal unit and for paediatrics 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) to meet Paediatric Intensive Care society standards[7]. Clear escalation and decision-making criteria is paramount.

4.52 It is disappointing that little progress has been made in considering alternative staffing models including Advanced Nurse Practitioners (ANP) and Physician Associates. You recognise in discussion that you are behind the curve on this. These roles can work very effectively, and ambitious alternative staffing models will be needed to support this model including consideration of hybrid roles where staff are trained in both paediatrics and neonates or midwives trained in initial stabilisation of neonates.

Recommendation: to be ambitious in considering alternative staffing models for the paediatric service

The Children's Assessment Unit

4.53 We congratulate you in developing your CAU and note the cramped conditions in which this currently operates. We note that there are plans to remodel the unit and expand the provision to 6 – 8 beds. We recognise that discussions are ongoing to decide the best location and we fully support the need to improve the current facilities.

Out of Hospital Model and Supporting Services

4.54 The population of Scarborough has high levels of deprivation with significant health needs of children. The daytime consultant and Tier 2 time could be spent developing integrated care, public health and prevention which the population desperately need and is a model that may well be attractive to paediatricians.

4.55 There was little discussion or information on the children's community nursing team and we understand that it is a very limited service at present. There is a much that can be done outside of hospital-based practice and we urge you to be brave and innovative in your community models, and in upskilling primary care, to help support the inpatient unit.

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

4.56 One particular issue we noted on discussion is the variable access to mental health services. You have a large proportion of children attending ED with substance abuse, alcohol intoxication and mental health related issues. The employment of youth workers alongside a viable mental health team may well encourage less of these behaviours. It is unfortunate that children with mental health problems are nursed in an open ward with age ranges 0-18 years present.

[7] https://PIC society standards 2015

Although you have challenges with your available space we advise that more thought needs to be given to the ward accommodation.

General Comments

4.57 The focus of our review is the proposed configuration of the urology, obstetrics and maternity services. To form a view of those proposals we have considered the ability of emergency medicine and acute medicine to support those models. Our comments on their relationship with those models are included within the relevant sections of this report. Our discussions with the clinical teams on our panel visit has also led us to consider a number of more general points which we advise are important considerations in your continued development of the acute services proposals for the York Foundation Trust and in particular Scarborough Hospital and the long-term success of the 3 services we are being asked to consider. Our panel were certainly impressed by the resilience, commitment and dedication of the clinical emergency medicine service. Our advice is that you consider the following points as you further develop your acute service model.

Emergency Medicine

4.58 The configuration of pre-hospital services has some inflexibility resulting in a high proportion of low acuity referrals in to the ED. An example of this is that all GP referrals are directed to the hospital ED as they are not eligible for the Urgent Treatment Centre (UTC). The UTC service is provided by a different provider and agreeing pathways of care and triage of cases is a work in progress. The lack of ownership of the UTC restricts training opportunities for the Emergency Medicine trainees which can only be overcome by seeing type 3 attendees in the main Emergency Department. Closer working between UTC and EM may enhance training opportunities and limit type 3 attendances through the main ED (which are currently about 4000 excess per year)

Recommendation: to encourage closer working between the Urgent Treatment Centre and Emergency Medicine

4.59 The Senate panel noted that in their view acute medicine is a much weaker partner to emergency medicine in Scarborough than in many other Trusts. We accept that this may be the necessary response to local circumstances and should be examined for its own quality and safety rather than compared with more conventional configurations elsewhere. If acute medicine is developed with the new build and flow improves the EM service may play a lesser role. We have noted that the Trauma Audit and Research data (TARN) for ED is very good despite the workforce pressures faced by the EM team.

The Out of Hospital Model

4.60 There are a number of fragile services which are outside the remit of this review but essential to the long-term sustainability of the hospital services. We discussed the fragility of primary care and social services in our visit to you which is contributing to your delayed transfer of care (currently running at 30%). You acknowledge that there is work to be done on improving patient flow through the

hospital and this needs to be a key focus of your continued discussions. Within your presentation to us you included information on the work underway to develop your prevention, community & primary care delivery model. The development of a strategic approach to integrated out of hospital care involving local authority, community and primary care partners and CCGs within the Scarborough locality, and across North Yorkshire as a whole, is key to the success of your hospital model and the services in question. The focus of our review was on selected acute services but it is clear that developing and investing in integrated care, public health and prevention is a key requirement for your population.

Clinical Training

4.61 The Senate advises that you give greater priority to your consideration of the training needs to support the reform and enhance recruitment. A programme of staff training and development is required to enable all healthcare professionals to work at the top of their professional mandate. As you are aware good quality clinical training is very important for the morale of hard-pressed clinicians. If the Trust invests further in providing time within job plans to allow clinicians to deliver high quality training it will lift morale, helps prevent burn out, improve training outcomes and ultimately support successful recruitment of those trainees in years to come. Trainers need the time to train if the trainees in EM and the tier 2 surgical doctors, ACP nurses and physicians associates are to be developed to support the proposed models. If all training posts in surgery are in York and all non-training grade doctors are in Scarborough it will damage morale and may lead to a divergence in standards of care.

4.62 You will also wish to consider that if access to UTC for ED trainees is restricted it will harm their training and further undermine the long-term recruitment of qualified EM consultants which the Scarborough model is heavily reliant on. We advise that breaking down what appears to be a growing York /Scarborough divide in training opportunity is a priority for the Trust. The programme needs to include development of Advanced Nurse Practitioners, Physician Assistants and others, perhaps including surgical care practitioners. Specific training programmes for trust grade doctors will also assist recruitment.

Recommendation: to invest in training provision and ensure there is equity in opportunity for the York and Scarborough workforce

The Hub and Spoke Model

4.63 We have discussed in this report how the model of hospital services is an issue. The simplicity of a York and Scarborough hub and spoke model is complicated by spreading staff and resources across the smaller sites and it is difficult to see how this fits with trying to sustain fragile services on the Scarborough site. We welcome that you are considering services at Malton and Bridlington hospitals in the next stage of your review.

4.64 Although there was a recognition of the neighbouring networks in our discussions with you it is not reflected in the documentation. With the change in configuration of services between York and Scarborough some patients will flow south to access care at Hull and some north to Middlesbrough. In broad terms you said that this was approximately 20% of the population to the North and 20% to the South. Those relationships with the wider Humber Coast and Vale Integrated Care System (ICS) are very important and you need to ensure your new models of care fit with their strategic approach. Similarly, you need to have conversations with the ICS for the South Tees geography. If you then focus your discussions more on the closer geography served by the Scarborough hospital and consider Scarborough hospital as part of an acute Trust working across a larger geography it changes the context of the acute services review.

Patient Centred Proposals

4.65 It is important within all these discussions to ensure that all the proposals are patient centred and that the needs of the population drive the decision making. In our discussions with you we noted that the public fear that Scarborough hospital is being 'wound up'. Communicating the positive vision for the future of Scarborough hospital is important to address that fear.

4.66 The travel times to York and neighbouring hospitals are long, roads are poor and in the summer months travel can take longer due to the influx of tourists, the winter can be problematic due to the weather. We note that there is a large proportion of the public in Scarborough who do not own a car and the return bus journey between York and Scarborough hospital can take 6 bus connections and many hours of travel. Train travel is also seen as unreliable. These transport issues are understandably a real concern to the public (and are noted in the 2019 Healthwatch report[8]) both in terms on the impact on the patient's care but also the family's ability to visit and support that patient. Patients and the public understand that there can be a need to travel to access the right care, but this needs to be balanced with every effort made to make as much of the patient pathway as local as possible and to use digital health systems to help support this approach.

4.67 We are pleased that you intend there to be meaningful engagement with the public early next year and note that there have been no discussions with the public yet on the services under review. It is important to have those early and ongoing discussions so that patients and the public can really help to inform your decision making.

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 proposals for urology, maternity and

[8] https://healthwatchnorthyorkshire.co.uk/Scarborough-Acute-services

paediatric services. It was a pleasure to meet your enthusiastic and committed clinicians.

5.2 In urology services the Senate agrees that there are strong drivers for a model whereby in-patients and emergency urological care is centred in York, given the practical difficulties of recruiting to and maintaining in-patient and on-call provision on two sites within the Trust. We are therefore supportive of the proposed acute urology configuration. However, we do have concerns with the proposals and our recommendations include the need to discontinue the joint on call rota between York and Harrogate, consolidate urological services on the York and Scarborough sites and develop a long-term strategy for the service. We have particular concerns with the proposed testicular torsion pathway and advise that you explore opportunities to offer surgery for this on the Scarborough site.

5.3 We agree with the proposal to retain a consultant led obstetric service on the Scarborough site and our main concerns with this model are the long-term sustainability of this obstetric model and the safety and sustainability of the neonatal unit. We recommend that you develop a robust strategy for neonatal nursing care and development, but we question the sustainability of this neonatal unit in the long term, if birth rates reduce.

5.4 The Senate also welcomes the discussions you have commenced on how to sustain a paediatric inpatient service at Scarborough hospital. At the moment the required case note review has not been performed to allow us to understand whether a low acuity model is viable. However, our main concerns with the proposed model are the difficulties in defining low acuity and communicating these thresholds effectively to your local population, holiday makers and primary care. To support this paediatric model we recommend that you focus on the education and training needed to support staff in stabilising a sick child and to consider the implications of the increased transfers. We also recommend that more efforts are made to develop alternative staffing models for the paediatric service and developing the supporting community paediatric service. For the paediatric population of Scarborough investment in integrated care, hospital at home services, prevention and mental health will help improve outcomes for the population and need to be considered in the proposals.

5.5 More broadly we recommend that you invest in training provision across the Scarborough services and ensure there is equity in opportunity for the York and Scarborough service to enable all healthcare professionals to work at the top of their professional mandate. More can be done to promote working as one Trust across two sites, developing a positive culture about the merits of both sites.

5.6 Finally, a clear and well-articulated vision for Scarborough Hospital is required to both support recruitment and to communicate with the public. Scarborough Hospital does have a sustainable future and is important for the community, both as an employer and provider of care.

5.7 We hope these comments are helpful to you in your further discussions.

APPENDICES

Appendix 1

LIST OF INDEPENDENT CLINICAL REVIEW PANEL MEMBERS

Chris Welsh, Yorkshire and the Humber Senate Chair

Dr Nicola Jay, Consultant Paediatrician Allergy & Asthma, Sheffield Children's Hospital NHS Foundation Trust

Karen Perring, Lead Nurse, Sheffield Children's Hospital NHS Foundation Trust

Dr Sandeep Kapoor, Consultant Paediatrician, Northern Lincolnshire & Goole NHS Foundation Trust

Dr Martyn Farrer, Consultant Cardiologist, South Tyneside & Sunderland Hospitals NHS Foundation Trust

Dr Ben Rayner, Emergency Medicine Clinical Director, Hull University Teaching Hospitals NHS Trust

Dr Meena Srinivas, Consultant Obstetrician & Gynaecologist, Barnsley Hospital NHS Foundation Trust

Mr Simon Harrison, Clinical Lead Urology, Get it Right First Time, NHS England

Mr Peter Sedman, Consultant Upper Gastroenterologist & General Surgeon, Hull & East Yorkshire Hospitals NHS Trust

Margaret Wilkinson, Lay Member, Yorkshire and the Humber Clinical Senate Assembly

Appendix 2

CONFLICTS OF INTEREST

Name	Title	Organisation	Date of Declaration	Reason for Declaration	Date of Response	Proposed way of Managing Conflict
Dr Ben Rayner	Consultant in Emergency Medicine	Hull University Teaching Hospitals NHS FT	Oct-19	As a Consultant in a neighbouring Trust you know many of the clinicians involved these proposals.	Ist November 2019	Through your employment in a neighbouring Trust you have worked with the clinicians at Scarborough Hospital but you have not been in a position to influence the proposals.The Senate therefore agrees to manage this Conflict of Interest by recording the declaration and agreeing to your participation in the review.
Peter Sedman	Consultant General Surgeon	Hull University Teaching Hospitals NHS FT	4th Nov 2019	As a Consultant in a neighbouring Trust you know many of the clinicians involved these proposals.	4th November 2019	Through your employment in a neighbouring Trust you have worked with the clinicians at Scarborough Hospital but you have not been in a position to influence the proposals.The Senate therefore agrees to manage this Conflict of Interest by recording the declaration and agreeing to your participation in the review.
Karen Perring	Lead Nurse	Yorkshire and the Humber Paediatric Critical Care Operational Delivery Network	Oct-19	As Lead Nurse of the Yorkshire & Humber Paediatric Critical Care ODN you have met with the paediatric team and have been made aware of the paediatric proposals. In due course you will be carrying out a service evaluation of anaesthetic and emergency departments around the management of critically ill children across all hospitals in Yorkshire and Humber and Scarborough will be included in this work.	1st November 2019	Through your role in the network you have been kept informed of the proposals but are not in a position to influence the proposals. The Senate therefore agrees to manage this Conflict of Interest by recording the declaration and agreeing to your participation in the review.
Mr Simon Harrison	GIRFT Clinical Lead for Urology	NHSE	Oct-19	As the GIRFT Clinical Lead for Urology you have been personally involved in preparing the GIRFT Programme National Specialty Report on Urology, published in July 2018, which includes information which is relevant to the issues under consideration in Scarborough. Also relevant to the issues under consideration is the British Association of Urological Surgeons document "Provision of Out of Hours and Emergency Urological Care: Guiding Principles for Clinicians", published in May 2019. In addition, the GIRFT Programme National Specialty Report on Paediatric Surgery will contain relevant discussion in relation to the management of testicular torsion. That document is currently in press. You have also been involved in the ongoing discussions regarding the development of interdepartmental networking in urology and the developing network incorporating the York, Hull and Northern Lincolnshire Trusts. However, you have not been involved in any other discussions about the internal configuration of the urology services in the York Teaching Hospital NHS Foundation Trust. You are aware of the urology proposals at Scarborough Hospital	Ist November 2019	Through your employment as GIRFT lead you have a national role which has given you knowledge of the Scarborough model but you have not been involved or influenced any discussions about the configuration of the urology services that we are being asked to review. The Senate therefore agrees to manage this Conflict of Interest by recording the declaration and agreeing to your participation in the review.

Appendix 3

ITINERARY FOR THE SITE VISIT ON 13TH NOVEMBER 2019

Clinical Senate Visit Agenda

Wednesday 13th November 2019 at 09:45 -16:00
Blue Room, North Entrance,
Scarborough Hospital,
Woodlands Drive, Scarborough. YO12 6QL

09:45	Arrival and Introductions – James Taylor, Medical Director YTHFT, Maddy Ruff, Programme Director Scarborough Acute Services Review	Blue Room
10:00	Presentation on Review – Background, progress to date and next steps. *To be delivered on the day*	Blue Room
11:00	Break Out Session including discussion with Urology and Paediatrics/ Obstetrics Clinical Leads and visit to Paediatric Ward	Blue Room, Olive Room, Acer House and Elm Room.
13:00	Lunch	Blue Room
13:45	Panel Reflection Time	Blue Room
14:30	Plenary Session • Further Questions and Feedback	Blue Room
15:45	Summary and Next Steps	Blue Room
16:00	Close	

Appendix 4

EVIDENCE PROVIDED FOR THE REVIEW

The review considered the following key evidence:

- Scarborough Acute Services Review: Executive Summary
- RCPCH - York and Scarborough Paediatric Service Review
- Urology Service Reconfiguration Oct 2019
- Management of Acute Urological Conditions in Scarborough
- Scarborough Acute Service Review Stage 1 Summary Technical Report
- Scarborough Acute Service Review Stage 2 Report
- Annex 1: The Case for Change
- Annex 2: Clinical Workstream
- Annex 3: Finance Workstream
- Scarborough Acute Services Review The Need for Change (Patient / Public Information)
- Scarborough Paediatric Case Note Review Proposal
- Scarborough Acute Services Review Glossary of Technical Terms
- Scarborough Acute Services Review Narrative Oct 2019
- Scarborough Acute Services Review Plan on a Page
- Briefing Scarborough Urology Service

The clinical review panel supplemented their understanding with:

- Their knowledge gained from the site visit to Scarborough Hospital in November 2019

Appendix 5

NHS
Yorkshire and the Humber
Clinical Senate

CLINICAL REVIEW

TERMS OF REFERENCE

TITLE: Scarborough Hospital Acute Services Review

Sponsoring Organisation: – Humber Coast and Vale Health and Care Partnership

Terms of reference agreed by: Maddy Ruff, Programme Director – Scarborough Acute Services Review and Joanne Poole, Yorkshire and the Humber Clinical Senate Manager

Date: 15th October 2019

1. CLINICAL REVIEW TEAM MEMBERS

Chair	Professor Chris Welsh	YH Senate Chair	
Paediatrics	Nicola Jay	Consultant Paediatrician Allergy & Asthma	Sheffield Children's Hospital NHS FT
	Karen Perring	Lead Nurse for the Yorkshire and Humber Paediatric Critical Care Operational Delivery Network	Sheffield Children's Hospital NHS FT
	Dr Sandeep Kapoor	Consultant Paediatrician	North Lincolnshire and Goole NHS FT
Acute Medicine	Martyn Farrer	Consultant Cardiologist	South Tyneside & Sunderland Hospitals NHS FT
Emergency Medicine	Ben Rayner	Emergency Medicine Clinical Director	Hull University Teaching Hospitals NHS Trust
Lay representative	Margaret Wilkinson	Lay Member	
Obstetrics	Meena Srinivas	Consultant Obstetrician and Gynaecologist	Barnsley Hospital NHS FT
Urology	Mr Simon Harrison	Clinical Lead - Urology	GIRFT - NHSE
General Surgery	Mr Peter Sedman	Consultant Upper Gastro & General Surgeon	Hull & East Yorkshire Hospitals NHS FT

2. AIMS AND OBJECTIVES OF THE REVIEW

Question: Based on the submission of evidence, is the Senate supportive of the outlined configuration of Acute Urology and Paediatrics/Obstetrics to ensure sustainability and deliver improved outcomes for the population of Scarborough? Can it advise on any clinical concerns or adverse impacts relating to this configuration and provide recommendations to mitigate these and ensure the safe and sustainable transition of services to the outlined configuration?

Objectives of the clinical review (from the information provided by the commissioning sponsor): The clinical review of these services is a key part of the Acute Services Review established to build an aligned consensus on how best to deliver high quality, sustainable acute services for the population served by Scarborough Hospital.

Scope of the review: Acute Urology, Paediatrics and Obstetrics, taking into account the recently implemented Acute General Surgery model and Emergency Department Acute Medical model.

The Senate will answer the above question based on the information provided in the documentation and through the discussion and information provided in the panel visit.

3. TIMELINE AND KEY PROCESSES

Receive the Topic Request form: 18th October

Agree the Terms of Reference: by end October

Receive the evidence and distribute to review team: 24th October

Pre-Panel Teleconference: 4th November

Programme for Panel Visit: To be confirmed by 4th November

Panel Visit: 13th November at Scarborough Hospital

Draft report circulated to the panel for comment: 20th November

Draft report submitted to commissioners: By 29th November

Commissioner Comments Received: within 10 days of receipt of the draft

Senate Council ratification; To be confirmed. Meeting dates are 22nd November 2019 and 20th January 2020. Email ratification if required

Final report agreed: following Council ratification

Publication of the report on the website: within 8 weeks of ratification by the Council unless requested otherwise by commissioners

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:

A. Scarborough Acute Services Review: Executive Summary
B. RCPCH - York and Scarborough Paediatric Service Review
C. Urology Service Reconfiguration Oct 2019
D. Management of Acute Urological Conditions in Scarborough
E. Scarborough Acute Service Review Stage 1 Summary Technical Report
F. Scarborough Acute Service Review Stage 2 Report

G. Annex 1: The Case for Change
H. Annex 2: Clinical Workstream
I. Scarborough Acute Services Review The Need for Change (Patient / Public Information)

The review team will review the evidence within this documentation and supplement their understanding with the clinical discussion at the 13th November panel visit.

6. REPORT

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

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

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

7. COMMUNICATION AND MEDIA HANDLING

The final report will be disseminated to the commissioning sponsor, provider, NHS England (if this is an assurance report) and made available on the senate website. Publication will be agreed with the commissioning sponsor.

8. RESOURCES

The Yorkshire and the Humber clinical senate will provide administrative support to the clinical review team, including setting up the meetings and other duties as appropriate.

The clinical review team will request any additional resources, including the commissioning of any further work, from the sponsoring organisation.

9. ACCOUNTABILITY AND GOVERNANCE

The clinical review team is part of the Yorkshire and the Humber Clinical Senate accountability and governance structure.

The Yorkshire and the Humber clinical senate is a non-statutory advisory body and will submit the report to the sponsoring organisation.

The sponsoring organisation remains accountable for decision making but the review report may wish to draw attention to any risks that the sponsoring organisation may wish to fully consider and address before progressing their proposals.

10. FUNCTIONS, RESPONSIBILITIES AND ROLES

The **sponsoring organisation** will

i. provide the clinical review panel with agreed evidence. Background information may include, among other things, relevant data and activity, internal and external reviews and audits, impact assessments, relevant workforce information and population projection, evidence of alignment with national, regional and local strategies and guidance. The sponsoring organisation will provide any other additional background information requested by the clinical review team.
ii. respond within the agreed timescale to the draft report on matter of factual inaccuracy.
iii. undertake not to attempt to unduly influence any members of the clinical review team during the review.
iv. submit the final report to NHS England for inclusion in its formal service change assurance process if applicable
v. provide feedback to the Senate on the impact of the Senate advice when this is requested by the clinical review team.

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.