

Clinical Senate Review
Of Transformation of Acute
Services in Southport and
Ormskirk Hospital NHS
Trust on behalf of
Southport and Formby CCG

Final Report V1.0

January 2019

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1. Chair's Foreword

- 1.1 Southport and Ormskirk Hospital (S&O) provides acute and community services for a population of c. 258,000 and employs a committed workforce of 3,500 staff. However as a small District General Hospital (DGH), sustaining services in 2 hospitals only 7 miles apart, it faces many challenges and there are areas of care that need to improve. The Care Quality Commission (CQC) report rated the Trust as 'requires improvement' in 2018 highlighting their concern with the workforce shortages creating substandard clinical outcomes. Workforce shortages are also one of the major challenges driving non-compliance with clinical standards and guidelines. There are also difficulties with access to services and patient flow, exacerbating the pressures on Accident and Emergency (A&E) services. In addition the services are not financially sustainable in their current form.
- 1.2 There is however much to celebrate within the services at the Trust. There is now a stable Executive team in place which is committed to moving forward with the programme of change. There is also a dedicated workforce at the Trust, showing real resilience in maintaining their commitment and passion through a sustained period of instability.
- 1.3 We very much welcomed the opportunity to work with the Trust and the Clinical Commissioning Groups (CCG) in considering the clinical scenarios for how the Trust may provide sustainable acute services for its local population. We hope that this report both challenges your thinking and interrogates the clinical models to help you to move forward and focus on the workable solutions. It is clear that substantial change is required. With an increasingly elderly population, 1 in 3 over the age of 65, the Trust needs to develop and reshape to respond to their needs yet also continue to provide planned care and acute services to the wider population.
- 1.4 We were asked to advise on the comprehensiveness of the Case for Change and advise on any clinical concerns within the proposed scenarios. We were also asked to consider each clinical work stream and assess whether there is a compelling clinical vision for the future which will address the strategic quality gaps identified. We hope that this report helps to move forward those discussions to a preferred model of services.
- 1.5 We thank the commissioners and the Trust for their hospitality during our 1 day site visit to both the Southport and Ormskirk Hospitals in October 2018. Meeting the hospital and primary care staff, and visiting the departments across both sites, gave us the opportunity to better understand the geography, the challenges and the proposed solutions and to talk to clinicians delivering the services.
- 1.6 I would also like to take this opportunity to thank the panel of clinical experts and lay experts who assisted with this review. I very much appreciate their enthusiasm and diligence in reviewing the detailed evidence provided to us.

Jeff Perring, Senate Vice Chair

2. Summary of Key Recommendations

- 2.1 The Senate is in agreement that the Case for Change does provide a comprehensive review of the issues facing the services and provides a compelling argument as to why the Southport and Ormskirk services need to change. Reconfiguring the services across the two sites is a necessity; however we have a number of clinical concerns that run through all of the scenarios presented. Of key importance is the lack of joined up thinking between community and Trust services, and the inconsistency of provision in community services, which are resulting in the failure to present a single view of care for the whole population. We are also concerned about the lack of a well-developed Sustainability Transformation Partnership (STP) view of the needs for this population which explores the feasibility of clinical partnerships with other providers.
- 2.2 Based on our independent clinical assessment our advice is that scenarios 2 – 4 are where the Trust need to focus with the Trust recognising and accepting that no option will be to the satisfaction of all parties. The agreed best option would be a new build located between the 2 existing sites but at the time of writing this report the funding for this was not secured. This would still require clinical partnerships with neighbouring Trusts to ensure the sustainability of some of the services. There is a time delay with any new build and services will still need to be delivered safely in the interim. The discussions for this interim solution include moving to a hot and cold site model on the 2 existing sites. There is no 'win win' outcome on this hot and cold site model, either the elderly population will not be best served by moving the services to Ormskirk (hot site) or the maternity population will be impacted if the decision is to move services to Southport (hot site). The 'no change' scenario does not have our support. Scenario 5 also does not have our support as from the information received we recommend that Accident and Emergency Services remain at the Southport site. We think there is opportunity for the Trust Executive to do more to present a compelling clinical vision, understood by all levels of staff, that there is a bright future for this hospital.
- 2.3 With regard to the specific clinical pathways we agree the following:
- The frailty pathway is well developed. We congratulate the Trust on the progress made with this pathway which receives our full support. We caution that the success of the proposed frailty pathway is dependent on integrating services with community providers and on successful recruitment of the necessary workforce.
 - The solutions for the women and children's services are less well developed. The small size of the obstetric unit means this service may be difficult to sustain long term, even if the workforce shortages can be addressed. A small unit may be sustainable if it remained at Ormskirk or if moved to a new build site. This combined

with the small size of the neonatal unit and their inability to meet BAPM standards leads us to suggest that Scenario 2 is less attractive than Scenarios 3 and 4. Critically the Local Maternity Service (LMS) view of the service is not known and the future for the obstetric services needs to be considered in conjunction with the LMS plan. The LMS plan was not published at the time of writing this report. The sustainability of the neonatal unit has also not been considered within the scenarios.

- It is clear that the paediatric A&E needs to be in the same place as the adult A&E but the wider challenges in the paediatric workforce are not addressed within scenarios 2- 4. We advise that the Trust needs to develop proposals for paediatric partnership working with other neighbouring providers regardless of whether the obstetric service remains on the same site.
- There are still gaps in the urgent and emergency care model of care and we question whether enough focus is given to the crowding and flow through the hospital. There are still too many direct lines to the A&E department in the proposed model and the sustainability of the critical care unit is also not adequately considered here. The critical care service is integral to the viability of most of the scenarios.
- The vision for developing Ormskirk into a sub-regional elective care centre is well received but the detail behind this and the fit with emergency surgery needs further development.

2.4 Our report provides further detail on these areas.

3. Background

Clinical Area

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

Population Needs	Average Weekly Demand
Adult A&E attendances	920/week
Paediatric A&E attendances	531/week
Deliveries	44/week
Day case and Elective Inpatient General Surgery Spells	96/week
Day case and Elective Inpatient Orthopaedic Spells	30/week

- 3.2 Services are split across the Southport and Ormskirk sites with Southport providing a Type 1 24/7 A&E for adults, and Ormskirk the equivalent for children. Medical specialties, including urology and orthopaedics are provided at Southport. Obstetrics, gynaecology and paediatric inpatient services are provided at Ormskirk. The 3 main CCG commissioners are Southport and Formby CCG, South Sefton CCG and West Lancashire CCG.
- 3.3 The North West Regional Spinal Injuries Centre at Southport hospital provides specialist care for spinal patients from across the North West, North Wales and the Isle of Man. This service is outside the scope of this review.
- 3.4 As a small DGH the Trust faces the challenges of maintaining the range of specialties it currently offers, maintaining and increasing its workforce and their skills, a workforce which is stretched across 2 sites, and meeting clinical standards and guidelines.

Role of the Senate

- 3.5 The Senate was approached by the Cheshire and Merseyside Health and Care Partnership (C&M HCP) in April to work with Southport and Formby CCG in reviewing the sustainability of acute services in Southport and Ormskirk Hospitals NHS Trust.
- 3.6 The C&M HCP advised the Senate that they had commissioned KPMG and the NHS Transformation Unit to support the development of the service change proposals for the acute services at this Trust and it is these proposals that the Senate would be asked to advise on. Due to the conflicts of interest within the local Senate, the Yorkshire and the Humber Senate was approached to provide the formal clinical advice on the preferred option into the Stage 2 assurance process.
- 3.7 The specific questions the Senate was asked to address are
- **Could the Senate advise on the Case for Change and whether this provides a comprehensive review of the issues facing the services. Considering the Case for Change, can the Senate review the proposed scenarios for service change and advise on any clinical concerns relating to any individual scenario?**
 - **For each clinical work stream (frailty, urgent care, elective care and women and children's services) is there a compelling clinical VISION for the future with a clear clinical argument to address the strategic quality gaps identified in the Case for Change? Please focus your advice on:**
 - **The proposed model of care**
 - **Whether the priorities for implementation are the right ones**

- **Whether the programme has considered all the key clinical interdependencies**
- **If there are any gaps in the clinical models presented and if so what further work needs to be undertaken**
- **Specific concerns about the workforce implications for the models proposed, deliverability and further options for us to consider further.**

Process of the Review

- 3.8 In May 2018 the Senate Council was informed of the request from C&M HCP and discussed the approach we should take to this review. Work commenced on assembling the expert clinical panel for the review. In July 2018 representatives from the Trust and the CCG were welcomed to the Senate Council to provide an overview presentation of the issues facing the Trust. The Senate Council further refined our approach to the review in the light of this discussion in agreement with the commissioning lead. The supporting information was received from the CCG on 11th and 12th of September and distributed to the panel on 14th September. Discussions took place with all panel members during the following weeks.
- 3.9 A site visit to the Southport and Ormskirk Hospitals took place on 2nd October and the itinerary of the site visit is included at Appendix 3. There was 1 additional member of the panel who was unable to attend the visit but still contributed to the teleconference and email debate. The details and short biographies of the full panel can be found in Appendix 1. The clinical panel followed up the site visit with a teleconference discussion on 8th October where the requirements for additional activity information were agreed.
- 3.10 The additional information was received on 18th October and the panel commented on this information through further email and teleconference. The report was drafted during the final weeks of October and early November and provided to the commissioners for comment on 14th November.
- 3.11 The Senate took the information received from the clinicians during the visit at face value and based their recommendations on the evidence received, which is listed at Appendix 5.

4. Recommendations

Could the Senate advise on the Case for Change and whether this provides a comprehensive review of the issues facing the services. Considering the Case for Change, can the Senate review the proposed scenarios for service change and advise on any clinical concerns relating to any individual scenario?

4.1 The Senate is in agreement that the Case for Change does provide a comprehensive review of the issues facing the services and provides a compelling argument as to why the Southport and Ormskirk services need to change. In our view the key drivers for change can be summarised as:

- Workforce shortages. At April 2018 there were 53.4 Whole Time Equivalent (WTE) vacancies across all services in the Trust and the workforce pressures drive the non-compliance with national standards and guidelines particularly the consultant review within 14 hours of admission. This leads to concern that basic standards of care are not being met.
- The unbalanced configuration of services, particularly the separate adult and paediatric A&E departments which stretch the emergency consultant cover further.
- The lack of clinical mass. As a small DGH it faces the challenges of maintaining small acute speciality teams to provide a 24/7/365 service.
- Patient flow. The lack of available beds increases the pressures in A&E, the length of patient stay has increased due to delayed discharges and patient care is being compromised.
- Given the small activity levels the Trust is challenged financially with the resulting difficulties in maintaining the estate and investing in service development.

4.2 The Senate was presented with five core scenarios which are driven by the proposals within emergency care and maternity with variations in the model for paediatric inpatient care:

- Scenario 1 - Do Nothing. Operational efficiencies and maximise productivity
- Scenario 2 - Consolidated Hot site with an obstetrics unit on the hot site
- Scenario 3 - Consolidated Hot site with Midwife Led Care and no neonatal unit
- Scenario 4 - Consolidated Hot site with no maternity on site deliveries and no neonatal unit
- Scenario 5 - Urgent Treatment Centre as part of a locality and neighbourhood hub. Therefore no A&E provision, emergency surgery, maternity on site deliveries or paediatric inpatient services.

4.3 In scenarios 2- 4 the Trust would provide 24/7 A&E, an Urgent Treatment Centre, Level 3 critical care, acute medicine with generalist focus and emergency surgery. The location of the hot site is presented as either Southport or Ormskirk in these scenarios.

4.4 We have the following clinical concerns which run through these scenarios:

- Looking wider than the Trust is essential to the success of all the scenarios. The models say that they lay out a vision for the hospital working in an integrated fashion with locality based hubs that coalesce services around populations, providing joined up local care and access to services that an increasingly elderly population need. In reality however the primary care offer is not strongly represented throughout these scenarios and we do not have a sense of how the community services are being developed as part of the solution. All parts of the system do not seem to be working together to provide a cohesive pathway for the patient. Many times throughout the day the message from staff was that there is a difference in community provision across the CCGs which complicates discharge procedures. The message was that there is a disconnect between the Trust and the CCGs resulting in inconsistency and inequity in provision. The organisations now need to move on from justifying the current position to working better together to provide that single view of care for the whole population. There is great potential here for developing out of hospital services.
- The discussions with partner organisations, including the ambulance services, seem to be in the very early stages and yet are integral to all the solutions. Our advice is that these discussions need accelerating to understand this system wide Sustainability Transformation Partnership (STP) view and we are not sure whether the sub regional health economy is organised yet to provide that.
- The scenarios considering a hot/ cold site will greatly affect the services that remain. In the presentation of these scenarios it seems that the focus at this stage has been to consider what models of care are possible rather than developing scenarios in response to the needs of the population.
- Critical care is badged as being Level 3¹ throughout scenarios 2- 4 but currently this service does not meet the national standards² with gaps in the workforce and high sickness levels. The Trust acknowledge that the service does not meet the staffing requirements but none of the proposed scenarios go into detail as to whether any of them mean they are more or less likely to meet these national standards. With most options retaining A&E and acute medicine the critical care unit would need to be retained³ and the sustainability of that service to support the acute medical model needs further thought.
- Regarding both elective and urgent care none of the scenarios have detail about the staffing implications for anaesthesia both at trainee and consultant level and how that need may be met potentially through partnership working.

¹ Comprehensive Critical Care, Department of Health 2001

² Guidelines for the Provision of Intensive Care Standards 2016

³ The Clinical Co-dependencies of Acute Hospital Services (SEC Clinical Senate) December 2014

- We are aware that the Trust will shortly look to consult with the public on the potential models of care but we think it is a missed opportunity not to engage the population in shaping those options. One example of this is the proposal for a Midwifery Led Unit, where there is much benefit to be gained in testing public opinion on this. The Trust may wish to consider a patient partners model similar to that used in the University Hospitals Leicester <https://www.leicestershospitals.nhs.uk/members/patient-partners/>
- 4.5 With regard to the scenarios, our advice is that we cannot provide support to Scenario 1. Given the scale of challenge facing the Trust this scenario will not do enough to make the services sustainable which we define as:
- sees and treats **enough patients** to operate a safe and efficient service
 - has an **appropriate workforce** to meet staffing needs
 - has **interdependent clinical services** in place and in reach to operate core services safely and effectively
 - is likely to be deliverable within the **resource envelope** that is likely to be available.
- 4.6 We also cannot provide support to scenario 5. Given the high proportion of elderly patients within the population, the level of deprivation and the lack of alternatives for emergency care, there is a need to provide the local population with a 24/7 A&E department. This scenario would also have a substantial impact on the ambulance services who may need to provide additional resources to manage the increased workload which would suggest that this is not a viable option.
- 4.7 We agree that reconfiguring services across the 2 hospital sites is the way forward and we recommend that scenarios 2 – 4 are where the Trust needs to focus. This reconfiguration of services will still be required even with a new build, recognising the time delay with its completion and the need to keep services sustainable in the interim. Our advice is that the separation of the paediatric A&E and adult A&E cannot continue as this configuration stretches the staff to the point at which both services become unsustainable. This issue would be addressed with these scenarios, but the wider issues of the paediatric workforce are not addressed. The Trust needs to recognise that whichever hot/ cold site option is chosen it will not be to the satisfaction of all parties. If Southport is chosen as the hot site our advice is that the obstetric service will not be sustainable as the numbers accessing that service will reduce leaving the service unviable. This will have the knock on effect of paediatrics needing to be provided in partnership with another unit. Scenario 2 therefore is not feasible if Southport is the hot site. A small obstetric unit could be sustainable if it remained at Ormskirk or if moved to a new build site. If Ormskirk is chosen as the hot site the elderly population will be disadvantaged and the poor infrastructure and transport links around the Ormskirk site will need to be addressed. It could be argued that as the frail elderly is a greater sector of the population served by the Trust that their requirements need to be prioritised on the Southport site. This option brings with it the challenge of maintaining the estate. The Trust needs to decide upon the hot/ cold model based on how their population needs can best be met through local provision and in partnership working with other providers. These

changes can only be made in the context of the STP. The ability of partner organisations to absorb the activity from the Trust was not available to the Senate.

- 4.8 We recognise that the preferred option is for a new build located between the 2 existing sites but at the time of writing this report the funding for this was not secured. The hot/ cold model is therefore presented as an interim solution with the longer term plan contingent upon the capital funding to build a new hospital midway between the 2 existing sites. We agree that this new build approach goes some way to mitigating the risks of maintaining local services for a population of only 230,000. Should this not be achievable because of the capital constraints, the interim solution will become the long term solution and this very much needs to be in partnership with other providers in the geography. This will bring the workforce into larger networks to give the best chance for long-term clinical sustainability into the future. Even this interim solution may take 5 years to achieve and requires capital investment. The Trust need to be open with the public about the timescales they are working to. There is however much that can be done which is not contingent upon the capital availability. A good example of this is in improving patient flow and the frailty pathway.

For each clinical work stream (frailty, urgent care, elective care and women and children’s services) is there a compelling clinical VISION for the future with a clear clinical argument to address the strategic quality gaps identified in the Case for Change? Please focus your advice on:

- **The proposed model of care**
- **Whether the priorities for implementation are the right ones**
- **Whether the programme has considered all the key clinical interdependencies**
- **If there are any gaps in the clinical models presented and if so what further work needs to be undertaken**
- **Specific concerns about the workforce implications for the models proposed, deliverability and further options for us to consider further.**

Opening Comments

- 4.9 There is a real need to shake the view of the future from being one of inevitable decline and for the executive team to present a vibrant future for the Trust. As yet however we do not agree that there is a compelling clinical vision for the future for each clinical work stream nor a cohesive message, understood by all levels of staff, that there is a bright future for this hospital but that change is needed to make that happen. It is difficult when the final destination is not agreed but now that there is a stable executive team in place we advise that the Trust invests the time in developing a strong, simple and consistent message to the staff that conveys how you want this Trust to be seen and what the staff can offer to deliver that.

4.10 The level of engagement, enthusiasm and commitment from the clinical leaders with whom we met was unquestionable but from discussion it was clear that this engagement is not widespread throughout the Trust. We heard that even if clinical leadership is nominally within the job plans the staff do not have time to practice this, particularly within the Band 7 nursing staff. It is clear that a thin slice of committed staff is not enough to carry through this level of change and you need broad organisational engagement. We encourage the Trust to look at how they can support and engage with staff further.

4.11 Our comments on each clinical work stream are detailed below:

Frailty

4.12 Currently the team of 3.6 substantive geriatricians, a dedicated Therapist Frailty Practitioner and a Lead for the Care of the Elderly deliver:

- Frailty in reach to the Emergency Department and the observation ward
- 2 specialist elderly care inpatient wards totalling 44 beds (a 5 day service)
- Inpatient rehabilitation services totalling 22 beds (5 day service)
- A general medicine/ Parkinson clinic once a week
- Complex pathology/geriatrics/ Parkinson clinic once a week
- A limited partial service of orthogeriatric in reach
- Inpatient referrals (5 day service)
- 1 in 12 involvement in the unselected general medicine acute take

4.13 During our visit we were informed of the lack of social care provision and the lack of alternative options for GPs which results in referrals to A&E. There are examples of good service, for example, the community respiratory service which should enable discharge and assist with admission avoidance. However, we received many messages throughout the day of the problems created by poor patient flow throughout the hospital. As a Senate we are in agreement that frailty pathways are an important part of the solution for the Trust to help address the current gaps in care and the resulting pressures this places on patient flow throughout the hospital. We were very pleased to see the focus the Trust has placed on developing the integrated frailty pathway and to have the opportunity to discuss its development with the lead Geriatric Consultant at the Trust. We also had opportunity to read the Integrated Frailty Pathway Project Initiation Document v1.5.

4.14 The work on the frailty pathway is not contingent on any final model for the Trust and we are pleased that the work has been prioritised and has excellent clinical leadership and the support of the executive team. It provides a great example of what can be achieved with the community and hospital services working more closely together. This relationship is still developing and we discussed on the panel visit that there are still 'quick wins' that can be achieved like providing the frailty team with access to the GP 'EMIS' system on the ward.

4.15 Broadly we agree with the model of care and its identified priorities. We can also confirm the interdependencies have been considered.

- 4.16 With regards to the workforce we note that in discussion the Trust is realistic in its approach to improving frailty provision, focusing on upskilling the workforce in recognition that it is unlikely to be able to recruit the 8.6 WTE Geriatricians which are recommended by the Royal College of Physicians for the size of population. We note however that within the draft frailty pathway there is a plan for the recruitment of 4 substantive WTE consultant geriatricians which is very ambitious and is unlikely to be realised within the first couple of years as projected. We advise to focus on the need to upskill the workforce in parallel to your recruitment efforts.
- 4.17 During the panel visits we were pleased that the clinical leads expressed their view that the future of frailty provision needs to be in the community. We discussed the risks of an ever expanding bed base and agreed how this isn't the right answer. We therefore recommend that the frailty pathway document reflects the approach of using a flexible multidisciplinary frailty team (the "Hospital Frailty Team") rather than having a defined geographical "unit" (the 12 beds proposed in A&E and Obstetrics). As we discussed the Trust need to ensure that they do not plan a vision for a future of more inpatient wards for elderly care. These patients need competent assessment and good pathways out of hospital into the community.
- 4.18 We advise the Trust to further consider the following points specifically on the Integrated Frailty Pathway draft:
- Page 10, section 2.4, Acute work stream key performance indicators (KPIs) – the KPIs should be widened to include indicators for the patient experience
 - Page 12, section 2.4, Care Home Standardisation work stream – the smart objectives needs to include specific examples of the approaches and processes that will be standardised. Our advice is that currently the listed KPIs are more appropriately listed as the benefits, and the listed benefits more appropriate as the KPIs.
 - Pages 12 and 13 – the work streams of social work, delirium, medicines management, out of hours and communications are all very important and detail is needed for their objectives, KPIs and benefits as none is currently provided.
 - Page 13 – more detailed information is needed for the two work streams of information sharing and business intelligence.
 - Page 14, section 2.6, Risk Log – the Community section lists partnership engagement as a risk but there is no mitigating action. On our visit we observed ongoing references to historical tensions between the trust and the two CCGs so this needs to be addressed as a priority for effective integrated working. The remainder of the risk log has very little detail to provide assurance.
 - Page 23, section 3.1, please reference our earlier point regarding the use of a flexible multidisciplinary frailty team rather than a defined geographical unit.
 - Page 28, section 3.6, Care Home Standardisation – we suggest including a recognised evidence based pathway for the diagnosis and management of suspected urinary tract infections (References would include Public Health England UTI Guideline July 2017, NICE QS90, SIGN88 July 2012).
 - Page 36 onwards, Appendix 2 - The Elderly Care Wards consultant is shown to have 18 sessions of Direct Clinical Care. Our understanding therefore is that this model is under resourced by 1 WTE Elderly Ward Consultant.

4.19 Although the frailty pathway is well thought through there are other internal efficiencies that can still be made to Trust processes to improve the flow of patients. The single handed nature of many of the medical sub specialties means that the Trust needs to look to partnership arrangements with other Trusts to move these services onto a sustainable footprint. Joint appointments and shared job plans are needed with an increased range of outpatient clinics and in reach services.

Urgent and Emergency Care

4.20 There are currently significant challenges in urgent and emergency care:

- The 4 hour access target is only achieved for 60% of patients. There are 40-50 medical admissions a day and 22 beds on the acute medical unit
- There is a shortage of qualified nursing staff leading to understaffing out of hours;
- There is a shortage of consultant cover exacerbated by the paediatric A&E being separate on the Ormskirk site.
- Delayed discharge from critical care is rising.
- There was a 5% growth in A&E attendances (Jul-16 to Dec-17) with an inconsistent primary care offering across the region.
- Issues with patient flow exacerbate pressures in A&E due to lack of available beds; this has led to front door pressures with extended ambulance waits. 11 hours of ambulance time are lost each day due to the delayed handovers at Southport

4.21 Given the high proportion of elderly patients within the population, the level of deprivation and the lack of alternatives for emergency care, we agree that there is a need to continue to provide the local population with 24/7 urgent and emergency care for adults.

4.22 In reference to the specific points you asked us to focus on we do agree that the integrated system model of care makes sense. We advise that there are still gaps in the model and not all the priorities for implementation are addressed. We advise the Trust to consider the following points.

4.23 In 2017/18 the Trust had 76,666 type 1 attendances and an additional 42,144 type 3 attendances across all sites. Our observation is that there is a very high proportion of urgent care episodes taking place outside of the acute sites. Developing an Urgent Care Centre wrapped around the A&E department will create more demand on site, significantly increasing the footfall at Southport. This effect will be compounded if one or more of the existing Urgent Care Centre (UCCs) are closed to resource it. The existing Urgent Care Centres have not reduced the unscheduled care attendances across the system in their 10 years of operation and there is evidence that co-located services can increase attendances independently of the UCC status- (reference <https://www.ncbi.nlm.nih.gov/pubmed/27068868>). We advise that this issue needs to be taken into account in the modelling.

4.24 Staffing integrated or co-located UCCs are problematic, and in most areas, recruiting GPs to staff such services consistently is a major challenge unless significant financial incentives are offered. Having senior clinical decision makers to correctly

assess the patient's needs is key to their success and the Trust need to ensure that they can recruit to those positions.

4.25 Reducing primary care attendances by streaming to an UCC does not generally improve flow, safety or quality indicators at a Type I ED (4hr performance and waiting time). In all the discussions and documentation received the issue with flow is a recurring theme. It is acknowledged in the urgent and emergency care model but it isn't the main focus. In 2017/18 the number of patients with over 12 hrs from Decision to Admit to admission was 169 which is much higher than the peer average. Length of patient stay has increased over the last two years at the Trust and exceeded the peer average by 0.7 a day in Q4 of 2017. Commissioners will understand the need to fully integrate the UCC and the A&E into the assessment model with each component working towards improving throughput and minimising unnecessary emergency admission and hospitalstays.

4.26 Crowding, flow through the hospital and quality markers require a specific, separate strategy which we understand is being developed as part of the detailed work on the Urgent and Emergency Care model. Reach-in Frailty/Geriatrics, targeted community services and ambulatory care as outlined are key to improving the issues with flow and the A&E cannot singlehandedly solve this issue. The frailty pathway is well in development and will help to address this but the following issues also need addressing:

- The out of hospital model seems to be patchy and we are unsure how good initiatives like the Sefton Transformation Project for example are replicated or integrated with other areas. The lack of maturity of these programmes is a real limiting factor in the Trust's ability to manage itsflow.
- There are still too many direct lines into the A&E department - GPs still refer directly to A&E due to their lack of alternatives; in the model for example there is a direct line from the nursing home into the department rather than a step between which offers an alternative in the community.
- Patients with back pain spend longer than clinically appropriate on the observation ward as there is no identified ward or consultant for them. More generally the fragility of the single handed specialist services creates delays in the system
- The Integrated Assessment Unit would be able to provide much more support to the model if it was adequately staffed

4.27 With regards to interdependencies the programme has not adequately considered the sustainability of the critical care unit. There are real difficulties in recruitment to Consultant Anaesthesia and Intensivist posts and the Guidelines for the Provision of Intensive Care Standards (GPICS) are not met, particularly, a Consultant Intensivist available 24/7 and able to attend within 30 minutes.

4.28 This situation is unlikely to improve without the attraction of major surgery. The regional workforce report https://www.ficm.ac.uk/sites/default/files/north_west_workforce_report_-_final_2017.pdf states that the unit is 3 consultants down currently; with expected retirements, the unit would need 5 additional consultants to split the anaesthesia and critical care rota and meet GPICS. Due to its small size the unit is expensive to run and it is not

cost effective to invest heavily in the unit to meet the GPCs standard. We are therefore not clear what approach the Trust are going to take to maintain this service which is critical to the Trust's acute model. Only scenario 5 does not retain the critical care service.

Elective Care

- 4.29 There are challenges within elective care. Referrals are falling with low theatre utilisation historically and the highest proportion of medical vacancies in the Trust are within the planned care division. This accounts for 60% of total vacancies. Day case performance is below peer average, particularly for urology and trauma and orthopaedics and there are issues with cancellations due to the lack of available beds.
- 4.30 At our visit we heard from clinicians about their ambitions to develop Ormskirk into a sub-regional elective day case centre for non-complex surgery. Orthopaedics is leading the way in this thinking with the suggestion that they will test the hot/ cold site split model with the potential for it to roll out to other elective services. 4 more orthopaedic surgeons have been recruited and a consultant of the week model put into operation. We were informed that there will be well developed hub and spoke arrangements with the Regional Trauma Centre and tertiary orthopaedics. Clinicians informed us of the opportunity to significantly increase the orthopaedic activity due to the high elderly population who are in good health and the good opportunities to attract significant amounts of work back from the private sector. We note that the service is working with the Getting it Right First Time (GIRFT) programme who agree that good progress is being made to develop the service in this direction. There are other examples of this hot/ cold site approach (Cramlington model). We caution that models predicated on increasing elective activity should be aligned with STP and commissioners' plans and the wider prevention agenda.
- 4.31 With regard to your specific questions we agree with the vision for the service, and the proposed model, but it currently seems limited to orthopaedics. We are not clear on the views of other specialties. We have also not seen any detail behind the activity which the Trust feel that they can attract to their elective centre.
- 4.32 We note that there is the proposal to have a Post Anaesthesia Care Unit (PACU) on site at Ormskirk but with regards to interdependencies our view is that there needs to be more detailed thinking on how this model will fit with emergency surgery. It is hard to define what PACU facility is required without knowledge of the elective and emergency surgery that is planned for this site.

Women and Children's Services

- 4.33 The challenges in this service are primarily in the obstetric workforce who are struggling to staff a middle grade rota for a relatively small stand-alone service (2300 births) and workforce. Within paediatrics the service would need to recruit a further two consultants to meet the 7 day service standards with regards to consultant review within 14 hours of admission. Staffing levels are insufficient to meet the Royal

College of Paediatrics and Child Health standard⁴ for acute paediatric care that require a consultant presence in the hospital at “busy” times. The service was also rated as ‘requires improvement’ with regards to safety at a recent CQC inspection. 80% of the 30,000 paediatric A&E attendances are classed as minor and having the paediatric A&E away from the adult A&E generates additional costs and pressures on the stretched workforce. Currently there does not seem to be a system level vision for women and children’s services across the STP footprint.

Obstetrics and Gynaecology services

- 4.34 The main risk to the service is the lack of suitable doctors at a middle grade level. This relates to both unfilled training posts and a lack of suitably qualified doctors to work at this level either as trust locums or as specialty doctors. For an obstetric unit to be safe there needs to be an obstetrician on site 24 hours a day with a competency equivalent to ST3 or above (RCOG Providing Quality Care for Women – A Framework for Maternity Services 2016). On our visit the Senate was informed of proposals to increase the consultant body which will allow consultants to fill some of the out of hours work. The proposal is for twilight shifts to be covered by a consultant and the night shifts covered by a non-consultant working on a 1 in 5 rota. The trust will wish to cost out this model compared with the current on call system (both at fully staffed and the actual cost, taking into account locum payments). There are a few areas which would need exploring in order to understand whether this is viable:
- Will this result in a contract compliant rota for doctors in training? This needs to be tested with Health Education England
 - Will the Local Education and Training Board (LETB) be assured that the doctors in training will have adequate training exposure (given that they will have a higher frequency of work at night without direct supervision)?
 - Is there sufficient elective work, capacity and space to support an increased pool of consultants and to support this model? This is a significant increase in the consultant workforce in order to cover the deficit in tier 2s and the Trust needs to evaluate what additional gynaecology work would be possible in order to support this model financially.
- 4.35 Even with these solutions the service remains small and difficult to sustain in the longer term. We need to understand what the Local Maternity System (LMS) view is on provision of maternity services in this area and this report was not available at the time of our visit. We heard on our visit that the Trust had sought help from neighbouring trusts when the middle grade rota was significantly depleted and that the surrounding units did not have capacity to assist. Any decision on provision of maternity care obviously impacts on neighbouring units and so any decision needs to be made in conjunction with the LMS. During discussion however there was no

⁴ Facing the Future - Standards for acute general paediatric services; RCPCH 2015

evidence of the LMS plan for the area which the Senate advises is a real gap in the current proposals.

- 4.36 The sustainability of the obstetric services depends on the final location of the hot site. If Southport is chosen as the hot site our advice is that the obstetric service will not be sustainable as the numbers accessing that service will reduce leaving the service unviable. A small obstetric unit could be sustainable if it remained at Ormskirk or if moved to a new build site.
- 4.37 The Trust discussed the proposal to have a ‘pop up’ Midwifery Led Unit (MLU) and the location for that is still in discussion. In our view a MLU is not a viable option, with the small size of the service we doubt whether this will be cost effective to run. There are examples across the country of MLUs operating at below the modelled activity due to public concerns regarding access to an obstetric unit in the event of complications and the need for Epidural pain relief and we therefore advise that the figures seem unrealistic. A pop up MLU may be a viable option if staffed by the community midwifery teams in a continuity of care model.
- 4.38 We note that the Trust has a successful gynaecology community service. There are strengths to the service for example in incontinence surgery and colposcopy.

Neonatal unit

- 4.39 The sustainability of the neonatal unit is an issue and has not been fully considered as a clinical interdependency. The neonatal unit is designated as a Local Neonatal Unit (LNU) which is defined by the British Association of Perinatal Medicine (BAPM)⁵ as providing special care and high dependency care and a restricted volume of intensive care (as agreed locally) and would expect to transfer babies who require complex or longer-term intensive care to a Neonatal Intensive Care Unit. The majority of babies over 27 week’s gestation will usually receive their full care, including short periods of intensive care, within the Local Neonatal Unit. Local Neonatal Units may receive transfers from other neonatal services in the network if they fall within their agreed work pattern.
- 4.40 The Senate questions the sustainability of this unit, due to its small size, although the service is currently delivering sufficient activity for an LNU. The service, however, does not meet the LNU BAPM standards for staffing which requires a separate Tier 1 rota exclusively for neonates. If the unit were re designated as a Level 1 Special Care Unit this would reduce the pressures on meeting the medical staffing rota but would impact on the Trust’s ability to support high risk births which will further decrease the activity and further question the long term sustainability of the obstetric service.
- 4.41 The small size of the obstetric unit gives rise to concern about the sustainability of the neonatal unit in the longer term. Our advice is that it will be difficult to sustain a Level 2 neonatal unit on either site due to the low numbers of deliveries in Ormskirk. The maintenance of skills for consultant and neonatal staff is a very important

⁵BAPM Service Standards for Hospitals Providing Neonatal Care 2010

concern in the long term. Even if there is considerable investment and recruitment of additional consultant and nursing staff to meet BAPM standards it is likely that despite the additional investment, the neonatal services may still continue to be sub-scale with the associated issues of maintenance of skills.

- 4.42 There are models explored within other neonatal networks of rotating staff through neonatal intensive care units to allow the staff to maintain skills and the Trust may wish to explore that with their network and to explore the possibility of receiving more special care babies from other neonatal units to keep the size of the unit viable.
- 4.43 Similarly there is a potential to explore the possibility of special care babies being cared for at home by parents and supported by a neonatal outreach community team rather than an in-patient unit. This would ensure care closer to home as soon as possible and is highly desirable whether the in patient service changes or not. The Trust may wish to explore how many of the SC babies are suitable for outreach care and potential bed days saved by such a model.
- 4.44 The sustainability of both neonatal and obstetric services depends on the final location of the hot site. A small obstetric unit and a neonatal unit could be sustainable at Ormskirk. However, if Southport is the hot site, obstetric activity is likely to fall and would be unsustainable. It's co-dependency with neonates would result in the loss of both services and would also impact on paediatric training and may result in difficulties attracting paediatric trainees. The LMS view of the obstetric service is required to inform the decision on the future of this service and this was not available at the time of writing this report.

Paediatric Services

- 4.45 Sustaining a low volume service will always be challenging particularly in retaining staff and maintaining their skills. A vision for this service, particularly meeting the challenges of the workforce, was not clearly presented to the Senate. 80% of the 30,000 paediatric admissions are less than 24 hour stays and there is much potential to remodel the service. Currently, however, the options for the development of the paediatric service seem less well developed. We support the direction of travel to develop more community services and a children's community hub. The need for an integrated approach across the Integrated Care System (ICS) / STP geography is clearly required. On our visit we discussed the challenges caused by the inequity in how community paediatrics services are commissioned by local CCG's and examples of variation within primary care also. This clearly needs to be addressed. There are very fragmented services for complex children and the Trust and CCGs need to work in partnership across the STP footprint to develop a coherent service. We also note that as yet there has been no engagement with the population on these models and this would really help to shape the offer. Other potential models within the scenarios, for example a Paediatric Assessment Unit (PAU), did not seem to be

well developed and there was no argument for or against this put forward to the Senate.

- 4.46 Clearly having a paediatric A&E separate to the adult A&E is an inefficient model and our advice is that if the paediatric A&E service is retained it needs to be physically located with the adult service to alleviate the pressures on the workforce. Due to those workforce pressures it could be questioned, however, whether the Trust are doing the right thing in trying to maintain their level of paediatric service. Currently the paediatric consultant needs to cover both the paediatrics A&E, a level 2 baby on the neonatal unit and a paediatric inpatient. This does not meet the Royal College of Paediatrics and Child Health (RCPCH) standards⁶ and in discussion there was no information presented on proposals to meet those standards. The scenarios do not address how the gaps in the paediatric workforce are going to be met and in reality the paediatric service can only be made sustainable by working in partnership with another provider.
- 4.47 There is opportunity here to think further about the community paediatric models and how these could be developed in this area. The providers could be at the forefront of developing integrated care models such as hospital at home, virtual ward rounds and hence would be attractive to trainees as a 'new models of care' training environment.

5. Summary and Conclusions

- 5.1 As a small District General Hospital, sustaining services in 2 hospitals only 7 miles apart, the Trust faces many challenges and there are areas of care that need to improve. Many of these are driven by the workforce shortages creating substandard clinical outcomes. There is however much to celebrate within the services at the Trust. There is now a stable executive team in place which is committed to moving forward with the programme of change and a dedicated workforce at the Trust, who have shown real resilience in maintaining their commitment and passion through a sustained period of instability.
- 5.2 The Senate is in agreement that the Case for Change does provide a comprehensive review of the issues facing the services and provides a compelling argument as to why the Southport and Ormskirk services need to change. Reconfiguring the services across the 2 sites is a necessity and that will be difficult to achieve when no hot/ cold site option will be to the satisfaction of all parties. The agreed best option would be a new build located between the 2 existing sites but at the time of writing this report the funding for this was not secured. This would still require clinical partnerships with neighbouring Trusts to ensure the sustainability of some of the services. There is a time delay with any new build and services will still need to be delivered safely in the interim. The discussions for this interim solution include moving to a hot and cold site model on the 2 existing sites. There is no 'win win'

⁶ Facing the Future - Standards for acute general paediatric services; RCPCH 2015

outcome on the hot and cold site model, either the elderly population will not be best served by moving the services to Ormskirk or the maternity population will be impacted by the decision to move services to Southport.

- 5.3 Our advice is that scenarios 2 – 4 are where the Trust need to focus. The ‘no change’ scenario does not have our support and neither does Scenario 5 as it does not retain Accident and Emergency Services at the site. Within the remaining scenarios our key concerns are:
- The small size of the obstetric unit may make this service difficult to sustain long term even if the workforce shortages can be addressed. This combined with the small size of the neonatal unit and their inability to meet BAPM standards leads us to suggest that Scenario 2 is less attractive than Scenarios 3 and 4. The sustainability of both neonatal and obstetric services depends on the final location of the hot site. A small obstetric unit and a neonatal unit could be sustainable at Ormskirk. The LMS view of the obstetric service is required to inform the decision on the future of this service.
 - It is clear that the paediatric A&E needs to be in the same place as the adult A&E but the wider challenges in the paediatric workforce are not addressed within scenarios 2- 4. We advise that the Trust need to develop proposals for paediatric partnership working with other providers regardless of whether the obstetric service remains on site.
 - There are still gaps in the urgent and emergency care model and we question whether enough focus is given to the crowding and flow through the hospital. There are still too many direct lines to the A&E department in the proposed model and the sustainability of the critical care unit is also not adequately considered here. The sustainability of the critical care service is integral to the viability of most of the scenarios.
 - The vision for developing Ormskirk into a sub-regional elective care centre is well received but the detail behind this and the fit with emergency surgery needs further development.
- 5.4 A key concern for the Senate is the lack of joined up thinking between community and Trust services, and the inconsistency of provision in community services, which are resulting in the failure to present a single view of care for the whole population. The discussions with partner organisations, including the ambulance services, seem to be in the very early stages and yet are integral to all the solutions. Our advice is that these discussions need accelerating to understand this system wide STP view.
- 5.5 There are outstanding individual clinicians working in the Trust but broader staff engagement is needed to achieve the commitment to the scale of change required. We are pleased to have the opportunity to work with the stable executive team and we support them in moving forward to develop a bright vision for the future of this hospital. The work underway with the development of the frailty pathway is an excellent example of what can be achieved.

APPENDICES

Appendix 1

LIST OF INDEPENDENT CLINICAL REVIEWPANEL MEMBERS

Council Members

Dr Jeff Perring, Yorkshire & the Humber Senate Vice Chair
Dr Nicola Jay, Consultant Paediatrician, Sheffield Children's Hospital
Dr Eric Kelly, GP & Chair of Bassetlaw Clinical Commissioning Group
Mark Millins, Associate Director Paramedic Practice, Yorkshire Ambulance Service NHS Trust

Assembly Members

Dr Shammi Ramlakhan, Consultant Adult and Paediatric Emergency Physician, Sheffield Children's Hospital
Dr Christopher Scott, Consultant Intensivist, Sheffield Teaching Hospitals NHS Foundation Trust
Dr Katherine Johnstone, Consultant Obstetrician and Gynaecologist, Harrogate and District NHS Foundation Trust
Dr Sharon English, Consultant Neonatologist, Leeds Teaching Hospitals NHS Foundation Trust
Dr Julia Dicks, Consultant Oncoplastic Breast Surgeon, Barnsley Hospital NHS Foundation Trust

Lay Members

Kirit Mistry

Clinicians from Other Senates

Dr Ben Pearson, Consultant Geriatrician, University Hospitals of Derby and Burton
Dr Zara Pogson, Consultant Respiratory Physician, Lincoln County Hospital
Joy Kirby, Regional Maternity Lead, NHS England (Midlands & East)

BIOGRAPHIES

Jeff Perring – Vice Chair of the Yorkshire and the Humber Clinical Senate

Qualified from the University of Liverpool in 1988 and specialised in Anaesthesia before moving into Paediatric Intensive Care, becoming a Consultant Intensivist at Sheffield Children's NHS Foundation Trust in September 2002 and the Director of the Paediatric Critical Care Unit (PCCU) between 2007 and 2015. Jeff was joint lead for the Yorkshire and Humber Paediatric Critical Care Operational Delivery Network (ODN) from 2013 to 2018 and am the regional representative on the Paediatric Critical Care Clinical Reference Group (CRG).

In 2015 Jeff became Associate and then Deputy Medical Director for the Trust taking a particular interest in patient safety and governance. In July 2018 he was appointed as

Medical Director for the Trust.

Jeff has been the Vice Chair of the Yorkshire and the Humber Clinical Senate for the last 4 years and have served on the Senate Council since its inception in 2013 taking participating in a number of reviews both within Yorkshire and the Humber and beyond.

Ben Pearson – Consultant Geriatrician

Trained in London and the East Midlands and was appointed as a consultant in geriatrics, general and acute medicine in Derby in 2004. Spent the first 10 years as a consultant setting up the acute medicine and ambulatory care services while developing leadership and management roles both internal and external to the hospital. Has been a department lead, clinical director and divisional medical director. During the last 4 years he has delivered a community geriatrics service focussing on care home medicine while maintaining acute admission and weekend on call duties. He is a CCG secondary care doctor (over 6 years Board experience) and a Clinical Senate Council member since they were established. He has a Master's degree in medical education and has published on the subject of clinical governance.

Mark Millins – Associate Director for Paramedic Practice

The Associate Director for Paramedic Practice with the Yorkshire Ambulance Service and the chair of the NHS Ambulance Services Lead Paramedic Group. A practicing paramedic for 28 years with previous experience as a senior lecturer in higher education lecturing pre and post registration paramedics. He was part of the editorial team for the 2013 and 2016 versions of the UK Ambulance Services JRCALC Clinical Practice Guidelines and a member of the Yorkshire and Humber Clinical Senate.

Nicola Jay – Consultant Paediatrician

After qualifying as a doctor in London (Royal Free Hospital MBBS, St Mary's Hospital/Imperial BSc physiology) Nicola trained in general paediatrics across three regions (Nottingham, Sheffield and Birmingham) with post graduate qualifications in Health Care Leadership (MSc) as well as Ethics & Law (PgDip). Has worked at Sheffield Children's Hospital as a consultant in paediatric allergy/asthma for a decade with research interests being prevention of food allergy as part of the BEEP study, looking at minority population to improve health, moving allergy services into the community to improve access and de-labelling of antibiotic allergy. Nicola sits on the paediatricians in medical management committee at the RCPCH which advises on national health policies and standards for young people and is a Council member for the Clinical Senate of Yorkshire & the Humber. Nicola's main additional role is as the clinical lead for the acutely unwell child managed clinical network (MCN) of South Yorkshire and Bassetlaw (Barnsley, Bassetlaw, Doncaster, Rotherham, Sheffield and Chesterfield/Mid Yorks NHS Trust). The MCN is a work stream of the Integrated Care System (ICS) aiming to improve equity of access, quality of care and subsequent reduction in inequalities of health for the children in our region by working closely together. Central to her vision is an NHS that unites across currently recognised boundaries to provide seamless care for all children that need health care.

Shammi Ramlakhan – Consultant Adult & Paediatric Emergency Physician

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

Chris Scott – Consultant Intensivist

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

Kirit Mistry – Lay Member

Kirit is the Co-Chair of the East Midlands PPI Senate and has significant paid and voluntary sector experience both as a patient and community activist in research and health services. He has particular experience and passion in the delivery of equality and diversity projects for BAME and seldom heard communities. His role is a freelance community, faith and patient engagement on Organ, Blood, Stem Cell, Diabetes, Kidney Disease, Mental Health and Substance Misuse.

Kirit is also co-chair of national Bame Transplant Alliance, interim chair of Patient Participation Group, Patient Member on LLR CCG's Diabetes Delivery Group and has set up Leicestershire's South Asian Diabetes Support Group and South Asian Health Action Charity a patient, carer and community-led charity.

Joy Kirby – Regional Maternity Lead

A practising midwife who qualified in 1981. Joy currently holds the post of Regional Maternity Lead NHS England - Midlands and East. This role provides professional midwifery leadership across NHSE Midlands and East and ensures a detailed knowledge of contemporary issues relating to midwifery practice and maternity services. Joy is also accountable for Patient Experience which is a thread running through all the significant programmes managed by NHSE. She previously held the post of LSA Midwifery Officer, NHS England - Midlands and East between 1996 – 2017, a statutory responsibility relating to supervision of midwives and improving quality of care and safety of women and their babies. Joy undertakes 100hrs of clinical practice per year at a local maternity unit and works in all areas of the service with a particular interest in Midwifery Led Care .

Zara Pogson – Consultant Respiratory Physician

Graduated at the University of Newcastle in 1999. Zara completed her HO and SHO in Newcastle Teaching Hospital with a brief interlude in Brisbane. After obtaining MRCP she worked for 6 months in ITU in St James Hospital in Leeds. She joined the East Midlands Specialist Register rotation in respiratory medicine in 2003. She worked in QMC, Nottingham City, Derby City Hospital, Lincoln County Hospital and Kings Mill Hospital. Zara completed a PhD in asthma at the University of Nottingham in 2009. She started working in Lincoln

County Hospital as a consultant in respiratory medicine in 2011. Her main areas of interest are airways disease and integrated care.

Sharon English – Consultant Neonatologist

Consultant in neonatal medicine and Lead Clinician at Leeds Children’s Hospital, with 14 years’ experience providing tertiary neonatal care in one of the busiest neonatal units in the UK. Established expertise in Healthcare Management and Neonatal Palliative Care. Member of the Yorkshire and Humber Clinical Senate since 2014. Expert Adviser for the NICE Centre for Guidelines (CfG), NHS England QST peerreviewer.

Katherine Johnstone – Consultant Obstetrician and Gynaecologist

Worked as a consultant obstetrician and gynaecologist at Harrogate and District NHS Foundation Trust since 2006, after completing specialist training in the Yorkshire region. During this time Katherine has been labour ward lead clinician and maintains an interest in labour ward, risk management and clinical governance and maternal medicine.

Katherine is a clinical and educational supervisor and has previously held the post of Foundation Training programme Director in Harrogate. She developed an interest in leadership as Clinical lead for Obstetrics and Gynaecology, completing an MSc in healthcare leadership in 2015. She has held the post of Clinical Director for Planned and Surgical Care since 2014 and is a non-voting member of the trust board.

Eric Kelly – GP and Chair of Bassetlaw CCG

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

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

Julia Dicks – Consultant Oncoplastic Breast Surgeon

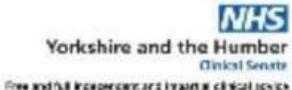
Appendix 2

PANEL MEMBERS' DECLARATION OF INTERESTS

No declarations of interest were made.

Appendix 3

ITINERARY FOR THE SITE VISIT

					
<p>Yorkshire and Humber Clinical Senate Visit to Southport and Ormskirk Hospital NHS Trust</p> <p>Monday, 1 October 2018 Dinner, 8.00pm at Ramada Hotel, Southport <i>Hosted by SOHT Executive Team</i></p> <p>Tuesday, 2 October 2018 A G E N D A (Revised)</p>					
Time					
	Whole Senate Team				
08.30	Panel collected from Ramada Hotel, Southport				
08.45	Discussion with Executive Management Team, S&O Trust			Boardroom, SDGH	
09.15	Panel discussion of issues and questions with Clinical Leaders <i>S&O Trust Leads presentations</i>				
10.20	Split into teams for site visits				
	Team 1: Southport Hospital <i>Co-ordinator: Juliette Cosgrove</i>		Team 2: Ormskirk Hospital <i>Co-ordinator: Jugnu Mahajan</i>		
10.20	Gather in Boardroom Site tour including AED, Frailty		10.20	Meet at Southport Hospital Main Hospital entrance <i>Depart for Ormskirk site</i>	
			10.50	Site tour including Paediatrics, Gynaecology, Obstetrics, Elective	
12.30	Lunch and informal discussions		12.15	Lunch and informal discussions	
13.00	Panel discussion about Frailty and Urgent Care (<i>Boardroom</i>)		12.45	Panel discussion about Paediatrics, Gynaecology and Obstetrics	
				Panel discussion about Elective	
14.30	Session closes		14.00	Return transport to Southport	
	Whole Senate Team				
14.30	Panel Reflection time			Boardroom, Southport DGH	
15.15	Panel discussion and wrap up with Senior Teams SOHT, S&F and WL CCGs				
16.00	Panel conveyed to train station/hotel.				

CLINICAL REVIEW

TERMS OF

REFERENCE

**TITLE: Transformation of Acute Services on behalf of Southport and Formby
CCG**

Sponsoring Organisation: NHS Southport and Formby Clinical Commissioning Group
Terms of reference agreed by: Melanie Wright, Programme Manager for Sefton Transformation and Joanne Poole, Senate Manager

Date: 22nd October 2018

1. CLINICAL REVIEW TEAM MEMBERS

Clinical Senate Review Chair: Jeff Perring, Yorkshire & the Humber Senate Vice Chair

Citizen Representative: Kirit Mistry

Clinical Senate Review Team Members:

Dr Shammi Ramlakhan
Consultant Adult and Paediatric Emergency Physician, Sheffield Children's Hospital

Dr Zara Pogson
Consultant Respiratory Physician, Lincoln County Hospital

Dr Christopher Scott
Consultant Intensivist, Sheffield Teaching Hospitals NHS Foundation Trust

Dr Ben Pearson
Consultant Geriatrician, University Hospital of Derby and Burton

Dr Nicola Jay
Consultant Paediatrician, Sheffield Children's Hospital

Dr Katherine Johnstone
Consultant Obstetrician and Gynaecologist, Harrogate & District NHS Foundation Trust

Joy Kirby
Regional Maternity Lead, NHS England (Midlands & East)

Dr Sharon English
Consultant Neonatologist, Leeds Teaching Hospitals NHS Foundation Trust

Dr Eric Kelly
GP & Chair of Bassetlaw CCG

Mark Millins
Associate Director Paramedic Practice, Yorkshire Ambulance Service

Dr Julia Dicks

Consultant Oncoplastic Breast Surgeon, Barnsley Hospital NHS Foundation Trust

2. AIMS AND OBJECTIVES OF THE REVIEW

Questions for the Review:

- Could the Senate advise on the Case for Change and whether this provides a comprehensive review of the issues facing the services. Considering the Case for Change, can the Senate review the proposed scenarios for service change and advise on any clinical concerns relating to any individual scenario?
- For each clinical work stream (frailty, urgent care, elective care and women and children's services) is there a compelling clinical VISION for the future with a clear clinical argument to address the strategic quality gaps identified in the Case for Change? Please focus your advice on:
 - The proposed model of care
 - Whether the priorities for implementation are the right ones
 - Whether the programme has considered all the key clinical interdependencies
 - If there are any gaps in the clinical models presented and if so what further work needs to be undertaken
 - Specific concerns about the workforce implications for the models proposed, deliverability and further options for us to consider further

Objectives of the clinical review (from the information provided by the commissioning sponsor): The advice will be used by the Health and Care Partnership as part of the Acute Sustainability Work stream work. It will also be used to inform next steps and dialogue with NHS England to progress to the next stage (Stage 2) of the service change process and will be referenced in any Pre-Consultation Business Case, resulting Business Case and related documentation.

Scope of the review: The Clinical Senate will focus their review on the above questions based on the information provided in the documentation. The clinical panel will supplement their understanding of the model through discussion with commissioners and a site visit by the review team members.

3. TIMELINE AND KEY PROCESSES

Receive the Topic Request form: Received by the North West Clinical Senate on 12th April 2018 and received by the Yorkshire & the Humber Clinical Senate on 30th April 2018

Agree the Terms of Reference: October 2018

Receive the evidence and distribute to review panel: Service Change Proposal and the Governance & Decision Making Framework for Acute Sustainability received on 12th September 2018 and distributed to the panel on 14th September 2018.

Teleconferences and panel visit: The clinical panel teleconferences arranged for 24th September and 8th October. A local site visit has arranged for the 2nd October for the panel members to meet with clinicians.

Draft report submitted to commissioners: 14th November 2018

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

Senate Council ratification and final report agreed; at the January 2019 Council meeting

Publication of the report on the website: timeline to be agreed with 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:

- Service Change Proposal Master 09082018
- Governance & Decision Making Framework for Acute Sustainability v0.4
- Supplementary information provided by the Trust in response to the Senate questions

The review team will review the evidence within these documents and supplement their understanding with a clinical discussion and a planned local site 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 and made available on the senate website. Publication will be agreed with the commissioning sponsor.

8. RESOURCES

The Yorkshire and the Humber clinical senate will provide administrative support to the clinical review team, including setting up the meetings and other duties as appropriate. The clinical review team will request any additional resources, including the commissioning of any further work, from the sponsoring organisation.

9. ACCOUNTABILITY AND GOVERNANCE

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

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

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

10. FUNCTIONS, RESPONSIBILITIES AND ROLES

The **sponsoring organisation** will

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

Clinical senate council and the **sponsoring organisation** will:

- i. agree the terms of reference for the clinical review, including scope, timelines, methodology and reporting arrangements.

Clinical senate council will:

- i. appoint a clinical review team, this may be formed by members of the senate, external experts, and / or others with relevant expertise. It will appoint a chair or lead member
- ii. endorse the terms of reference, timetable and methodology for the review
- iii. consider the review recommendations and report (and may wish to make further recommendations)
- iv. provide suitable support to the team and
- v. submit the final report to the sponsoring organisation

Clinical review team will:

- i. undertake its review in line the methodology agreed in the terms of reference
- ii. follow the report template and provide the sponsoring organisation with a draft report to check for factual inaccuracies
- iii. submit the draft report to clinical senate council for comments and will consider any such comments and incorporate relevant amendments to the report. The team will subsequently submit final draft of the report to the Clinical Senate Council
- iv. keep accurate notes of meetings

Clinical review team members will undertake to:

- i. commit fully to the review and attend all briefings, meetings, interviews, and panels etc. that are part of the review (as defined in methodology).
- ii. contribute fully to the process and review report
- iii. ensure that the report accurately represents the consensus of opinion of the clinical review team
- iv. comply with a confidentiality agreement and not discuss the scope of the review nor the content of the draft or final report with anyone not immediately involved in it. Additionally they will declare, to the chair or lead member of the clinical review team and the clinical senate manager, any conflict of interest prior to the start of the review and /or materialise during the review.

END

Appendix 5

EVIDENCE PROVIDED FOR THE REVIEW

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

- Service Change Proposal Master 09082018
- Sefton Health & Care Partnership - Governance and Decision-Making Framework for Acute Sustainability
- Northern England Clinical Senate advice to the Southport and Ormskirk Hospital NHS Trust, December 2017
- Senate Data Request

Additional information was requested to respond to the following questions:-

ED

- Age (Adult/Paediatric) distribution for both Type 1 and Type 2 attendances for the area covered by the CCGs and at each site
- Referral source for Paediatric ED
- 999 Mode of Arrival for Paediatric and Adult ED
- Stroke Thrombolysis figures
- Walk in Centre and Minor Injury Unit figures (Ormskirk)
- Obstetric & Gynae attendances at Southport ED/WiC (numbers transferred/referred to Ormskirk)
- Admission/referral rate for Paeds ED (and destination/speciality)

Ambulance services

- A breakdown of the ambulance attendances at each site.
- Has any modelling work been done with North West Ambulance Service

Paediatrics and neonates

- more detail about the 80% attendances that are counted as minor- medical/injury, length of stay in ED
- activity data neonatal cots
- activity data paediatric inpatients, number, conditions and LOS
- do you have a paediatric workforce plan?-
- can you describe your community paediatrics service and who is this provided by.

Maternity

- Proposed staffing model including the proposed middle grade rota for obstetrics and gynaecology
- The LMS proposals

Critical Care

- the staffing implications for anaesthesia both at trainee and consultant level under each scenario and how that need may be met

- Has the critical care network for the area commented on the Trusts proposed scenarios?

Elective Care

- What is your number of hospital medical beds and the occupation rate of these. What is your 4 hour target data?
- How many consultants in medicine do you have, in what speciality and how many vacancies are you carrying?
- Can you provide more information on the model of community respiratory services. Is there an early assisted discharge services, admission avoidance, pulmonary rehabilitation, oxygen services and complex case management services and who provides that in each CCG?
- What changes have been made (if any) since the NW Senate report that have impacted on increasing the day case rates