Proposed Reconfiguration of Paediatric and Maternity Services at The Friarage Hospital, Northallerton
## Glossary of Health and Medical Terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
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<tbody>
<tr>
<td>Acute Care</td>
<td>Medical or surgical treatment usually provided in a general hospital.</td>
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<tr>
<td>Care Pathway</td>
<td>An agreed and explicit route an individual takes through health and/or social care services that detail the activities and professionals involved at different times and stages.</td>
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<tr>
<td>Care Pathways/Patient Pathways</td>
<td>Structured, multi-disciplinary plans of care designed to support the implementation of clinical guidelines and protocols. They provide detailed guidance for each stage in the management of a patient (treatments, interventions etc) with a specific condition over a specific period of time. They aim to improve, in particular the continuity and co-ordination of care across different disciplines and sectors.</td>
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<tr>
<td>Clinical</td>
<td>Literally means ‘belonging to a bed’ but is used to denote anything associated with the practical study or observation of sick people</td>
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<tr>
<td>Clinical Commissioning Group (CCG)</td>
<td>Under the Health and Social Care Act (2012) from 1 April 2012 CCGs (made up of GPs from constituent practices and other primary care professionals) will take over from Primary Care Trusts the responsibility for commissioning hospital and other healthcare services for the local population. Front line clinicians are provided with the resources and support to become more involved in commissioning decisions and clinicians have greater freedoms and flexibilities to tailor services to the needs of the local community.</td>
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<tr>
<td>Clinician</td>
<td>A qualified professional who carries out clinical work as opposed to experimental/research work. Can include doctors, nurses, therapists etc.</td>
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<td>Clinical Model of Care</td>
<td>See Models of Care</td>
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<tr>
<td>Commissioning</td>
<td>A continuous cycle of activities that underpins and delivers on the overall strategic plan for healthcare provision and health improvement of the population. These activities include stakeholders agreeing and specifying services to be delivered over the long term through partnership working, as well as contract negotiation, target setting, providing incentives and monitoring.</td>
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<tr>
<td>Community Health Services</td>
<td>Treatment provided to people outside of hospitals, together with preventative services such as immunisation, screening or health promotion.</td>
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<tr>
<td>Consultant</td>
<td>Senior physician or surgeon advising on the treatment of a patient.</td>
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<tr>
<td>Day Care</td>
<td>Health care services provided during the day, without being admitted to a hospital bed overnight, for example, blood transfusions, chemotherapy.</td>
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<tr>
<td>Diagnostics</td>
<td>Procedures used to distinguish one disease from another, for example, laboratory tests, x-rays, endoscopies</td>
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<tr>
<td>European Working Time Directive (EWTD)</td>
<td>The EWTD is a directive from the Council of Europe (93/104/EC) to protect the health and safety of workers in the European Union. It lays down minimum requirements in relation to working hours rest periods</td>
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<tr>
<td>Elective</td>
<td>A planned episode of non-urgent care, usually involving a day case or inpatient procedure.</td>
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<tr>
<td>Emergency</td>
<td>An urgent unplanned episode of care.</td>
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<tr>
<td>General Practitioner</td>
<td>A doctor who has a medical practice (general practice) in which he treats all illnesses. Usually referred to as a GP and sometimes known as Family Doctor/Practitioner.</td>
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<tr>
<td>Governance:</td>
<td>This refers to the “rules” that govern the internal conduct of an organisation by defining the roles and responsibilities of groups (e.g. Board of Directors) and individuals (e.g. Chairman Chief Executive Officer)</td>
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<tr>
<td>Independent Contractors</td>
<td>A term used within the NHS to describe General Practitioners, Dentists, Opticians, Pharmacists and other private therapists who contract with the NHS to provide services within the community but who are not directly employed by the NHS.</td>
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<tr>
<td>Independent Sector</td>
<td>Private and voluntary organisations providing health and social care services to the community.</td>
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<tr>
<td>Integrated Care</td>
<td>Bringing together health, social care and voluntary and private sector services to provide a ‘one-stop shop’ for health and social care. May include community wards, outpatient clinics, GP and dental practices, social services department.</td>
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<tr>
<td>Integrated Health &amp; Social Services</td>
<td>Bringing together commissioning and provision of services by health and local authorities to work in partnership and deliver integrated care for patients.</td>
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<tr>
<td>Intermediate Care</td>
<td>Short term intervention (usually up to six weeks) by a multi-disciplinary team, provided in patients’ own homes or a care environment, aimed at preventing hospital admissions or facilitating hospital discharge.</td>
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<tr>
<td>Local Involvement Networks (LINks)</td>
<td>Local Involvement Networks (LINks) are made up of individuals and community groups which work together to improve local services. Their job is to find out what the public like and dislike about local health and social care. They will then work with the people who plan and run these services to improve them. This may involve talking directly to healthcare professionals about a service that is not being offered or suggesting ways in which an existing service could be made better. LINks also have powers to help with the tasks and to make sure changes happen.</td>
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<tr>
<td>Local health economy:</td>
<td>This term refers to the different parts of the NHS working together within geographical area. It includes GP practices and other primary care contractors (e.g. pharmacies optometrists).</td>
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<tr>
<td>Long term conditions</td>
<td>Conditions (for example, diabetes, asthma and arthritis) that cannot, at present, be cured but whose progress can be managed and influenced by medication and other therapies.</td>
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<tr>
<td>Managed care</td>
<td>Patients with complex needs are identified and supported by skilled</td>
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<td>practitioners working for an integrated care system.</td>
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<td>Minor injuries</td>
<td>Examples are cuts, bruises, scalds and suspected closed limb fractures.</td>
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<td>The role of a minor injury unit or service would be to provide treatment</td>
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<td>for such minor injuries.</td>
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<td>Models of Care</td>
<td>Guidance on ways of treating patients that are based on clinical evidence.</td>
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<tr>
<td>National Clinical Advisory Team (NCAT)</td>
<td>The NCAT are part of the Department of Health and provide clinical experts</td>
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<td></td>
<td>to support advise and guide the local NHS on service reconfiguration</td>
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<td>proposals to ensure safe effective and accessible services for patients.</td>
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<td>NHS Foundation Trust</td>
<td>Public bodies providing NHS hospitals, community and mental health care</td>
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<tr>
<td></td>
<td>and ambulance services.</td>
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<tr>
<td>Out of Hours Services</td>
<td>Medical cover provided outside the normal working hours of community</td>
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<td>health care professionals, usually from 6pm-8am Monday – Friday and 24</td>
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<td>hours during weekends and Bank Holidays.</td>
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<tr>
<td>Neonatal practitioner</td>
<td>Healthcare professional caring for the health of new born babies.</td>
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<tr>
<td>Obstetrician</td>
<td>Senior doctor/consultant working in the field of medicine concerned with</td>
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<td>the care of women during pregnancy, childbirth and the period following</td>
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<tr>
<td></td>
<td>birth.</td>
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<tr>
<td>Obstetrics</td>
<td>The field of medicine concerned with the care of women during pregnancy,</td>
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<tr>
<td></td>
<td>childbirth and the period following birth.</td>
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<tr>
<td>Open access</td>
<td>Facility offered to those children where parents can phone the ward and</td>
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<td></td>
<td>self-refer directly, without going through the GP or A&amp;E.</td>
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<td>Overview and Scrutiny Committees</td>
<td>The role of overview and scrutiny differs from authority to authority and</td>
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<td>can usually be ascertained with reference to the Council's Constitution.</td>
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<td>This is often undertaken by questioning executive councillors, council</td>
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<td>employees and representatives of other organisations such as NHS on</td>
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<td></td>
<td>decisions made and policies being pursued in the local area. This kind of</td>
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<td>formal holding to account usually happens &quot;in committee&quot;.</td>
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<tr>
<td>Paediatrician</td>
<td>Senior doctor/consultant working in the field of child healthcare.</td>
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<tr>
<td>Paediatrics</td>
<td>General medicine relating to child healthcare.</td>
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<tr>
<td>Payment by Results</td>
<td>This term refers to the flow of money in the NHS in England. Under payment</td>
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<td>by results the money received by NHS Trusts directly relates to the number</td>
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<tr>
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<td>of operations and other activity undertaken.</td>
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<tr>
<td>Primary Care</td>
<td>Services provided by family doctors, dentists, pharmacists, optometrists</td>
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<tr>
<td></td>
<td>and ophthalmic practitioners together with district nurses and health</td>
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<tr>
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<td>visitors, with administrative support.</td>
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<tr>
<td>Primary Care Services</td>
<td>Care provided by GPs and other healthcare workers in the community.</td>
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<tr>
<td>Term</td>
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<tr>
<td>Primary Care Trusts (PCTs)</td>
<td>Free-standing statutory NHS bodies with responsibility for delivering health care and health improvements to their local areas. They commission or directly provide a range of community health services as part of their functions. They will be disbanded from 31 March 2012 and their commissioning role will be passed to Clinical Commissioning Groups.</td>
</tr>
<tr>
<td>Providers</td>
<td>Organisations providing healthcare services.</td>
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<tr>
<td>Risk assessment</td>
<td>The identification and analysis of relevant risks to the achievement of objectives.</td>
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<tr>
<td>Risk</td>
<td>The possibility exposure to some form of loss or damage.</td>
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<tr>
<td>Secondary Care</td>
<td>Specialist health care services that treat conditions which normally cannot be dealt with by primary care practitioners (i.e. GPs, therapists, community nurses etc) or which are as the result of an emergency. It covers medical treatment or surgery that patients receive in hospital following a referral from a GP. Secondary care is made up of NHS foundation, ambulance, children’s and mental health trusts.</td>
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<tr>
<td>Social Care</td>
<td>Care provided in people’s own homes or in care/residential homes which does not require nursing skills, for example, washing, dressing, and housework, help with eating.</td>
</tr>
<tr>
<td>Specialist</td>
<td>Someone devoted to the care of a particular part of the body, or a particular aspect of diagnosis.</td>
</tr>
<tr>
<td>Specialist Services</td>
<td>Advice guidance and assessment provided by professionals with particular expertise.</td>
</tr>
<tr>
<td>Stakeholder</td>
<td>Organisations and individuals with an interest in the activities of an organisation.</td>
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Executive Summary

Introduction
In July 2011, South Tees Hospitals NHS Foundation Trust (STFT) approached NHS Hambleton, Richmondshire and Whitby Clinical Commissioning Group (CCG) regarding concerns about the future sustainability of paediatric services at The Friarage Hospital, Northallerton (FHN).

A series of discussions between the GP commissioners and consultant staff from the hospital took place in the autumn of 2011. The CCG then invited the National Clinical Advisory Team (NCAT) to visit in December 2011 to review the clinical case. The NCAT report led to a decision to have a conversation with local patients, the public, NHS partners, the Local Authority, the voluntary sector and other stakeholders about the problems the service faces and also to include in that conversation the future of maternity services at the FHN as this is fundamentally linked to the paediatric service in terms of sustainability. These conversations took place from April to June 2012.

As well as conducting a comprehensive engagement exercise the CCG and STHT also spent time developing their understanding of the current clinical evidence by interrogating the academic literature and looking at models from around the country. Assessments of the possible impact of any changes to the service which might result were also undertaken including overall risk, travel, ambulance services, impact on neighbouring trusts, the local economy and equality.

This report details the clinical case for change, the results of the engagement exercise, the various assessments and a review of the evidence. It also details the method by which the potential options were assessed and the outcome of that option appraisal. It is the next step in a complex process but is not a decision. The process is as follows:

- This paper outlines the preferred clinical option chosen by the GP Council of the CCG and a recommendation that that be included in any consultation going forward.
- The CCG will make a formal recommendation to the NHS North Yorkshire and York (NHS NYY) Board to consider.
- The NHSNYY board will then make a decision about which options to take to public consultation (following a successful assurance assessment by the SHA)

The clinical case for change
There is a strong clinical case for change of the services and these are detailed below:

- FHN is a very small hospital. The Royal College of Paediatrics and Child Health (RCPCH) classify it as a very small paediatric unit (less than 1500 unscheduled admissions per year). The maternity unit has 1250 deliveries per year which makes it one of only eight units in the country delivering less than 1500 babies per year.

- Changes in the way we treat children and the general improvement in our health means fewer unwell children need to stay in hospital overnight but can, instead be safely cared for in their own homes with their families. The average length of stay for a child at FHN is now 0.7 of a day. These children can be supported by the Paediatric Assessment Unit or Community Nursing Teams in their own home. The small group of children who are very unwell and need to stay overnight require a higher level of both medical and nursing intervention, skills and competency and care in an environment that meets their needs.
• Women with uncomplicated births now often choose to leave hospital after only a few hours, reducing the need for post natal beds. However there is also an increase in high risk pregnancies overall. This is due to demographic factors including obesity, increased age at first pregnancy and a higher rate of multiple pregnancy (twins, triplets etc). Many of these women already deliver their babies at James Cook University Hospital so they have access to more comprehensive services, should they require them, including a Paediatric Intensive Care Unit (PICU).

• The way doctors are trained and want to work when they become consultants has changed. Advances in medical care means doctors develop advanced skills in specific areas within a specialty (care of the new-borns, asthma, diabetes etc), rather than have generalist skills. Replacing the current FHN consultant workforce, several of whom are coming up to retirement with similar doctors with the same wide range of generalist skills is becoming increasingly challenging.

• Higher safety and quality standards have been introduced to improve patient care. These require clinicians to train and work in environments where they have regular exposure to large numbers of patients with varied and complex problems so that they are able to maintain and develop their clinical skills. These guidelines suggest doctors should work in large clinical teams to give patients access to specialist high quality care at all times.

The evidence
A review of the available evidence supported the clinical case for change. At the request of local politicians and the Rt Hon William Hague the Trust and the CCG have carried out further work “to leave no stone unturned” to look at small paediatric and maternity units throughout the UK and see if any alternative models had been overlooked and which might address the issues of sustainability and clinical risk. Richmondshire District Council also undertook a survey of small hospitals and shared its findings widely. The conclusion from this work was that these units are experiencing similar difficulties, albeit in different timeframes and that the issues faced here are replicated across the country. Some solutions requiring significant investment are unaffordable financially but also do not deliver a sustainable model for the future.

Impact assessments
These are detailed in the main document. Travel was an issue raised during the engagement exercise by the public on many occasions. Analysis of the data shows all residents will be able to access a consultant led inpatient unit within an hour drive by car and 98% within 45 minutes travel time by car whatever option is adopted. The other local providers include:

• York Hospitals Foundation Trust
• County Durham and Darlington NHS Foundation Trust
• Harrogate and District NHS Foundation Trust
• James Cook Hospital, STFT.

A plan to strengthen community transport to support those most disadvantaged by any changes is being developed. Work with the Yorkshire Ambulance Service and other ambulance trusts is underway to develop more detailed proposals. Work to date indicated the impact would be small but plans are in place to provide additional resource whilst any new services are put into place, even if only temporarily until the impact can be properly assessed.
Principles underpinning the CCG’s approach:

- The CCG must commission services that are safe and sustainable.
- The CCG is committed to working in an open, honest and transparent way, ensuring at every point we listen carefully to the messages from the public and stakeholders.
- The CCG is committed to developing a safe sustainable and vibrant future for the Friarage Hospital.
- The CCG’s strategy includes a commitment to provide care as close to patients’ homes as is clinically safe to do. The Group is keen to develop community services so care that has traditionally been delivered in an acute hospital setting can be delivered in patients’ homes, local surgeries or community hospitals.
- The CCG has a statutory responsibility to commission services for its residents within the financial envelope allocated to it by the National Commissioning Board. NHS North Yorkshire and York has declared a countywide deficit of £19M for 2012/13. The CCG is actively planning how to reduce the deficit by improving pathways of care across the system. It is a significant challenge. There is no additional money within the system to fund extra investment.
- The CCG cannot consult on an option it cannot afford to commission unless it is able to include plans which clearly demonstrate where the additional funding can be found from within its financial envelope. Therefore any additional investment would require that money to be taken away from another service at present providing care for people in Hambleton Richmondshire and Whitby.
- At present the CCG has delegated responsibility from North Yorkshire and York NHS Cluster for commissioning. After successful authorisation in November 2012 the CCG will take on statuary responsibility from April 1st 2013.

Option appraisal

The CCG went through a rigorous option appraisal exercise during which the original 7 options discussed with the public during the engagement exercise were reduced to 3 using a framework outlined in detail the main document. The 3 remaining options were:

Option 1 - Sustaining a consultant led paediatric service and maternity unit, requiring significant investment to achieve safety standards although this service would remain fragile in terms of sustainability.

Option 2 - Paediatric Short Stay Assessment Unit (PSSAU) and midwifery led maternity service with full outpatient services and enhanced community service provision. This would be delivered within tariff, so therefore would require no additional investment by the CCG. Minor additional transport costs would be incurred but it is hoped that ambulance costs would be met by efficiencies elsewhere in the system locally.

Option 3 - Paediatric outpatient services and enhanced community services and a midwifery led unit. Similar costs to Option 2.

The GP Council, consisting of a representative from each practice developed a clinically preferred option using the scoring tool which had been used previously in each practice and then collating the scores. The clinically preferred option was option 2. The rationale behind the decision was that it offered the best access to high quality services within the financial envelope available. Option 1 was both unsustainable and unaffordable and Option 3 provided reduced access.
Assurance process
1. Assessment of the clinical case for change by NCAT December 2011.
2. Assessment against the 4 reconfiguration tests by NCAT August 2012.
3. Assessment of the process undertaken and readiness for consultation by Gateway (a gateway 0 review) August 2012. This gave the process an Amber rating and an action plan has been developed to address the recommendations (see appendix).
4. A full NHS North of England Service Change Assurance Process (SCAP) will be undertaken by the SHA in October 2012.

Recommendations:
The Shadow Governing Body (SGB) of the CCG is requested to consider the proposals for service reconfiguration of paediatric and maternity services at the Friarage Hospital Northallerton and to:

- Agree that the clinical case for change is made.
- Endorse the outcome of the GP Council of Members to recommend that the PCT considers proceeding to public consultation including the CCG clinically preferred option
- Consider the breadth of the consultation exercise and offer a view on the issues to be consulted on.
- Agree the action plans to address the Gateway 6 recommendations before formal consultation begins.

The Board of NHS North Yorkshire and York Cluster is asked to consider the outcome of the SGB deliberations and the recent NCAT and Gateway August 2012 Report and:

- Comment on the process to date and the level of assurance obtained.
- Agree that the clinical case for change is made.
- Agree on the options and issues to be included in the consultation process (after full SCAP approval by the SHA).
- Endorse the action plan produced by the CCG to deliver the recommendations of the Gateway0 review requiring support from the PCT regarding managerial capacity.
1. Introduction

1.1 This report outlines proposals by local commissioners from the CCG for the reconfiguration of services at FHN, which is part of the STFT. The proposals include options for the reconfiguration of paediatric and maternity services.

1.2 The proposals have been subject to the usual review and assurance process. Department of Health guidance requires that public consultation can only begin once SHA approval has been given. Approval for these proposals is being sought at SGB level because of the potential contentiousness and likely public, political and media interest.

1.3 The business case will seek to demonstrate compliance with the Department of Health four tests which include:
   - Support from GP commissioners;
   - Strengthened public and patient engagement;
   - Clarity on the clinical evidence base; and
   - Consistency with current and prospective patient choice.

1.4 NHS NYY will undertake a review of evidence presented to them by the CCG as part of their service change assurance process to ensure that the CCG has complied with the requirements.

1.5 The NCAT Review was undertaken in August 2012 to provide assurance that the case for change has been made by South Tees Hospitals NHS Foundation Trust and their findings will be reported to the CCG Shadow Governing Body (SGB).

1.6 The Department of Health Gateway Review team has undertaken a review at the end of August 2012 to provide assurance on the process of developing proposals for change so far and the plan to take this forward. This report is included within Appendix 7.

1.7 From the outset the CCG was keen to develop a pre consultation engagement process that enabled the public to express their views and inform the decision making process.

1.8 The CCG Group has delegated responsibility from NHS NYY to commission health care services for the registered population living in an area in Hambleton (apart from 6 electoral wards in the Easingwold area), Richmondshire and Whitby. The boundary of the CCG and key towns and villages are shown on the following map overleaf.

1.9 This geographically large locality is situated in rural North Yorkshire, covering nearly 1000 square miles including parts of the Yorkshire Dales and the A1 corridor to the east and across to the coastal town of Whitby and its surrounding villages.

1.10 The population of approximately 142,000 live mainly in small towns and villages. Northallerton is the largest centre of population with approximately 18,000 people and the largest British Army garrison in the UK is situated at Catterick in Richmondshire.

1.11 There are currently 24 GP practices (22 civilian and 2 military) in the CCG and the Hambleton and Richmondshire population is served by one district general hospital within the boundary of the CCG, the FHN which is part of the STFT and County Durham and Darlington NHS Foundation Trust.
1.12 FHN is the smaller of two hospitals run by STFT (the other hospital being the James Cook University Hospital in Middlesbrough (JCUH)). FHN has 209 inpatient beds and 24 day-case beds, and provides a range of inpatient and outpatient services including A&E, general medicine, trauma and orthopaedics, surgery, paediatrics and maternity, pathology and diagnostics.

1.13 The CCG is the main commissioner of services at the Friarage Hospital. The Hambleton and Richmondshire populations also access paediatric and maternity services in neighbouring areas as follows:

- Darlington Memorial Hospital provided by County Durham and Darlington Foundation Trust. The hospital serves mainly the communities of Richmondshire including the Dales.
- Harrogate Hospital provided by Harrogate and District Hospitals Foundation Trust. Patients living in Thirsk and Masham areas sometimes use the services offered by the Trust.
- York Hospital provided by York Hospitals Foundation Trust provides a service to patients living in Thirsk and the surrounding villages.

1.14 All providers provide outpatient paediatric services and community paediatric and maternity services.

1.15 There is a high level of local support for the FHN and the important contribution that it makes to enabling local access to high quality secondary care. However, feedback from local people and many General Practitioners indicates that there is a real desire to develop more robust community services to increase the quality of care closer to home.
1.16 STFT, Harrogate and District NHS Foundation Trust, County Durham and Darlington NHS Foundation Trust and York Hospital provide a range of community health services to the area.

1.17 Community health services in Hambleton and Richmondshire include four hospitals (based at Northallerton (DGH), Thirsk, Richmond and Whitby (3 Community Hospitals) and provide a range of intermediate care, district nursing, health visiting and midwifery services, community paediatrics, community equipment and a range of therapy services including physiotherapy, speech and language therapy and occupational therapy. The area also has a community-based child development unit, a joint equipment store and community children’s nursing run as a hospital outreach service.

1.18 Probably due to the large military population, Richmondshire is one of the only two districts in the county which does not currently have a higher proportion of older people than the national average, but the growth in the elderly population over the next three years will be significant. The Richmondshire birth rate is comparable to national average while the Hambleton birth rate is below average.
2. Background

2.1 In 2011, the CCG was approached by South Tees Hospitals NHS Foundation Trust clinicians and managers, who set out their concerns that the current provision of services at FHN was in need of change.

2.2 These concerns were that:

- there is no middle grade cover (FHN is unique in this);
- there are comparatively low numbers of junior medical staff (all GP trainees);
- the only senior medical opinion out of hours is provided by consultants on-call at home, which requires consultants to live close to the hospital – or frequently to be resident – and the on-call commitment is onerous;
- the request for FHN consultants to provide cover for the maternity unit and SCBU means that FHN consultants need to be generalists which limits the opportunity for sub-specialty interests (and consultants with these skills are becoming rare because of changes in training); and
- as a result there are no locally delivered sub-specialty clinics and the consultant posts are attractive to a limited scope of applicants (the unit was experiencing difficulty in recruiting to consultant posts); maintaining staff skills across the board is difficult because of low volume and the lack of opportunity for specialist development.

2.3 Based on the concerns raised by STFT, the CCG then sort advice from the NCAT, which visited the trust in December 2011 and then again in August 2012. They proposed 7 options to the CCG in December 2011. The report can be found in Appendix 3.

2.4 The NCAT team agreed that there was a clinical case for change for paediatric services and advised that in view of the clinical relationship between paediatric and maternity services, the Trust and the CCG should develop options for both paediatric and maternity services. The following recommendations were made in December 2011 and are summarised below:

- STFT proceeds with its work to redesign the paediatric service.
- The CCG and STFT start a process of public engagement as soon as possible.
- The CCG and STFT consider the consequences for the maternity services at FHN and look to develop a sustainable vision for maternity services on the FHN site in keeping with the above conclusions.
- The CCG and STFT, in consultation with the public describe a vision for children’s and maternity services which will be centred at FHN. This should be part of a bigger piece of work which describes the vision for FHN as a small hospital serving the community of Northallerton and beyond, which is of high quality, sustainable and affordable.
- The CCG and STFT should approach the local authority and patient groups to consider the need to set up a working group with the aim of improving transport services between the two hospitals of FHN and JCUH.
- The CCG and STFT should approach Yorkshire Ambulance Service and the North East Ambulance Service to discuss the needs for ambulance service provision in the light of the above future service redesign.
- The STFT should consider the requirements for parental accommodation at JCUH.
- STFT should ensure there are good and close working relationships between the community and acute paediatricians.
- The CCG should lead the work required to develop clinical pathways in liaison with trust paediatricians and other key stakeholders.
2.5 An extensive period of public engagement followed to explore the issues facing the services and discuss local concerns about the future. This has also involved fact-finding by members of the Scrutiny of Health Committee of North Yorkshire County Council, the CCG and the STFT, including visits to Horton General Hospital, Banbury; NHS South Tyneside and Ashington Hospital, Wansbeck. This is explained in more detail in section 7 – Pre-Consultation, Engagement and National Research.

2.6 Whilst this engagement exercise arose from a clinical concern that the paediatric service was unsustainable and in urgent need of change, during the twelve months since initial the discussions took place, the vulnerability of Obstetrics at the FHN has recently come sharply into focus with the near collapse of the middle grade system due to sickness and maternity leave, leaving only 50% of cover in place. This has been covered by the current four consultants working additional hours as first second and third on call residential to cover the unit from 21.00 to 09.00hrs Friday, Saturday and Sunday, as well as being third on call during the daytime cover at weekends. Clearly this impacts onto the week ahead and their current work commitments as well as covering additional labour ward sessions during the working week and doing fully booked clinics without registrar assistance. There is now a clinical consensus that this service is in urgent need of change independently of issues related to the paediatric service.

2.7 The governance and assurance process has been established. The accountability for the project rests with NHSNYY until April 2013 when it will be transferred to the CCG following successful authorisation. The Senior Responsible Officer for the project is the Shadow Accountable Officer, Dr Vicky Pleydell. It was important that this project was clinically led and she has established the project team, across both the CCG and STFT to support the development of this project. The terms of reference of the group can be found in Appendix 1A and other terms of reference for the NCAT Visit and the Stakeholder Group can also be found in Appendix 1B and 1C, which will be three phases to the project and are detailed below:

**Phase 1 of the project included:**

- An extensive public engagement exercise which informed the commissioner’s option appraisal process and commissioning intentions.
- Development of options and proposals for the provision of services.
- Development of reasonable assumptions about the impact of each option on patient flow.
- Analysis of the impact of each option on travel times and transport arrangements, equity and impact on other trusts.
- Development of criteria that the CCG Governing Body would use to prioritise services.
- Development of an option appraisal process that engaged the constituent practices in determining which options would be part of a formal consultation exercise.
- Development of a business case which would make the case for change set out the options appraised including the impact assessment concluding with recommendations on which options go forward to formal consultation.
Phase 2, if it proceeds would entail:

- A formal consultation process on a shortlisted range of options.
- Detailed design of the pathways to enable detailed commissioning plans to be developed.
- A decision about which options and model of service will be commissioned in the future and from which providers.
- Development of a plan for implementation of the preferred option.

Phase 3 if it proceeds would entail:

- Implementation of the preferred option.

The key milestones for the project are outlined below:

**Key milestones for each phase of the project**

<table>
<thead>
<tr>
<th>Phase</th>
<th>Date</th>
<th>Key Milestone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase 1</td>
<td>July 2011</td>
<td>STFT Trust publishes a report on their concerns about paediatric services at Friarage Hospital Northallerton.</td>
</tr>
<tr>
<td></td>
<td>August 2011</td>
<td>Extraordinary CCG meeting held with GPs.</td>
</tr>
<tr>
<td></td>
<td>December 2011</td>
<td>NCAT undertake informal review.</td>
</tr>
<tr>
<td></td>
<td>February 2012</td>
<td>Joint communication and engagement plan developed.</td>
</tr>
<tr>
<td></td>
<td>March 2012</td>
<td>Clinical Options developed.</td>
</tr>
<tr>
<td></td>
<td>April 2012</td>
<td>Pre-engagement period commences.</td>
</tr>
<tr>
<td></td>
<td>May 2012</td>
<td>Pre – engagement events.</td>
</tr>
<tr>
<td></td>
<td>June 2012</td>
<td>Engagement period ends.</td>
</tr>
<tr>
<td></td>
<td>July 2012</td>
<td>STFHT draft business case received. Option appraisal criteria developed and tested. GP event held.</td>
</tr>
<tr>
<td>Phase</td>
<td>Date</td>
<td>Key Milestone</td>
</tr>
<tr>
<td>-------</td>
<td>------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>September 2012</td>
<td>11th September 2012 – CCG SGB Meeting papers to be ready and to be made public. 17th September 2012 – SGB Meeting to be held in public. 18th September 2012 – Business case will be amended to reflect the recommendation accepted or amended by the CCG SGB and papers will then be submitted on the same day to NHS NYY. 25th September 2012 – The NHS NYY Board will consider the recommendations proposed and make recommendation of options which will proceed to formal consultation.</td>
</tr>
<tr>
<td>Phase 2</td>
<td>October 2012</td>
<td>NHS Yorkshire and the Humber Service Change Assurance Process (including NCAT and Gateway Reviews). Consultation process and documentation developed.</td>
</tr>
<tr>
<td></td>
<td>November 2012</td>
<td>Public consultation commences.</td>
</tr>
<tr>
<td></td>
<td>February 2013</td>
<td>Public consultation ends.</td>
</tr>
<tr>
<td></td>
<td>March 2013</td>
<td>NHS NYY Board makes decision on options to be implemented.</td>
</tr>
<tr>
<td>Phase 3</td>
<td>April 2013 onwards</td>
<td>Implementation of option.</td>
</tr>
</tbody>
</table>
3. Health Needs Assessment and Commissioning Vision
A detailed Health Needs Assessment has been completed by the CCG and can be found in full in appendix 2.

3.1 Key demographic information

Age and gender profile
3.2 The chart below shows that in total there are 31,610 people aged 0-19 years within Hambleton and Richmondshire Districts. There are more males than females in all age bands, but particularly in the 15-19 year age band in Richmondshire. In Richmondshire, 94.7% people aged 0-19 years are White. The largest ethnic minority group of children and young people in Richmondshire is mixed. Of the population aged 0-19 years in Hambleton, 96.1% are White. The largest ethnic minority group of children and young people in Hambleton is mixed.

Profile of the child and maternal population in Hambleton and Richmondshire

Population projections
3.3 The population projections for Hambleton and Richmondshire are in the table overleaf and show that for 0-19 year age bands there will be a slight reduction by 2035. There is a slight increase projected in 0-4 year olds in the next 5 years, which follows through to the 5-9 year age band in 10 years (particularly for Hambleton), and similarly for the 10-14 year age band in 15 years.

3.4 There may be some local variation in population due to housing developments and or changes in military personnel but it is not known whether these will affect a net increase in children or just shift the population within the districts. The numbers are likely to be small compared to the overall population in the districts.
Population projections for Hambleton and Richmondshire

The chart below shows the current population profile of females aged 15-44 years which is the usual age range for looking at fertility within a population. Looking at 5-year age bands, there are fewer females in the 20-35 age bands than 15-19 and 35-44 years.

**Table 3 - population estimates for females aged 15-44 years**
The number of 15-24 year olds is set to decrease in both Hambleton and Richmondshire over the next 15 years, and then increase post 2025.

In Hambleton, the 25-34 year old age band is set to increase to 2020, then drop for Richmondshire and Hambleton for the following ten years.

The number of 35-44 year olds is set to drop over the next 10 years and then increase for the next ten years.
The current (2010) fertility rates (i.e. number of live births per 1000 women aged 15-44 years) for Hambleton (58.7) and Richmondshire (59.3) are similar to the North Yorkshire rate (58.1) and below the rate for England (65.5). This is detailed below:

3.5 With the projected changes in age demographics, the projected change in number of births for Richmondshire is that it will remain between 600 and 700 births per year, and for Hambleton that it will remain around 900 births per year up until 2031. Birth rates vary according to the different age bands with the highest rates in North Yorkshire in the 25-34 year old range.
3.6 There has been a change in birth rates by age band over the last 10 years, with the biggest increase being in the 35-39 year old age group. Births to mothers over 40 years old have decreased by 24.0%.

The health of children in Hambleton and Richmondshire

3.7 Infant mortality is a crude measure of child and maternal health. Infant mortality rates in Hambleton and Richmondshire are lower than the average in England. The numbers are small so the rates can vary and have wide confidence intervals.

<table>
<thead>
<tr>
<th>Region</th>
<th>Infant Mortality Rate 2007-2009 (Number of deaths within first year per 1000 live births)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hambleton</td>
<td>4.24</td>
</tr>
<tr>
<td>Richmondshire</td>
<td>3.11</td>
</tr>
<tr>
<td>Yorkshire &amp; Humber</td>
<td>5.5</td>
</tr>
<tr>
<td>England</td>
<td>4.7</td>
</tr>
</tbody>
</table>

Source: ONS Births by area of usual residence
3.8 Babies who are born with a low birth weight (i.e. less than 2.5kg) can be a better marker of maternal and neonatal health. Although Richmondshire has the highest rate of low birth weight babies in North Yorkshire, the rates of low birth weight babies born in Hambleton and Richmondshire are not statistically different from England or North Yorkshire.

Risk factors for poor child health
3.9 The levels of childhood obesity in Hambleton and Richmondshire are generally below the England average. The levels of children who are overweight are similar to the England average.

3.10 Immunisation coverage rates for childhood diseases compare favourably with the rest of North Yorkshire. North Yorkshire’s rates are better than England. The coverage of Diphtheria, Tetanus, and Pertussis (DTaP), Polio (IPV) and Haemophilus influenza (HiB) vaccines aged 1 year and 5 years in 2010/11 for Hambleton, Richmondshire and Whitby CCG were 95.0% and 82% respectively. MMR coverage for 2 year olds and 5 year olds was 91% and 86% respectively in 2010/11.
3.11 Teenage pregnancy is associated with worse maternal and child health outcomes. Teenage pregnancy rates for Hambleton and Richmondshire are lower than the average in England and Yorkshire and Humber. However, there are few ‘hotspots’ with higher local rates around Northallerton, Catterick and SW Thirsk.

3.12 Breast feeding initiation rates at FHN are not collated as they are recorded at STFT level. STFT has a rate (79%) which is mid-range compared to the other main providers in North Yorkshire.

3.13 Smoking rates in mothers at time of delivery (11%) are mid-range compared to other main providers in North Yorkshire. Smoking in pregnancy causes low birth weight and is a main preventable cause of inequalities in child health.

3.14 Local data on children’s smoking behaviours is not routinely collected. However, amongst a sample of children in school years 6, 8 and 10, of those asked whether they had ever smoked a cigarette, during 2010 20% said that they had, a slight increase from the 2007 survey in which 19% had smoked a cigarette. (Ofsted and DSCF Tellus surveys)

3.15 Child Poverty (as measured by percentage of households with children in which income is less than 60% of the national median) is a risk factor for poor child health. All seven district council areas in North Yorkshire have a level of child poverty that is below the national average. However, there are still 1,620 and 980 children living in poverty in Hambleton and Richmondshire respectively (2009). There are some hot spots around Richmond/Catterick and also Northallerton where rates are higher.

3.16 There are pockets of deprivation (as measured by the Index of Multiple Deprivation 2010) across the CCG. These are concentrated on parts of Richmond, Colburn and parts of Northallerton.
3.17 Looked after Children can have poorer health outcomes. 11.3% and 8.2% of Looked after Children in North Yorkshire live in Hambleton and Richmondshire respectively. Across North Yorkshire the data shows that in recent years the percentage of looked after children in North Yorkshire who receive an annual health assessment is well below the average for statistical neighbours and for England as a whole.

3.18 Hambleton and Richmondshire have high rates of hospital admissions in children as a result of injury (145.6 and 155.8 per 1000 children) compared to England (117.4 per 1000 children). In North Yorkshire, the hospital admission rate due to alcohol-specific conditions amongst 18 year olds is higher than the national average. However, district specific rates have wide confidence intervals and are not statically different to the England rate.

<table>
<thead>
<tr>
<th>Source: Local Alcohol Profiles for England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 18s admitted to hospital with alcohol specific conditions, crude rate per 100,000 population</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate per 100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Craven</td>
</tr>
<tr>
<td>45.2</td>
</tr>
</tbody>
</table>

Conclusions of health needs assessment

3.19 The key conclusions therefore are:

- Population projections for age groups potentially affected by changes to paediatric and maternity services show that the paediatric population is unlikely to change significantly over the next 20 years; and that there is likely to be a drop in females aged 15-44 years in the next 10 years, which then returns to current levels.

- Planned developments (e.g. Sowerby Gateway, military changes) are unlikely to have a significant impact on paediatric or maternity admissions.

- The general fertility rate (i.e. number of live births per 1000 women is likely to remain stable for the next 20 years.

- General markers of child health (e.g. low birth rate, childhood obesity, immunisation rates) for Hambleton and Richmondshire are good compared to England.
• General markers of maternal health (e.g. breast feeding and smoking) are good compared to North Yorkshire as a whole – although there are some issues around providing the data at geographical rather than hospital level.

• Deprivation (which is associated with poorer health) is higher in parts of Richmond, Colburn and parts of Northallerton

3.20 Therefore, any change in paediatric and maternity services needs to take into account these highlighted issues. It also needs to reflect that demand for these services is not increasing and for the main part remains static.

3.21 In particular, attention however should be paid to ensure that the needs of vulnerable groups who have risk factors for poor child and maternal health are taken into consideration. Any increase in access to services in more deprived areas should be encouraged (e.g. Catterick). This population groups nearest hospital is not STFT but Darlington Memorial Hospital which is within 13 miles as opposed to the Friarage Hospital which is within 23 miles. The impact of deprivation on travel is included in more detail in the Equality and Travel Impact assessments.

**Commissioning Vision**

3.22 A joint strategic needs assessment, often referred to by its abbreviation JSNA, brings together local authorities, the community and voluntary sector service users and NHS partners to research and agree a comprehensive local picture of health and wellbeing needs. It also supports and encourages organisations to work together when developing services. This section outlines North Yorkshire's Joint Strategic Needs Assessment, published in June 2012.

3.23 North Yorkshire’s Joint Strategic Needs Assessment, (JSNA) looks at what we know about the people of North Yorkshire and their current and future health and wellbeing needs. It does not look at the particular needs of individual people; it looks at the ‘big picture’ of people’s needs and where needs are not being met as well as they could be. It sets out to answer the following:

- What do people need?
- What are we doing already?
- Is it working?
- Are there things we should be doing but are not? and
- Are we targeting services properly?

3.24 The CCG has used the North Yorkshire JSNA to establish its commissioning priorities and reviewed the issues mentioned during the engagement events for the Hambleton and Richmondshire areas and North Yorkshire. Issues detailed below were mentioned during the JSNA events held in Richmondshire and Hambleton during December 2011. This is summarised below:

<table>
<thead>
<tr>
<th>Issues mentioned during discussion at the Richmondshire JSNA event</th>
<th>Hambleton</th>
<th>Richmondshire</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access</td>
<td>Access to services – transport, appointment times</td>
<td></td>
</tr>
<tr>
<td>Active Transport</td>
<td>Communication</td>
<td></td>
</tr>
<tr>
<td>Ageing</td>
<td>Deprivation</td>
<td></td>
</tr>
<tr>
<td>Alcohol and mental health</td>
<td>Lifestyle education – all ages, but start early</td>
<td></td>
</tr>
<tr>
<td>Issues identified across North Yorkshire</td>
<td>Education</td>
<td>Local data plus local assets solutions</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>-----------</td>
<td>---------------------------------------</td>
</tr>
<tr>
<td>Employment (learning disabilities, youth)</td>
<td>Need for more customer focus</td>
<td></td>
</tr>
<tr>
<td>Housing</td>
<td>Partnership working</td>
<td></td>
</tr>
<tr>
<td>Hospital discharge – joined up working</td>
<td>Prevention – including housing, physical fitness etc.</td>
<td></td>
</tr>
<tr>
<td>Isolation (Social Integration)</td>
<td>Whole person – person centred approach, more generic approach</td>
<td></td>
</tr>
<tr>
<td>Keeping people happy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prevention (obese)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respect for other people</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support officer</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**A: Give every child the best start in life**
- Reduce inequalities in the early development of physical and emotional health, and cognitive, linguistic, and social skills.
- Ensure high quality maternity services, parenting programmes, childcare and early years education to meet need across the social gradient.
  - Build the resilience and wellbeing of young children across the social gradient.

**B: Enable all children, young people and adults to maximise their capabilities and have control over their lives**
- Reduce the social gradient in skills and qualifications.
- Ensure that schools, families and communities work in partnership to reduce the gradient in health, wellbeing and resilience of children and young people.
  - Improve the access and use of quality life-long learning across the social gradient.

**C: Create fair employment and good work for all**
- Improve access to good jobs and reduce long-term unemployment across the social gradient.
- Make is easier for people who are disadvantaged in the labour market to obtain and keep work.
  - Improve quality of jobs across the social gradient.

**D: Ensure a healthy standard of living for all**
- Establish a minimum income for healthy living for people of all ages.
- Reduce the social gradient in the standard of living through progressive taxation and other fiscal policies.
  - Reduce the cliff edges faced by people moving between benefits and work.

**E: Create and develop healthy and sustainable places and communities**
- Develop common policies to reduce the scale and impact of climate change and health inequalities.
  - Improve community capital and reduce social isolation across the social gradient.
3.25 The CCG has a vision for **integrated services across both primary and secondary care** in order to deliver **high quality services** with care closer to home for the patients where clinically appropriate. The CCG will focus heavily in the coming years on ensuring the **distribution of funding matches current health need**. We are seeing reductions in the lengths of stay of patients and more treatments being moved to day case or outpatient appointments. This therefore creates the need for less investment in secondary care and a redistribution of funding into community care.

3.26 Services for children therefore need to focus on **developing strong community teams**, thereby allowing children to be supported and treated at home, whilst also maintaining specialist input, from secondary care. This is also the same for maternity and mothers are spending less time in hospital, **opting for home births and deliveries in midwifery led units** and post-delivery support at home through strong midwifery and health visiting teams.

3.27 Our commissioning vision is to offer this range of choice to expectant mothers. Patients tell their GPs they do not want to attend hospital if they can be supported in the community and this message was born out through the engagement process. Open Access patient parents advised they regular attend hospitals for IV therapies which could be delivered at home and would be seen by them as a great improvement in care. **Bringing services home will be a cornerstone of commissioning intentions.**

3.28 NHSNYY has for many years been **financially challenged and it is anticipated that the new CCG will inherit a proportion of the outstanding debt**. We must therefore ensure all services are sustainable and affordable and are mindful wherever possible we will need to make efficiencies whilst also continuing to improve health outcomes.

3.29 The CCG is developing its vision and commissioning intentions for paediatric services and its approach will include:

- **Partnership working** to improve the health and well-being of our children and their families by focusing on promoting exercise, nutrition and sexual health.
- **High quality services** to improve the management of chronic diseases in children.
- High quality care in the community: primary care, health visiting, voluntary sector, charitable and social care working in a joined up way to support children and their families.
- **Strengthened community nursing and therapies** to support children with complex problems more effectively at home through the commissioning of high quality, locally accessible, convenient outpatient care which meets the need of children and their families reducing unnecessary travel.
- High quality **cost effective** specialist hospital services.
4. Current Services for Paediatrics and Maternity

This section has been written by STFT and has been approved and verified by the CCG.

Geography, activity levels and patient choice

4.1 STFT offers paediatric and maternity services at both the James Cook University Hospital (JCUH) in Middlesbrough and the FHN – the two hospitals are some 22 miles apart, an average journey time of 36 minutes. FHN predominantly serves the populations of the districts of Hambleton and Richmondshire in North Yorkshire.

4.2 Services are delivered on an integrated basis with common standard operating procedures and policies, being managed on both sites by the Division of Women and Children. Women and children and their families can exercise choice as to which hospital to use, but JCUH offers a level of specialist care which is not available at the smaller FHN (including neonatal intensive care and paediatric intensive care facilities) and in some instances children and women requiring the services offered at JCUH will be directed there for their care. Hambleton and Richmondshire are rural districts with few large centres of population.

Activity on the paediatric ward by activity type and postal sector; average annual admissions in the period 2008/9, 2010/11 and 2011/12.

<table>
<thead>
<tr>
<th>Postal Sector</th>
<th>Elective Admissions</th>
<th>Emergency Admissions by source</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>A&amp;E</td>
<td>GP</td>
</tr>
<tr>
<td>DL6 - Northallerton East</td>
<td>48</td>
<td>84</td>
<td>129</td>
</tr>
<tr>
<td>DL7 - Northallerton West</td>
<td>46</td>
<td>82</td>
<td>117</td>
</tr>
<tr>
<td>DL8 - Bedale &amp; Wensleydale</td>
<td>54</td>
<td>46</td>
<td>87</td>
</tr>
<tr>
<td>DL9 – Catterick</td>
<td>47</td>
<td>69</td>
<td>106</td>
</tr>
<tr>
<td>DL10 - Richmond</td>
<td>49</td>
<td>53</td>
<td>63</td>
</tr>
<tr>
<td>DL11 - Swaledale</td>
<td>6</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>HG4 – Masham</td>
<td>12</td>
<td>10</td>
<td>25</td>
</tr>
<tr>
<td>TS9 - Stokesley</td>
<td>12</td>
<td>9</td>
<td>22</td>
</tr>
<tr>
<td>TS15 – Hutton Rudby</td>
<td>3</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>YO62 - Helmsley</td>
<td>6</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>YO7 – Thirsk</td>
<td>60</td>
<td>78</td>
<td>125</td>
</tr>
<tr>
<td>Other</td>
<td>90</td>
<td>45</td>
<td>34</td>
</tr>
<tr>
<td>Total</td>
<td>433</td>
<td>487</td>
<td>734</td>
</tr>
</tbody>
</table>

Financial year 2009/10 has been excluded from the period as the ward was shut during summer 2009

Obstetric admissions by delivery type and patients postal sector

<table>
<thead>
<tr>
<th>Postal Sector</th>
<th>Non-delivery overnight admissions</th>
<th>Deliveries</th>
</tr>
</thead>
<tbody>
<tr>
<td>DL6 - Northallerton East</td>
<td>37</td>
<td>169</td>
</tr>
<tr>
<td>DL7 - Northallerton West</td>
<td>41</td>
<td>150</td>
</tr>
<tr>
<td>DL8 - Bedale &amp; Wensleydale</td>
<td>19</td>
<td>112</td>
</tr>
<tr>
<td>DL9 – Catterick</td>
<td>47</td>
<td>230</td>
</tr>
<tr>
<td>DL10 - Richmond</td>
<td>28</td>
<td>153</td>
</tr>
<tr>
<td>DL11 - Swaledale</td>
<td>6</td>
<td>17</td>
</tr>
<tr>
<td>HG4 – Masham</td>
<td>13</td>
<td>65</td>
</tr>
</tbody>
</table>
4.3 The average journey time to the FHN for paediatric admissions is 17 minutes and 20 minutes for obstetric deliveries – only 2% of the population have journey times of in excess of 40 minutes 1% of more than 60 minutes to reach FHN.

4.4 There are paediatric and maternity services used by the Hambleton and Richmondshire population in Darlington at the Memorial Hospital, York at York General Hospital and in Harrogate at Harrogate General Hospital. Uptake of services in these hospitals by Hambleton and Richmondshire residents is currently low, although for some populations these hospitals offer comparable or shorter journey times than to FHN or JCUH. This is set out in detail in section 9.

**Average annual admissions under paediatric specialty by children registered with a Hambleton and Richmondshire GP practice by provider (2008/9, 2010/11 and 2011/12)**

<table>
<thead>
<tr>
<th>Provider</th>
<th>Admissions</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>County Durham &amp; Darlington FT</td>
<td>89</td>
<td>5%</td>
</tr>
<tr>
<td>North Tees &amp; Hartlepool FT</td>
<td>30</td>
<td>2%</td>
</tr>
<tr>
<td>Harrogate FT</td>
<td>6</td>
<td>0%</td>
</tr>
<tr>
<td>Scarborough &amp; NE Yorkshire</td>
<td>3</td>
<td>0%</td>
</tr>
<tr>
<td>York FT</td>
<td>5</td>
<td>0%</td>
</tr>
<tr>
<td>Leeds</td>
<td>51</td>
<td>3%</td>
</tr>
<tr>
<td>Newcastle upon Tyne FT</td>
<td>96</td>
<td>5%</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Sub-total Non-STHFT</td>
<td>280</td>
<td>15%</td>
</tr>
<tr>
<td>FHN</td>
<td>1,369</td>
<td>73%</td>
</tr>
<tr>
<td>JCUH</td>
<td>221</td>
<td>12%</td>
</tr>
<tr>
<td>Total</td>
<td>1,870</td>
<td>100%</td>
</tr>
</tbody>
</table>

*Source: CHKS*

**Average annual deliveries by women registered with a Hambleton and Richmondshire GP practice by provider (2008/9, 2010/11 and 2011/12)**

<table>
<thead>
<tr>
<th>Provider</th>
<th>Deliveries</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>County Durham &amp; Darlington FT</td>
<td>46</td>
<td>4%</td>
</tr>
<tr>
<td>North Tees &amp; Hartlepool FT</td>
<td>3</td>
<td>0%</td>
</tr>
<tr>
<td>Harrogate FT</td>
<td>6</td>
<td>0%</td>
</tr>
<tr>
<td>Scarborough &amp; NE Yorkshire</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>York FT</td>
<td>2</td>
<td>0%</td>
</tr>
<tr>
<td>Leeds</td>
<td>1</td>
<td>0%</td>
</tr>
<tr>
<td>Newcastle upon Tyne FT</td>
<td>2</td>
<td>0%</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0%</td>
</tr>
</tbody>
</table>
4.5 The only alternative hospitals offering neonatal intensive care or paediatric intensive care are in Leeds and Newcastle. For some very specialist types of care – surgical procedures for children under one year, all cardiac surgery, transplantation – children from Hambleton and Richmondshire will be referred to these centres. Women with particular risk factors may need to receive care or have their deliveries in these centres.

Paediatric service at FHN

4.6 The children’s service provides both an inpatient and outpatient service and interfaces with community care. The children’s services ward at the FHN comprises 14 beds. The beds are used both for inpatient stays and as an assessment facility. Children can be admitted to the ward for diagnostic tests and investigations or for management of general medical illnesses for the acutely unwell child or child with complex needs. There is also some planned minor plastic and orthopaedic surgery.

4.7 Since 2008, children requiring emergency surgery and trauma surgery have been transferred to The James Cook University Hospital (JCUH). The practice of transferring children’s surgery to larger centres is similar to the practice across England. The change of practice is in response to recommendations to ensure that surgical and anaesthetic clinicians caring for children conduct enough procedures to retain their skills and competence.

4.8 Services are provided to children from 0 -16 years and any young person aged 16 – 18 subject to the child’s physical and mental capacity, the reason for admission and their choice of place of care. The ward assesses and admits children from:

- Accident and Emergency.
- General Practitioners/Out of Hours services.
- Self-referral for those patients with open access.

4.9 Open access is provided long term to some children with complex health needs to provide speedy access to specialist paediatric help. It is also provided short term to children who have been discharged as this facilitates early discharge from hospital.

4.10 There is a 10 cot Special Care Baby Unit (SCBU) at the FHN which cares for preterm babies and babies with problems at birth. Babies can be stabilised on ventilation if required, before being transferred to the JCUH for intensive/high dependency care and then returning to the FHN for on-going special care.

4.11 There are 5.5 whole time equivalent (wte) consultant paediatricians based at the FHN – 4.8 wte participate in the on call rota. There is limited rotation to JCUH to help maintain skills. All consultants at FHN complete an annual 2 week rotation to JCUH. JCUH based consultants who have dual skills rotate to FHN 1 week per year, plus when extra cover is required and offer support if available. However, this does not improve demands for frequency of on-call. Average annual activity for children at FHN over the last few years (2008/9, 2010/11 and 2011/12) is shown below.

<table>
<thead>
<tr>
<th>Sub-total Non-STHFT</th>
<th>60</th>
<th>5%</th>
</tr>
</thead>
<tbody>
<tr>
<td>FHN</td>
<td>1,103</td>
<td>87%</td>
</tr>
<tr>
<td>JCUH</td>
<td>98</td>
<td>8%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1,261</td>
<td>100%</td>
</tr>
</tbody>
</table>

*Source: CHKS*
All activity by people 18 and under

<table>
<thead>
<tr>
<th>Activity type</th>
<th>16 or under</th>
<th>17 &amp; 18</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatients on Children's ward</td>
<td>1,872</td>
<td>17</td>
<td>1,889</td>
</tr>
<tr>
<td>Inpatients on other wards</td>
<td>134</td>
<td>279</td>
<td>413</td>
</tr>
<tr>
<td>Paediatric specialty outpatient</td>
<td>2,688</td>
<td>93</td>
<td>2,781</td>
</tr>
<tr>
<td>Other specialty outpatient type</td>
<td>6,561</td>
<td>1,645</td>
<td>8,206</td>
</tr>
<tr>
<td>Children's ward attendances</td>
<td>496</td>
<td>10</td>
<td>507</td>
</tr>
<tr>
<td>A&amp;E attendances</td>
<td>5,520</td>
<td>902</td>
<td>6,422</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>17,271</td>
<td>2,947</td>
<td>20,218</td>
</tr>
</tbody>
</table>

Children’s ward admissions by type

<table>
<thead>
<tr>
<th></th>
<th>Elective</th>
<th>Non-elective</th>
<th>Subtotal</th>
<th>(Overnight)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admissions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paediatrics</td>
<td>116</td>
<td>443</td>
<td>718</td>
<td>1,391</td>
</tr>
<tr>
<td>Surgical</td>
<td>317</td>
<td>44</td>
<td>16</td>
<td>363</td>
</tr>
<tr>
<td>Total</td>
<td>433</td>
<td>487</td>
<td>734</td>
<td>1,456</td>
</tr>
</tbody>
</table>

Average length of stay on the children’s ward

<table>
<thead>
<tr>
<th></th>
<th>Overnight cases only</th>
<th>All cases</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Elective</td>
<td>Non-elective</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>3.0</td>
<td>1.9</td>
</tr>
<tr>
<td>Surgical</td>
<td>1.2</td>
<td>2.0</td>
</tr>
<tr>
<td>Total</td>
<td>2.0</td>
<td>1.9</td>
</tr>
</tbody>
</table>

Bed usage on the children's ward

<table>
<thead>
<tr>
<th></th>
<th>Overnight</th>
<th>Any time of day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum inpatients</td>
<td>12</td>
<td>22</td>
</tr>
<tr>
<td>90th percentile</td>
<td>8</td>
<td>15</td>
</tr>
<tr>
<td>Median</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td>10th percentile</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Minimum</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Average</td>
<td>4.4</td>
<td>9.7</td>
</tr>
<tr>
<td>Beds on ward</td>
<td>14</td>
<td>14</td>
</tr>
<tr>
<td>Average occupancy</td>
<td>31%</td>
<td>69%</td>
</tr>
</tbody>
</table>

4.12 Paediatric activity tends to be strongly seasonal with peaks in winter in most years often followed by a peak in spring. But even during these periods the average overnight occupancy does not go above 50%. Over the past 3 full years’ worth of data, the proportion of North Yorkshire and York patients who give birth in the FHN and resulted in an admission to the Special care Baby Unit (SCBU) is 6.4% (average 76 admissions per year).
Annual average activity in SCBU for the three years of 2008/9, 2010/11 and 2012/13 is shown below.

<table>
<thead>
<tr>
<th>SCBU activity</th>
<th>NYY mothers</th>
<th>Other (mothers living outside of NYY area)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>FHN births using SCBU</td>
<td>77</td>
<td>46</td>
<td>123</td>
</tr>
<tr>
<td>Total births</td>
<td>1,187</td>
<td>112</td>
<td>1,299</td>
</tr>
<tr>
<td>% to SCBU</td>
<td>6.5%</td>
<td>41.1%</td>
<td>9.4%</td>
</tr>
<tr>
<td>Transfers in to SCBU</td>
<td>21</td>
<td>12</td>
<td>33</td>
</tr>
<tr>
<td>Total babies using SCBU</td>
<td>98</td>
<td>58</td>
<td>156</td>
</tr>
</tbody>
</table>

4.13 The high proportion of SCBU births to non-NYY mothers’ and the relatively high number of babies being transferred in reflects deliberate policy by STFT to make use of the FHN SCBU which normally has available capacity.

Lengths of stay on SCBU

<table>
<thead>
<tr>
<th>Length of stay (nights)</th>
<th>Cases</th>
<th>% of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>9</td>
<td>6%</td>
</tr>
<tr>
<td>1 - 7</td>
<td>49</td>
<td>31%</td>
</tr>
<tr>
<td>8 - 14</td>
<td>51</td>
<td>33%</td>
</tr>
<tr>
<td>15 - 21</td>
<td>28</td>
<td>18%</td>
</tr>
<tr>
<td>22 and over</td>
<td>19</td>
<td>12%</td>
</tr>
<tr>
<td>Total</td>
<td>156</td>
<td></td>
</tr>
<tr>
<td>Median length of stay</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Average length of stay</td>
<td>12.0</td>
<td></td>
</tr>
</tbody>
</table>

Bed usage on the SCBU

<table>
<thead>
<tr>
<th></th>
<th>Overnight</th>
<th>Any time of day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum patients</td>
<td>12</td>
<td>14</td>
</tr>
<tr>
<td>90th percentile</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>Median</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>10th percentile</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Minimum</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Average</td>
<td>5.2</td>
<td>5.7</td>
</tr>
<tr>
<td>Beds on ward</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Average occupancy</td>
<td>52%</td>
<td>57%</td>
</tr>
</tbody>
</table>

Maternity services at the Friarage Hospital

4.14 The maternity service provides both an inpatient and outpatient consultant led antenatal care, intrapartum (during delivery) consultant and midwife led care, in patient consultant and midwifery led post natal care and midwife led community ante natal and post natal care based in GP surgeries and at home (up to 28 days post-delivery), parenthood education, and a home delivery service. The number of home births is small (19 in 2011/12).

4.15 A consultant satellite Ante Natal Clinic (ANC) is facilitated once a week at Catterick. Ante natal ultrasound services are also provided within the unit and at the satellite clinic. The
inpatient maternity service FHN comprises 5 delivery rooms and 18 antenatal/postnatal beds. Consultant led outpatient services are delivered in 5 sessions within the ante natal clinic and the maternity day unit which is open from 09:00hrs to 17:00 hrs Monday to Friday. The maternity day unit also facilitates early pregnancy assessment and treatment. Intra partum care is not provided for women under 32 weeks gestation due to the lack of neonatal intensive care facilities on site.

4.16 Women under this gestation admitted in labour are transferred to JCUH. Women with severe medical co-morbidities are also transferred to JCUH where specialist services are available. Women between 32 and 37 weeks where early delivery is necessitated are transferred to FHN from JCUH when possible and if suitable to optimise the provision of the special care cots at FHN. The unit assesses and admits women referred from:

- Community midwives.
- General Practitioners.
- Self-referral.
- Accident and emergency.

4.17 Open access is provided to all women during pregnancy and for up to 28 days post-natally via a 24 hour advice line manned by the midwives in the unit.

4.18 Consultants who work at FHN are all require to be obstetrics and gynaecology trained and skilled as cross cover is required. There are only 4 consultants covering the service with same day cover back up from an associate specialist doctor. 3 of the consultants rotate to JCUH to conduct some gynaecology work to maintain sub-specialist skills and 3 JCUH based consultants do some input into clinical commitments at FHN to support this. Only 3 consultants are on the out of hours on-call rota. This means that at peak holiday periods consultants work a 1:2 rota. The unit does not have support of Neonatal Intensive Care and births where this is a requirement are transferred to JCUH.

### Obstetric admissions at FHN by delivery type over time

<table>
<thead>
<tr>
<th></th>
<th>Elective caesarean</th>
<th>Emergency caesarean</th>
<th>Assisted breech</th>
<th>Normal breech</th>
<th>Assisted Normal</th>
<th>Normal</th>
<th>Total</th>
<th>Caesarean rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual totals</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2008/9</td>
<td>145</td>
<td>155</td>
<td>0</td>
<td>4</td>
<td>137</td>
<td>821</td>
<td>1,262</td>
<td>24%</td>
</tr>
<tr>
<td>2009/10*</td>
<td>96</td>
<td>89</td>
<td>4</td>
<td>2</td>
<td>85</td>
<td>684</td>
<td>960</td>
<td>19%</td>
</tr>
<tr>
<td>2010/11</td>
<td>138</td>
<td>122</td>
<td>0</td>
<td>5</td>
<td>119</td>
<td>847</td>
<td>1,231</td>
<td>21%</td>
</tr>
<tr>
<td>2011/12</td>
<td>158</td>
<td>142</td>
<td>0</td>
<td>4</td>
<td>100</td>
<td>910</td>
<td>1,314</td>
<td>23%</td>
</tr>
<tr>
<td>3 year average (excl 9/10)</td>
<td>147</td>
<td>140</td>
<td>0</td>
<td>4</td>
<td>119</td>
<td>859</td>
<td>1,269</td>
<td>23%</td>
</tr>
</tbody>
</table>

*Only low-risk deliveries were undertaken for part of this year because of the temporary closure to high risk obstetrics

### Clinical indicators

4.19 Paediatric and obstetric mortality rates are low in the UK. This means that interpreting the crude figures for individual units can be difficult as variations on small numbers tend to be exaggerated. An additional problem is that there is considerable variation in the type of cases, and therefore the risk of death, that different hospitals deal with. The sickest children and the highest risk pregnancies will be sent to hospitals with the best facilities to deal with them. This then means that these hospitals will have higher mortality rates than hospitals dealing with less complex cases.

4.20 Further problems with comparisons are caused by data quality problems and differences in how hospitals record cases which means that the figures may not be
equivalent. Given these caveats information is presented on local providers for the three year period of 2008/9, 2010/11 and 2011/12.

4.21 The source of the information is the CHKS benchmarking service and as noted later there are some known inaccuracies in the STHFT information. As there may also be unknown inaccuracies in the information for other providers the figures must be treated with care and any small differences between providers should not be taken as real. The number of deaths is the total for the three years, not the average of the period.

Recorded paediatric deaths in hospital (3 year total)

Deaths and admissions under paediatric specialty

<table>
<thead>
<tr>
<th>Provider</th>
<th>Deaths</th>
<th>Deaths /1,000 admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>County Durham &amp; Darlington FT</td>
<td>11</td>
<td>0.4</td>
</tr>
<tr>
<td>North Tees &amp; Hartlepool FT</td>
<td>8</td>
<td>0.5</td>
</tr>
<tr>
<td>Harrogate FT</td>
<td>4</td>
<td>0.5</td>
</tr>
<tr>
<td>Scarborough &amp; NE Yorkshire</td>
<td>5</td>
<td>0.7</td>
</tr>
<tr>
<td>York FT</td>
<td>11</td>
<td>1.4</td>
</tr>
<tr>
<td>Sub-total local DGH</td>
<td>39</td>
<td>0.6</td>
</tr>
<tr>
<td>Leeds</td>
<td>160</td>
<td>4.1</td>
</tr>
<tr>
<td>Newcastle upon Tyne FT</td>
<td>101</td>
<td>2.0</td>
</tr>
<tr>
<td>Sub-total local Teaching</td>
<td>261</td>
<td>2.9</td>
</tr>
<tr>
<td>FHN</td>
<td>3</td>
<td>0.7</td>
</tr>
<tr>
<td>JCUH</td>
<td>24</td>
<td>1.2</td>
</tr>
<tr>
<td>STHFT total</td>
<td>27</td>
<td>1.1</td>
</tr>
<tr>
<td>Total</td>
<td>327</td>
<td>1.8</td>
</tr>
</tbody>
</table>

Source: CHKS

4.22 Whilst not providing the full range of paediatric specialist services, JCUH does provide paediatric intensive care and as such receives children that would not be kept in a district general hospital.

Recorded maternal deaths in hospital (3 year total)

Deaths with a maternity method of delivery or under a maternity specialty

<table>
<thead>
<tr>
<th>Maternal deaths</th>
<th>Cases</th>
<th>Rate 1,000 deliveries</th>
</tr>
</thead>
<tbody>
<tr>
<td>County Durham &amp; Darlington FT</td>
<td>1</td>
<td>0.06</td>
</tr>
<tr>
<td>North Tees &amp; Hartlepool FT</td>
<td>2</td>
<td>0.19</td>
</tr>
<tr>
<td>Harrogate FT</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>Scarborough &amp; NE Yorkshire</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>York FT</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>Sub-total local DGH</td>
<td>3</td>
<td>0.06</td>
</tr>
<tr>
<td>FHN</td>
<td>1</td>
<td>0.26</td>
</tr>
<tr>
<td>JCUH</td>
<td>1</td>
<td>0.08</td>
</tr>
<tr>
<td>STHFT total</td>
<td>2</td>
<td>0.12</td>
</tr>
<tr>
<td>Total</td>
<td>5</td>
<td>0.08</td>
</tr>
<tr>
<td>National rate</td>
<td>(1)</td>
<td>0.11</td>
</tr>
</tbody>
</table>

Source: CHKS

(1) Deaths per 1,000 maternities in 2006-2008. (BJOG). The national figure per delivery will be higher
4.23 The reported death at FHN is an error. This was actually an elderly gynaecology case mis-recorded under the obstetrics specialty. The corrected mortality rates are 0.0 at the Friarage, 0.06 for STHFT as a whole and 0.06 for the total.

Recorded stillbirths and neonatal deaths in hospital (3 year total)
Deaths with a neonatal HRG

<table>
<thead>
<tr>
<th>Provider</th>
<th>Stillbirths</th>
<th>Neonatal deaths</th>
<th>Combined</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cases</td>
<td>Rate 1,000 births</td>
<td>Cases</td>
</tr>
<tr>
<td>County Durham &amp; Darlington FT</td>
<td>48</td>
<td>2.7</td>
<td>16</td>
</tr>
<tr>
<td>North Tees &amp; Hartlepool FT</td>
<td>0</td>
<td>0.0</td>
<td>33</td>
</tr>
<tr>
<td>Harrogate FT</td>
<td>13</td>
<td>0.0</td>
<td>8</td>
</tr>
<tr>
<td>Scarborough &amp; NE Yorkshire</td>
<td>0</td>
<td>0.0</td>
<td>2</td>
</tr>
<tr>
<td>York FT</td>
<td>0</td>
<td>0.0</td>
<td>10</td>
</tr>
<tr>
<td>Sub-total local DGH</td>
<td>61</td>
<td>1.2</td>
<td>69</td>
</tr>
<tr>
<td>Leeds</td>
<td>146</td>
<td>5.1</td>
<td>68</td>
</tr>
<tr>
<td>Newcastle upon Tyne FT</td>
<td>126</td>
<td>6.1</td>
<td>57</td>
</tr>
<tr>
<td>Sub-total local Teaching</td>
<td>272</td>
<td>5.5</td>
<td>125</td>
</tr>
<tr>
<td>FHN*</td>
<td>47</td>
<td>3.6</td>
<td>37</td>
</tr>
<tr>
<td>JCUH</td>
<td>47</td>
<td>0.0</td>
<td>0</td>
</tr>
<tr>
<td>STHFT total</td>
<td>47</td>
<td>2.8</td>
<td>37</td>
</tr>
<tr>
<td>Total</td>
<td>380</td>
<td>3.3</td>
<td>231</td>
</tr>
<tr>
<td>National rate</td>
<td>(1)</td>
<td>5.2</td>
<td>(2)</td>
</tr>
</tbody>
</table>

Source: CHKS
(1), (2) & (3): England and Wales 2009 ONS. The combined figure included as stillbirths may be recorded as a neonatal death.

4.24 There was in fact one neonatal death at the FHN during this 3 year period. The corrected rates are given below:

<table>
<thead>
<tr>
<th>Provider</th>
<th>Stillbirths</th>
<th>Neonatal deaths</th>
<th>Combined</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cases</td>
<td>Rate 1,000 births</td>
<td>Cases</td>
</tr>
<tr>
<td>FHN *</td>
<td>0</td>
<td>0.0</td>
<td>1</td>
</tr>
<tr>
<td>JCUH</td>
<td>47</td>
<td>3.6</td>
<td>37</td>
</tr>
<tr>
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<tr>
<td>Total</td>
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</table>

4.25 The Friarage hospital has the highest overall spontaneous delivery rate of the most relevant local services (only Scarborough is higher). The C-section rate at JCUH is comparable but a higher instrumental delivery rate means the spontaneous delivery rate is lower. The increased C-section and instrumental delivery rates at the other three closest providers mean their spontaneous delivery rates are significantly lower than the FHN is comparable to the FHN in all delivery methods. See chart overleaf:
4.26 The use of episiotomy with spontaneous delivery is higher than at the FHN all units have a delivery without intervention rate that is above the England average - except York and Harrogate.

**Primary care across Hambleton and Richmondshire**

4.27 There is a full range of primary care services available in the area including general practice, pharmacy, dentistry and optometry services. The clinical reputation of these services is very good. General Practice is well thought of and many locally trained GPs continue to work in the area. There is only one single handed practice, so there is a wide range of skills and colleague support available to practices across the area.

4.28 There are traditionally strong relationships between primary and secondary care. Medical staff and consultants regularly come out to do GP updates and training events and the consultant teams readily make themselves available to discuss cases with local GPs.

4.30 Practices offer extended opening hours and most offer minor injury services commissioned by NHS NYY as from a broad range of locally commissioned enhanced primary care services.

4.31 The Out of Hours arrangements in Hambleton and Richmondshire are provided by Harrogate and District NHS Foundation Trust. The service operates from Catterick Garrison and FHN. The service is provided mainly, although not entirely by local GPs.

4.32 Midwives from STFT work in practices to provide antenatal care and there are well organised children's safeguarding arrangements.
Community services across Hambleton and Richmondshire

4.34 Harrogate and District NHS Foundation Trust currently provide community services for children with complex needs and disabilities in the Hambleton and Richmondshire locality through the Community Paediatrics and Specialist Children’s Services. The Specialist Children’s Services covers:

- neuro-disability including complex disability and autistic spectrum disorders,
- sensory impairment,
- communication disorders,
- learning difficulties and
- Neuro-developmental follow-up of pre-term babies.

4.35 The Community Paediatrics Service is provided to children up to the age of 19 and treats a full spectrum of childhood disability including:

- Complex neuro-disability (e.g. Cerebral Palsy)
- Significant developmental delay
- Co-ordination disorders (including fine motor skills)
- Muskulo-skeletal conditions specific to childhood
- Complex conditions
- Sensory impairment
- Significant communication disorders
- Autism Spectrum Disorder (ASD)
- Multi agency planning
- Paediatric consultation for the specialist children’s service team

4.36 Additionally the CCG commissions Health Visiting and School nursing services for this locality via Harrogate and District NHS Foundation Trust.
5. The Case for Change

This section has been written by STFT and has been verified and approved by the CCG.

5.1 Healthcare systems across the country are facing the challenge of responding to changes in the population that they serve, typically the demands of an increasingly older population, rising public expectations and continuous drive to improve standards of care and clinical outcomes.

5.2 The same is true for paediatric and maternity services where the needs of the population have changed and where the bar for clinical standards has been raised by recent clinical guidance. Across the country commissioners and providers are considering how to respond to the challenge of achieving the best outcomes for patients when the volume of patients who require care from specialist teams is low. This issue affects rural areas particularly.

National context for paediatric services
5.3 The National Service Framework for Children, Young People and Maternity Services (CNSF) highlighted that children are healthier than ever before and death in childhood is thankfully rare. The reason for this improvement is better access to health care, advice with early intervention and surveillance all of which have aided increased health awareness as have improvements in technologies, medications, treatments and on-going support. The resultant effect is that there are reduced hospital admissions in children’s services and reduced lengths of stay (often for a few hours only). It is especially important to keep hospital admissions short as children can find going into hospital a daunting experience.

5.4 There is however, a smaller group of children who do need hospital admission beyond short stay assessment and treatment and this group is usually acutely unwell. These children need a greater level of both medical and nursing intervention, skill and competency and care in an environment that meets their needs. Without the ability to provide the skills and the right environment the safety and sustainability of current service configuration cannot be maintained.

5.5 The national direction of travel for patients with long term conditions is to be supported in the community spending less time in hospital which is considered better for the patient in terms of clinical outcomes, but also for the NHS by avoiding expensive hospital.

5.6 The Royal College of Paediatric and Child Health (RCPCH) identified in its 2011 report “Facing the Future” that there are 218 paediatric units in the United Kingdom, 76 of which see fewer than 2,500 emergency admissions per annum.

National context for maternity services
5.7 The UK has a declining infant, neonatal and maternal mortality rates which is similar and comparable to other developed countries. In the period 2000 to 2009 mortality rates gradually improved to 7.6/1000 total births (6.8/1000 adjusted rate). However to further enhance this and ‘elevate standards of care’ a co-ordinated network approach to communication and consistency is recommended by Royal Colleges delivered through shared standards, protocols, and information and performance data.
5.8 In obstetrics the number of births is rising and has increased by 19% overall since 2000 but this rise is not uniform. Locally, there has been no rise in birth rate at FHN but there has been an increase at JCUH. Coupled with the rise in birth rate is a rise in complexity due to changing demographic factors:

- Increased age of first time mothers
- Obesity
- Multiple pregnancy
- Existing co-morbidities

5.9 These changes have led to pressure on services in terms of volume, intensity and types of care.

5.10 Evidence is suggestive of regional variations in quality of care provision and clinical outcomes. For example rates of caesarean section vary between 14.9% and 32.1%. Approximately 40% are planned and 60% unplanned. 70% of caesarean sections can be attributed to 1 of 4 indications:

- Failure to progress in labour
- Foetal distress
- Breech presentation
- Repeat caesarean section

5.11 There is no evidence that any rise in caesarean section rates is attributable to maternal request. Variation is most probably related to differences in thresholds for intervention at institutional and practitioner levels and variations in preferred models of care.

5.12 There is also evidence that suggest socio-economic status and antenatal risk factors are correlated and lead to poorer infant health outcomes. Young and single mothers, multiparous mothers\(^1\), mothers from black and minority ethnic groups are all more likely to be poor antenatal attendees and are associated with poorer health outcomes – lower birth weights, higher infant mortality, higher incidence of congenital abnormalities and less likely to breastfeed.

5.13 The outcomes for those with existing health complexities are highly likely to have inter-generational effects. CNSF was aimed at reducing these inequalities and recommended targeted interventions to support those with poorest outcomes to ensure good antenatal and postnatal care.

5.14 There are 220 maternity units in UK, 179 of which were in England. Only 8 deliver fewer than 1500 babies a year. In addition there are approximately 90 stand alone Midwifery Led Units (MLUs) in the UK.

5.15 Choice should be a fundamental principle when offering maternity services. These choice guarantees were clarified within the Maternity Matters programme and are:

- Choice whether, where and when to seek care
- Choice of care or treatment offered
- Choice of date and time of appointment
- Choice of place of birth (home/hospital) and/or doctor

5.16 The Royal College of Obstetricians and Gynaecologists (RCOG) expert advisory group recognise that clinics may be influenced by availability of services, aligned to level of complexity and risk and needs to be informed choice. Choice offered to women should allow appropriate use of resource to ensure clinical needs are met. Care Quality Commission (CQC) “mindful choice needs to be realistic, balancing wants and needs with what is
affordable and what resources can be made available” and **British Association of Perinatal Medicine (BAPM)** – “choice is not appropriate in the case of specialist care (such as Neonatology). When needed, people should go to the appropriate specialist centre: the same principle must apply to the totality of women’s services.

**National standards and guidance for paediatric services**

5.17 There have been successive reports since the mid 2000’s raising concern about the future sustainability of UK paediatric services. The concerns are in response to the changes in child health, the reduction in utilisation of inpatient units and the changes in workforce training, demands and configurations. Sustainability of services in their current configuration is not achievable due to significant workforce pressures.

5.18 The most overriding pressure is the availability and sustainability of the demands on the current paediatric medical workforce at both a consultant and trainee level (Royal College of Paediatrics and Child Health (RCPCH) in 2011; Facing the Future). Hospital health services have medical cover provision in the following way:

- **Tier 1** – junior doctors in training
- **Tier 2** – senior doctors in training - Specialty Training Grade (ST) or above who have achieved level 1 competencies of RCPCH framework of competencies
- **Consultant tier** – qualified doctors

5.19 In hospital children’s services, the expectation is that there should be 24 hour on site access to staff at tier 1 and tier 2. Consultants are on call from home and available to immediately attend the unit when called. When tier 2 cannot be achieved the consultant should be resident on a 24 hour basis. It is argued that consultants ‘make better decisions more quickly and are critical to reducing the costs of patient care while maintaining quality’.

5.20 The RCPCH study highlighted was the harsh reality that it would be impossible: -

- To staff in a safe and sustainable way all the in-patient paediatric rotas that currently exist.
- Comply with European Working Time Regulations (EWTR).
- Continue with the present numbers of consultants and trainees.

5.21 The conclusion by the RCPCH was ‘doing nothing’ was ‘simply not an option’ and five interlocking proposals were recommended:

1. Reduce the number of in-patient units.
2. Increase the number of consultants.
3. Expand significantly the number of registered children’s nurses.
4. Expand the number of GPs trained in paediatrics.
5. Decrease the number of paediatric trainees.

5.22 In order to identify the means of reducing in-patient units each service was considered by the volume of admissions:

1. Very small <1500 emergency admissions/yr (1456 non-elective admissions)
2. Small >1501 – 2500 emergency admissions/yr.
4. Large >5000 emergency admissions/yr.

5.23 Very small units were to be considered being proximal (within 30 minutes’ drive to another unit) or distal (not within 30 minutes’ drive to another unit).
5.24 The RCPCH clearly state that it is these very small and a number of the small units that would have no middle grade rota and a number would close. However distal very small units should consider conversion to a short stay paediatric assessment unit (SSPAU).

5.25 The RCPCH identified that within the UK that this would affect 48 of the current 218 paediatric units 32 of which would need to consider creating a SSPAU taking into account the issues of politics, history and public opinion. SSPAU could be a long day service up to a 23 hour service but should cover times of peak demand. It has been highlighted that there are 3 levels of configuration possible:
1. No change.
2. Moderate change – SSPAU
3. Maximum change – affecting 76 small and very small units, the very small units probably closing.

5.26 In December 2010, the RCPCH published “Facing the Future: Standards for Paediatric Services” which outlines 10 minimum standards for acute, general paediatric care. These standards are intended to support a safe and sustainable quality paediatric service for children and young people. The report “Facing the Future: A Review of Paediatric Services (discussed above) modelled the potential implications of these standards for paediatric services in the UK. These 10 standards require:

1. Every child or young person who is admitted to a paediatric department with an acute medical problem must be seen by a paediatrician on the middle grade or consultant rota within four hours of admission.
2. Every child or young person who is admitted to a paediatric department with an acute medical problem must be seen by a consultant paediatrician (or equivalent staff, specialty and associate specialist grade doctor who is trained and assessed as competent in acute paediatric care) within the first twenty four hours.
3. Every child or young person with an acute medical problem who is referred for a paediatric opinion must be seen by, or have the case discussed with, a paediatrician on the consultant rota, a paediatrician on the middle grade rota or a registered children’s nurse who has completed a recognised programme to be an advanced practitioner.
4. All SSPAUs (Short Stay Paediatric Assessment Units) should have access to a paediatric consultant (or equivalent) opinion throughout all the hours they are open.
5. At least one medical handover in every 24 hours should be led by a paediatric consultant (or equivalent).
6. A paediatric consultant (or equivalent) should be present in the hospital during times of peak activity.
7. All general paediatric inpatient units should adopt an attending consultant system, most often in the form of the consultant of the week system.
8. All general acute paediatric rotas should be made up of at least 10 wte’s, all of whom must be WTD compliant.
9. Specialist paediatricians should be available for immediate telephone advice for acute problems for all specialties, and for all paediatricians.
10. All children and young person’s social care (or their equivalent), police and health departments should have access to a paediatrician with child protection experience and skills (of at least Level 3 safeguarding competencies) available to provide immediate advice and subsequent assessment, if necessary, for children under 19 years of age where there are child protection concerns. The requirement is for advice, clinical assessment and the timely provision of an appropriate medical opinion, supported with a written document.

National standards and guidance for maternity services

5.27 The Royal College of Obstetricians and Gynaecologists (RCOG) in their paper High Quality Women’s Health Care (2011) identified there is a requirement to change the focus on health care provision the drivers being:

1. To focus around the needs of the women – ‘right care, right time, right place’
2. Ensure services are safe and effective
3. Meet expectations of users
4. Ensure services are efficient
5. Provide local service provision
6. Respect women’s informed choices
7. Adopt proactive approaches to prevention rather than reactive influences to change
8. Impact of EWTR
9. Planned reduction in training numbers
10. Increased need for 24/7 consultant present in units
11. To drive care in the community
12. To develop appropriate skills and professionals

5.28 The above pressures bring about the need to consider reconfiguration and the following principles were recommended:

- Women should be at the centre of their own care
- Healthcare standards must be consistent, evidence based and applicable to all providers
- Care should cause minimal disruption for women
- Care should be personalised, ensuring risk assessment, continuity of care and choice (influenced by safety and availability of services)
- Quality of care should be uniform

5.29 In planning or reviewing the impact of any such changes the RCOG identify the most appropriate approach should be in a multi-professional and multi-disciplinary way. The scale of the challenge will lead to changes in service configuration to ensure delivery of optimal care. The RCOG recognise it will not be possible for all hospitals to continue to provide the full range of obstetrics and gynaecology care in the present configuration. With the implications of reduced trainees the present number of units providing obstetrics and gynaecology is likely to reduce. RCOG are clear that the outcome of the change of focus will lead to:

- More midwife led-deliveries
- Expansion of nursing roles
- Reduction in number of hospital units and services
- Urgent need to focus on complicated/complex care

5.30 The Clinical Negligence Scheme for Trusts (CNST) sets out staffing levels for midwifery and support staff, obstetricians and anaesthetists which are based on the Safer Childbirth (2007) document from the Royal Colleges of Obstetricians and Gynaecologists, Midwives, Anaesthetists and Paediatrics and Child Health. The standards are:
5.31 Midwives: the minimum midwife-to-woman ratio is 1:28 for safe level of service to ensure the capacity to achieve one-to-one care in labour. **Obstetric medical staffing:** these were adapted from a RCOG publication “The Future Role of the Consultant” which proposed levels of consultant presence on labour wards and the target dates by which this cover should be achieved.

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<td>&gt;6000</td>
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5.32 40 hours of dedicated labour ward cover is, in practice, the standards required for a unit the size of FHN. For category A units, there should be a consultant obstetrician plus one specialist trainee, who should have at least 12 months’ experience in obstetrics and gynaecology.

5.33 Anaesthetists and assistants: for any obstetric unit there should be ten consultants programmed activities or sessions per week, to allow full ‘working hours’ consultant cover. In addition to this, there should be a separate consultant anaesthetist for each formal elective caesarean section list (there are 2 at FHN).

5.34 Each consultant-led obstetric unit should have a lead obstetric anaesthetist with programmed activities or sessions which reflect both clinical activity and the associated administrative work that this entails.

5.35 There must be a ‘duty anaesthetist’ immediately available for the obstetric unit 24 hours a day. This anaesthetist will normally have had more than 1 year of experience in anaesthesia and must have been assessed as being competent to undertake such duties. There should also be 24 hrs availability of an anaesthetic assistant.

5.36 Paediatricians: when an obstetric unit provides neonatal special care but is not intending to provide neonatal intensive or high-dependency neonatal care (level 1 unit) there should be:

- A designated link paediatrician for the labour ward and neonatal service, responsible for the clinical standards of care of newborn babies.
- Consultant paediatricians: 24-hour availability of a consultant paediatrician (or equivalent non-consultant career-grade doctor) trained and assessed as competent in advanced neonatal life support, who can attend within 30 minutes. A number of the consultants currently at live within 30 minutes of the Friarage Hospital. Through retirement this is likely to change however. The last recruitment has been filled as a job share by two candidates who currently reside in Newcastle which is 1.5 hours’ drive from the Friarage Hospital site. Due to the recruitment challenges this was the only option.
• Middle-grade doctors: 24-hour availability of resident doctors holding MRCPCH or equivalent, who have completed general professional training. These doctors should be trained and assessed as competent in advanced neonatal life support.
• Specialty trainees (STs) years 1–2 and advanced neonatal nurse practitioners (ANNPs): 24 hour cover by an ST1/2 or ANNP who is trained and assessed as competent in neonatal life support.

**Workforce issues for the paediatric services**

5.37 The principle of the reconfiguration being proposed are that all children and young people will be seen in paediatric departments and will receive high quality consultant delivered care or care from medical trainees/children’s nurses with right training, skill set and knowledge and that this will ensure:

- Safe and sustainable services.
- Offer training opportunities to maintain skill and competency.
- Prevent poor use of consultants (unplanned resident to cover middle grades).
- Increase GP opportunities to be trained in paediatrics.
- Make paediatrics a more attractive career prospect.

5.38 To achieve any model, consultant workforce expansion is required (3,084 WTE up to 4,500 – 4,900 WTE). Junior medical tiers need to reduce in number as well as increase the number of GP trainees (of current trainees only 40% have a paediatric placement).

5.39 Availability of the right staff with the right skills and competency is a key driver to attain quality based safe and sustainable services. Many nursing and medical Royal Colleges have clarified appropriate staff to patient ratios in general paediatric wards, Paediatric Intensive Care Units (PICUs), Paediatric High Dependency Units (PHDUs) and neonatal units. Also clarified is the correct training skill, and competency that those staff should have to ensure any presenting child can be assured quality and safety of care provided. NHS quality of care and patient safety strategy can only be achieved if the appropriate numbers of well trained staff are in place to deliver care as a minimum requirement.

**Medical staff**

5.40 Standard 8 of RCPCH recommends that a minimum of 10 WTE should be on any rota tier. The EWTR mandated a working week of no more than 48 hours. As a result the Academy of Medical Royal Colleges have stated that in order to protect adequate training time, as well as cover for annual leave and recovery periods, 10 wte doctors in a rota are required. The current numbers of trainees provided is proving difficult to cover current rotas. To keep all current rotas and increase to 10 wte would mean trainee expansion. This expansion however would mean that there would not be enough consultant posts at the point of completion of their 10 year training and would incur a high level of unemployment - despite a predicted consultant expansion to attain minimum 10 wte rotas. The ratio of consultant to trainees is currently 1:1.21 to be in a steady state to ensure trainees secure a consultant post the ratio is required to be 1:3 based on the current 100 per year of consultants that leave.

5.41 In a RCPCH 2009 survey three quarters of responding trusts raised concerns that they would not be able to cope with demands placed on them to cover rotas. The dilemma therefore is that there are too few trainees for all current rotas but too many for predicted number of consultant posts and to cover consultant requirements despite consultant expansion. The increased feminization of the medical workforce in particular the paediatric specialties will have a further impact on the rotas as trainees take maternity leave and reduced working time impacting on the length of training and the hours that they wish to work on appointment as a consultant. Community paediatricians are not part of the paediatric
numbers recommended for hospital rotas. The recommended availability is 4.5WTE/300,000 population.

**Nurses**

5.42 The CNSF recognises the need for Registered Sick Children’s trained nurses to care for children and young people to ensure their unique needs are addressed. There is a national shortfall of children’s nurses. This means that to develop nursing roles to support deficits in the medical rotas is difficult at this time. BAPM identified this shortfall nationally and to keep the current configuration of medical tiers in neonates using advanced nursing skills would require an increase in over 300 Advanced Neonatal / Paediatric Nurse Practitioners (ANNP/APNP) for Tier 1 to account for reduction in junior medical staff and an increase in 240 consultants for Tier 2 resident rotas. The consequence of insufficient numbers of staff on rotas is a threat to patient safety as they may not have the expertise, skill or experience required to provide appropriate services.

**Workforce issues for the maternity services**

5.43 In 2008 there were two key publications – Safe births: everybody’s responsibility (Kings Fund) and Towards Better Births (Health Commissioning Consortium - HCC) – setting out the need to focus on main factors to achieve safe, sustainable equitable maternity services to women.

5.44 Staffing was a clear element to safety and sustainability of services both midwifery and medical. However it is now recognised that increasing staff numbers is not the whole answer, effective deployment – right staff doing the right thing at the right time and in the right place - is the key.

5.45 Recommendations for safe staffing levels are designed to deliver a safe, high quality maternity service as described in Maternity Matters (DOH 2007). Recommendations can be found in RCM (2009), RCOG Review Safer Childbirth (2007), and NHS Litigation Authority (2010). This staffing covers recommendations of Midwifery, Labour cover, birth models, recovery, theatre and HDU.

**Medical staff**

5.46 In Obstetrics and Gynaecology, the target for future workforce determines that 3000-3300 consultants are needed with current present configuration of hospitals and standards for delivery suite presence. Currently there is a workforce of 2186.

5.47 It is envisaged that there will be a significant bulge in retirements of senior and experienced consultants in obstetrics and gynaecology. Factors influencing the bulge are considered to be the potential of being resident on-call and changes to NHS pensions and the impact of the European Working Time Regulations (EWTR) – 48 hr week introduced in August 2009 - means that there is an impact on the number of staff available. The consequence of this has been:

- Impact on rotas and ability to staff 24/7, 365 days
- Units rely on doctors in training to provide majority of out of hours care
- Quality and comprehensiveness of doctors training due to reduced working week
- Recruitment and retention of staff issues
- Need to meet professional standards
- Need to meet service/safety standards: -
  - 24 hour labour ward cover
  - Growing complexity of case mix
  - Increased operative births
  - Reduction in trainee numbers, hours and experience
5.48 It is recognised in “Towards Better Births” that Trusts face significant challenges to achieve the required increase in consultant numbers - both economically and because of the availability of specialists.

5.49 It is also recognised that a period of transition will be required to implement changes but the demand on labour wards and need for compensatory rest means the gynaecology sub-specialty will be depleted if colleagues fulfil both roles - hence the drive to recognise consultants either as obstetricians or gynaecologists. This adds a further complexity for small units requiring dual roles.

5.50 The Kings Fund recognised a further dimension of reforms to postgraduate medical training programmes in that there are now some concerns regarding the experience of newly qualified specialists. In view of this mentoring and support systems need to be in place from senior colleagues. This can pose a problem when high levels of expansion happen quickly. The increased feminisation of medical workforce should also be considered as reduced full-time working takes place as fewer are full time and resident consultant posts are unattractive. A review in 2012 showed that the feminisation is set to continue: 41% of existing consultants are female, however 73% of existing trainees are female.

**Midwifery**

5.51 Recruitment and retention of midwives is key to maternity services success in order not to limit women’s choices. Currently there are 20,000 midwives but the current birth rate would be suggestive of a need for 25,000. North East midwifery shortfall is 4% whereas Yorkshire and Humber has a 17% shortfall based on the number of births. The majority are female and most work part time. There is concern as a large number are nearing retirement and the rising birth rate is putting pressure on services. Failure to address shortages has nationally led to reduced morale and exit from the profession and impacts on high and rising litigation costs.

**Neonatal staff**

5.52 The speciality of paediatrics is under the same pressures as obstetrics and gynaecology with difficulty in providing a safe and sustainable workforce environment for all inpatient paediatric rotas. Neonatology is the largest sub-speciality of paediatrics. Although there has been consultant growth in the last decade on average there are fewer than 6 consultants for each BAPM level 3 Neonatal Intensive Care Unit (NICU) (63 units) against the recommended minimum 7. All level 3 units should have a separate consultant rota. There is a shortage of nurses across neonatal units and failure to meet the BAPM requirements of Special Care Baby Unit (SCBU) 1:4, High Dependency Unit (HDU) 1:3 and Neonatal Intensive Care Unit (NICU) 1:1 nursing with a recommendation of a minimum standard of 3 staff on duty. Lack of juniors at tier 1 level can be partly solved by Advanced Neonatal Nurse Practitioners (ANNP) and to lesser extent tier 2 rotas. However these staff members need to be trained, skilled and utilised effectively.

**Anaesthesia**

5.53 RCoA evidence suggests that the anaesthesia workforce is already overstretched and not all consultant led obstetric units have the recommended number of consultant sessions and therefore are not meeting standards.

**GPs**

5.54 GP involvement in maternity care has declined. The concern was such that a consensus statement has been developed and approved by the Royal College of General Practitioners (RCGP), Royal College of Midwives (RCM) and Royal College of Obstetrics and Gynaecologists (RCOG) outlining the minimum GP competencies to deliver minimum identified care provision.
5.55 The Children’s Unit and the Maternity Unit at FHN are amongst the smallest in the country – with 1400 non elective admissions per annum the Children’s unit is classified by the Royal College of Paediatrics and Child Health (RCPCH) in their report “Facing the Future” (2011) as “very small”, one of the units which would need to change or close because of changes in child health, reduction in the utilisation of inpatient units and changes in workforce training.

5.56 There are 1250 deliveries a year in the maternity unit – only eight units in England deliver fewer than 1500 babies per annum. The children’s ward runs at 69% average occupancy during the day and 31% overnight with an average length of stay of 0.9 days. The low levels of activity mean that the units run with small medical, nursing and midwifery teams. Uniquely, the paediatric service operates with only consultant and junior medical staff with no middle grade (senior trainees). The bigger the range of cases and volumes of activity the wider the clinical experience and the limitation of cases seen has been expressed a clinical safety issue highlighted by the consultants.

5.57 The principal concern about the paediatric service is therefore that at night, the cover for the paediatric ward is provided by junior medical staff and nurses without any more senior doctor being available within the hospital.

5.58 For overnight medical cover, from 22.00 – 08.00 hrs, the obstetric service relies on a rota of only six middle grade staff, with no juniors. The consequence of these small teams is that:

- Paediatric consultants who work at FHN have to be able to provide skilled care to sick children and neonates; obstetricians have to be obstetric and gynaecology trained and skilled as cross cover is required - training is increasingly specialised so that consultants with these skill sets are becoming a rarity;

- Consultants are expected to be available close by to attend the unit regularly and to undertake on call duties very frequently (well above levels recommended by Royal Colleges);

- It is difficult to provide cover in the case of sickness or absence – and it is very difficult to obtain locum cover; the existing teams are expected to work increased hours to keep the service operational if there is a problem. The vulnerability of Obstetrics at the FHN has recently come sharply into focus with the near collapse of the middle grade system due to sickness and maternity leave, leaving only 50% of cover in place.

5.59 The current model of medical staffing for both paediatrics and obstetrics is not sustainable and could therefore lead to worse clinical outcomes. The volume of activity in the units means that:

- There is limited exposure for maintenance of skills – this is dealt with in part by rotation to (JCUH) and peer working which is not available at the Friarage hospital and therefore it is harder to maintain skills;

- Currently the FHN cannot take care of very sick children so they are transferred to JCUH paediatric intensive care unit. Recognising early signs of deterioration can be clinically difficult for junior medical staff. There is therefore a clinical risk those
children may not be identified early and could be at greater risk and therefore worse clinical outcomes.

- There is limited opportunity for the development of sub speciality interests which means that the local population is deprived of locally delivered sub speciality clinics. The service delivered has the risk of being of lower quality than should be expected because sub-specialism cannot be delivered and maintenance of skills is difficult.

5.60 The future supply of medical staff will make an already fragile situation more difficult:

- The RCPCH have warned that it will be impossible to staff all the inpatient rotas that currently exist in a safe and sustainable way and comply with European Working Time regulations. There are too few trainees to staff current rotas (increased feminisation of the workforce will have a further impact on rotas in future) but to expand numbers to the required level will result in over supply for the predicted number of future consultant posts, even allowing for planned consultant expansion from the current 3,000 posts to 4,500;

- In obstetrics, consultant expansion is required and at the same time there is increase in retirements of senior and experienced consultants in obstetrics and a reduction in trainee numbers.

5.61 The requirement to protect training time and ensure high quality consultant delivered care has resulted in standards being set for medical staffing which many units are struggling to meet and which are undeliverable at FHN:

- The Academy of Medical Royal Colleges state that in order to provide adequate training time, cover annual leave and recovery periods, 10 whole time equivalent doctors in a rota are required. This is standard 8 of RCPCH guidance.

5.62 This represents a significant increase on existing staffing levels at FHN. There is no prospect of the children’s unit being able to achieve a 10 wte middle grade rota (there is insufficient workload to provide training opportunities) and the obstetric unit is struggling to sustain its middle grade rota (which relies on only six posts) and absence of middle grades will make it non-compliant with Clinical Negligence Scheme for Trusts (CNST) minimum standards. In the health needs assessment there are changes in MOD staff and housing locally but none of them are deemed of sufficient magnitude to have any material impact on the volumes of activity. The full and supporting health needs assessment is attached in Section 4.

5.63 In the absence of middle grades, the alternative for both services is to move to a consultant delivered service (i.e. one which is reliant on consultant staff throughout the day and night to deliver the service) – this would require more than the recommended 10 wte staff at the consultant tier to ensure that the rota is covered and recovery periods for staff are accommodated. The additional staff will be caring for very low numbers of patients – further compounding concerns about maintenance of skills and retention of staff. Permission for middle grade allocation will only be given to units where there is considered enough exposure to a range of clinical activity and caseload variety. The FHN is considered too small to provide this adequate training and therefore there is no prospect of this.
5.64 The Royal Colleges have explicitly set out their views that a reconfiguration of services is needed to ensure quality and safety in future. The RCPCH envisages two viable scenarios: moderate reconfiguration (the conversion of a number of very small inpatient units to Short Stay Paediatric Assessment Unit (SSPAU’s) and ‘maximum’ reconfiguration (some units would close). The RCOG recognise that it will not be possible for all hospitals to continue to provide the full range of obstetrics and gynaecology care and that the number of units is likely to reduce. – the outcome of this will lead to more midwife led deliveries and an expansion of nursing roles, as outlined in our commissioning vision.

5.65 The practical difficulties of achieving safe and sustainable levels of medical cover are being experienced in children’s and obstetric units throughout the country, even in those with significantly higher throughput than FHN (the business case sets out the experiences of NHS South Tyneside and Oxford University Hospitals NHS Trust) leading to proposals for reconfiguration.

**Insights from the NCAT visit (December 2011)**

5.66 Following the discussions between clinicians from STFT and GPs from the CCG in July 2011, the CCG decided to invite the NCAT team to undertake an informal review which took place in December 2011. A copy of the full report is attached as Appendix 3. The following summarises the key findings of the review in terms of the sustainability of current services at the Friarage.

- NCAT agreed with the conclusions reached by the clinicians from STFT that their current service which relies on the clinical staffing arrangements described above is not sustainable particularly those clinicians who see very few cases do not maintain their skills.

- The NCAT team suggested that patients attending A&E or referred by their GP could be seen in a paediatric assessment unit which would have the facility to observe children for a few hours to monitor their condition and to see the effect of any treatment.

- NCAT felt that there should be ease of access to outpatient and observation facilities staffed with appropriate specialist nursing and within a child friendly environment. Both services would be able to provide a high quality model of care and respond to the needs of the majority of patients.

- The NCAT felt that children who need in patient care should be in a unit which has the full support of on-site trainees and senior opinion backed up by high dependency and intensive care skills. They supported the movement of inpatient beds to the James Cook University Hospital in Middlesbrough.

- The NCAT agreed that while experienced GPs may have skills to assess and monitor children, future GPs are unlikely to have the level of skill required.

- The NCAT agreed that the ambulance service needs to be involved in the planning of services and suggested that it would be advantageous if ambulance crews attending patients in rural settings had advanced life support skills and skills in the care of children.

- The NCAT highlighted the challenge of clinical inter-relationship between paediatric and obstetric care. They felt that without consultant paediatric cover at the FHN Northallerton for SCBU and high risk deliveries that it would not be possible to maintain an obstetrician led maternity service.
NCAT felt that the number of deliveries at the FHN was too small to maintain a 98 hour consultant presence on the labour ward and those other models of care should be explored, including a maternity led delivery unit where the outcome for patients can be very good with the retention of outpatient based maternity services.

5.67 The findings of the NCAT review helped to develop the commissioning intentions and options described in the next section. Two NCAT visits have taken place and we are awaiting the report from their most recent August 2012 visit.

Insights from the Gateway review
5.68 This is the first Gateway review and was completed over three days in August 2012. A full report can be found in Appendix 9. Their rating of the delivery confidence is AMBER. The description of amber is ‘successful delivery appears feasible but issues require management attention. The issues appear resolvable at this stage of the programme if addressed promptly.

There recommendations and timescales are detailed below along with how the CCG propose at action the recommendations:

<table>
<thead>
<tr>
<th>Ref. No.</th>
<th>Gateway Recommendations</th>
<th>Gateway Recommended Timing</th>
<th>HRW CCG Actions following receipt of recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Ensure that there is complete clarity on what the approval bodies are expecting to see in the CCG’s pre consultation Business Case especially the level of detail for the options and the financial implications.</td>
<td>Do Now</td>
<td>The approval process has been agreed above with both the SHA and PCT. We have also sent draft copies of the report to PCT Deputy Chief Executive for review and to Tim Barton for review from the SHA. We continue to work closely with provider trusts throughout the approval process to ensure they are all well briefed. Therefore we have actioned this recommendation.</td>
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<tr>
<td>2.</td>
<td>Ensure that adequate contingency plans are in place to respond if the current service can no longer be provided.</td>
<td>Do Now</td>
<td>We have requested a detailed contingency plan from South Tees and are meeting with them on the 7th September 2012 to discuss a number of items in more detail and this will be one of the key discussion items. We will outline with South Tees a key programme of work for the consultation process and will ensure we have more detailed specification relating to the proposed options so these can be costed in more detail and in order to properly assess service requirements.</td>
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<tr>
<td>3.</td>
<td>Put in place more rigorous project and programme management disciplines including risk management for future phases</td>
<td>Do by end September 2012</td>
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<td></td>
<td>We have allocated a dedicated Associate Programme Director, Sarah Ferguson to support the process moving forward and have allocated a support team which will include Programme Manager and an Engagement Manager, all of whom have been allocated to the CCG by the PCT.</td>
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<td></td>
<td>These Programme team will ensure a robust programme management approach is adopted through a MSP approach and will ensure:</td>
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<td></td>
<td>People have clear roles, responsibilities, leadership and lines of communication. Vicky Pleydell will remain the Senior Clinical Sponsor for the programme.</td>
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<td></td>
<td>We will adopt a programme planning through the development of a Programme Plan to ensure that control is established and maintained and all key milestones are met in full and progress is carefully monitored.</td>
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<td></td>
<td>We will ensure we track the benefits of the options and optimise quality to ensure the programme and outcomes are fit for purpose and suitable monitoring arrangements are in place.</td>
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<td>We will ensure open and honest stakeholder engagements as no decision has been made and ensure all interested parties are appropriately involved in the programme.</td>
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<td></td>
<td>We will identify relevant issues and risk and ensure we have a clear strategy for dealing with current and anticipated problems and mitigating all risks.</td>
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<td></td>
<td>We will ensure that the programme is fit for purpose and that we keeping monitoring information about the programme and ensure it is up-to-date and accurate.</td>
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<td>4.</td>
<td>Put in place effective governance arrangements during transition from PCT to CCG and post March 2013 for this project and its subsequent phases.</td>
<td>Do by October/November 2012</td>
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<td></td>
<td>As part of the governance requirements we will ensure that through the transition period there are governance arrangements in place. The PCT and the CCG have however been very clear that the process is being actively led by the CCG in shadow form. We will continue to work closely with the PCT and LAT as it develops.</td>
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<tr>
<td>5.</td>
<td>Review the resources, experience and capability required to execute the consultation and subsequent phases of this project.</td>
<td>Do Now</td>
<td>We have completed this resource review and through working with the PCT allocated a strong team to support the next phase of consultation.</td>
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<tr>
<td>6.</td>
<td>Implement a rigorous quality assurance process to ensure a professional and effective public consultation including reviewing the timescales and milestones for the consultation period.</td>
<td>Do Now</td>
<td>The quality assurance process will be part of the programme management. We will develop a detailed Gantt chart and track all task required and progress will be monitored through a weekly review and through the programme board. This will ensure all timescales and milestones for the consultation period is met.</td>
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**Summary**

5.69 The combination of low demand and staffing models reliant on experienced, generalist staff make the current services at FHN operationally very fragile. The standards required in future and the prospects for trainee recruitment and recruitment and retention of suitably trained and experienced consultant staff make the current models unsustainable. The joint commissioning objectives sought from change are therefore:

1. To ensure that services can operate safely and are compliant at least with relevant minimum standards;
2. To ensure that the services offered are sustainable;
3. That the services offered meet the needs of the local population and have the confidence of the clinical community;
4. To have an open and honest debate about the challenges of the locality; and
5. The outcome of this proposal furthers our strategic vision.
6. Options Developed

6.1 The options to be considered have been developed over the last 12 months. Initially, STFT proposed 7 options for the future provision of paediatric services delivered from the Friarage Hospital in July 2011. These were based on:

- A review of current standards and clinical guidance.
- A review of published material about service reconfiguration in other parts of the country.
- Knowledge about the teams in other units and the range of services delivered.
- Lessons learned from the temporary closure of the children’s department and operation of a midwifery led unit for three months during 2009 due to staff sickness and unfilled vacancies.

6.2 The options at the beginning of the pre-consultation process and those developed throughout the pre-consultation process are detailed below:

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
<th>Criteria (met/Failed)</th>
<th>Ruled in/out</th>
</tr>
</thead>
</table>
| Option 0* | Do nothing - this means that services would remain the same for as long as they are available. | This would carry significant risks:
- services falling short of the required standards of care
- Closure of paediatric and maternity services on an unplanned basis.
- Transfer of services to other providers on an unplanned basis with a negative impact on ambulance services.
Do nothing was not considered as deemed feasible and with support from NCAT it has been agreed this is a viable option. This was therefore removed through the CCG prioritisation process. | Ruled out |
| Option 1 | Keep the service as it is and have more senior doctors present on site or use specialist nurses. | Maintaining the present service with investment and retained as option 1. | Ruled in |
| Option 2* | Run the Friarage Hospital as a ‘small and remote unit’ | This was removed because the Friarage did not fulfil the criteria for small and remote. The RCPCH in its document “Quality and Safety Standards for Small and Remote Paediatric Units” (May 2011) defines remote as referring to the distance from larger urban centres and their associated health care facilities. Small refers to populations in smaller towns and villages or other smaller settlements, sometimes referred to as rural. Such areas vary widely in terms of population density and distribution however the document is not explicit in its definition. It is debatable whether the FHN can be viewed as remote; however some of the population who use the services do live in more rural and remote areas.

The RCPCH have proposed standards to ensure quality and safety for small and remote (S&R) paediatric units of the NHS. S&R units should provide the same quality and safety of care as other units and the best possible standards of care. RCPCH accepts slightly lower standards for S&R hospitals with no resident consultants as few seriously ill children come in at night. However, the RCPCH also states that there should be a minimum of 6 wte consultants and a minimum of 10 wte junior doctors. The guidance states resident rota | Ruled out |
personnel must have skills that our junior doctors will not be able to achieve as although they undertake a one day training course for paediatric life support and neonatal life support this does not provide sustainable skills due to limited exposure to sick children and neonates at FHN.

| Option 3* | Run a five-day working ward | The CCG and the South Tees Hospitals NHS Trust feel that the five day ward offers no benefit – either the ward remains open, with significant investment required or there should be a transition to an alternative model. This option is likely to be confusing for patients and difficult and potentially unsafe to operate. This has not been pursued further and has been removed. It was felt this option did not address all of the issues with recruitment and skills retention. | Ruled out |

| Option 4 | Run a paediatric day-unit (as a five or seven-day service). | Retained as option 2 dependent on whether it is medically staff or staffed by ANNP's (specialist nurses) | Ruled in |

| Option 5 | Provide enhanced outpatient services (emergency as well as routine), increase specialist clinics and run a ‘see and treat’ facility’ but with no inpatient facility. | Retained as option 3 | Ruled in |

| Option 6* | Provide outpatient services | Removed during the CCG prioritisation process as felt not to be consistent with commissioning vision for local services. | Ruled out |

| Option 7* | Do not provide a children’s service at the Friargate Hospital. This would mean that the commissioner does not commission paediatric services at the Friargate Hospital site from South Tees NHS Hospitals Foundation Trust. This is included in the option appraisal process only to ensure that Commissioners consider the risks involved in this outcome. It is not an option that the Hambleton Richmondshire and Whitby Commissioning Group wish to pursue. | Removed during the CCG prioritisation process as felt not to be consistent with commissioning vision for local services. | Ruled out |

*The greyed out options have been removed throughout the process as not feasible or sustainable and therefore have been discounted.
6.3 For the purpose of naming the options going forward there will be Options 1-3 which are combinations of the paediatric and maternity service models retained above and for consistency, these new options are summarised below:

1     Inpatient paediatric unit and high risk obstetrics retained (investment required)
1a     Inpatient paediatric unit and high risk obstetrics (supported by specialist nurses known as ANNPs/investment required)

2     Outpatient only paediatric service with midwifery led unit
2a    Outpatient only paediatric service with no deliveries at FHN

3     Paediatric Assessment unit model for paediatrics with midwifery led unit
3a    Paediatric Assessment unit model – no deliveries at FHN

6.4 It is these options which will be appraised. Below is a more detailed explanation of the paediatric options:

Option 1: Inpatient paediatric service retained - Services would continue in their present format with an inpatient ward at the FHN staffed in a way that ensures current standards can be met. If this could be achieved, it would provide a level of paediatric medical cover which would allow continuation of a high risk obstetric service and SCBU at the Friargate.

This Option requires a consultant delivered service where consultant staff are resident in the hospital. This requires an establishment of 12 wte consultant paediatricians. This would still require some second tier support. In option 1a, Advanced Neonatal Nurse Practitioners (ANNPs) have been considered to support the tier 1 (junior medical staff) rota to increase the sustainability of neonatal services.

Under this option and all the options, a daily clinic at Catterick Garrison is proposed to improve accessibility offering some urgent slots to those service users which face a long journey to FHN and to serve the large garrison population.

Option 2: Paediatric Short Stay Assessment Unit (SSPAU) - a short stay assessment unit would be provided five days a week at the FHN in line with best practice guidelines from the RCPCH which is to provide services matched to peak demand to provide rapid assessment and treatment, with children then either discharged or transferred to another unit. Patients will be referred by GPs or will be prearranged admissions. Opening hours under consideration are 10 am to 10 pm with the last child to be seen no later than 8pm as it can take two hours for all necessary assessments to be carried out. GPs have asked whether a weekend service would be possible and further discussions are taking place to assess the feasibility of this.

There would be no inpatient care available at the FHN. Outpatient and community paediatric services would continue – with enhancements to the current level of service. An emergency clinic will be offered to provide rapid access and there will be, as above, urgent slots available at clinics at Catterick.

Within A and E there will be no change for the arrangements for children with major or minor injuries. For children with minor illness who may need the input of a paediatrician it is proposed that there is a cohort who would be appropriately seen in the assessment unit. When the assessment unit is closed (after 10pm and at weekends) children would need to be directed elsewhere. A protocol setting out the arrangements for any child who presents at A and E will be in place. The role of the GP as first contact is crucial in this, as is education with families.
This option offers the opportunity to deploy medical and nursing time released from the inpatient ward to enhance services by providing increased specialist nursing whereby epilepsy, respiratory and cystic fibrosis nurses could establish monthly clinics. It would not be possible to sustain high risk obstetric services and the SCBU if this option were implemented.

**Option 3: Outpatient services only** - Children would continue to have access to outpatient facilities at the FHN. There would be the prospect of local sub-specialist care through collaborative working with the JCUH consultant team.

As part of the clinic provision an urgent clinic would be developed for assessment of children who are unwell but do not require admission. This model was adopted during the temporary closure in 2009. It also allows assessment of children referred for child protection medicals. There would be no area for observation of children and so strict criteria for GPs to follow would be developed for children to be referred to urgent outpatients. Any child potentially requiring admission would not be seen at FHN.

Surgical services will continue to be offered at the FHN – these patients could be managed in a surgical day unit setting rather than the children’s assessment unit. Children with minor injuries could continue to attend A and E as now. The protocol which applied during the temporary closure in 2009 would apply – i.e. that parents will be advised not to take sick children to A and E at FHN and ambulances will not bring sick children to FHN. The first point of contact for a parent with a sick child should be the GP who will advise where the child should be taken. A protocol setting out the arrangements for any child who presents at A and E will be in place. High risk maternity and SCBU services could not continue to operate at the Friarage if this option were pursued.

**Maternity and neonatal services**: the following options are explored:

**Option 1: High risk obstetrics retained** - this requires an expansion in medical staffing numbers either to meet current standards (10 wte per rota tier) or, as middle grade staff expansion is not achievable, via a consultant delivered service with support from junior staff – in either case, very significant expansion of medical staff is required. It would require 12 wte consultants with 10 juniors (SHO grade). A consultant delivered obstetric service alone would not offer a sustainable solution - a sustainable solution for paediatrics would also be necessary to ensure that there is a neonatal support.

**Option 2: Freestanding midwifery-led unit** - A freestanding midwifery led unit (FMLU) would be staffed and run by midwives and offer intrapartum care to low dependency women at low risk of complications in labour. Obstetric, anaesthetic and neonatal care would be provided at JCUH should they be needed and women and babies would be transferred by ambulance if necessary. Consultant obstetric antenatal care would continue to be provided in the ante natal clinic and some ante natal assessment services would be provided. Midwifery ante natal and post natal care would continue to be provided unchanged within the community. There would also be room to consider locating other services within the unit such as ante natal booking clinics, post natal clinics, breast feeding support and parent education.

**Option 3: No deliveries at FHN** - This assumes that there are antenatal services only provided at FHN. Community midwifery would continue to be offered on the same basis as now. Women would have the choice of place of delivery but this would not include FHN.
7. Pre-Consultation and Engagement

7.1 As CCG and commissioners for local services we will need to assess whether the four tests for service reconfiguration (set down by the Secretary for State in 2010) have been met:
1. GP engagement
2. Public and patient engagement
3. Clarity on the clinical evidence base

7.2 Through the engagement process we have sort to ensure all of the four tests are met fully. Outlined at the end of this section and following extensive consultation is how we have met the expectation above and the summary of supporting evidence. We will first outline the detailed process undertaken to achieve this outcome.

Involvement of patients, the public and staff

7.3 A four month engagement exercise was carried out between February and June 2012 by the CCG in connection with the future of children's and maternity services at the Friarage Hospital, Northallerton, which is operated by South Tees Hospitals NHS Foundation Trust.

Purpose of engagement

7.4 The purpose of the engagement exercise was to:
- explain to everyone with an interest in children’s and maternity services – patients, parents, the public, elected members, local authorities, partner organisations – the issues facing those services in the future, and the various options which were being considered in an effort to find a solution;
- understand the views of local people about the various options;
- ensure that the views of local people were taken into account in developing recommendations for the future of children’s and maternity services; and
- assure the local community that the Friarage Hospital was the key component of the CCGs vision for the future

7.5 The process of engagement has been clinically led – with all public meetings hosted by a GP and a paediatrician with strong support from other clinical colleagues.

7.6 The findings from the exercise form part of the evidence being presented to the Board of NHS North Yorkshire and York, which is responsible for making a final decision on the proposals, as well as demonstrating compliance with the national requirement for strengthened public and patient engagement in the process of service change.

The engagement process

7.7 A communications and engagement strategy and plan was drawn up by the communications/engagement teams at NHSNYY and STFT at the end of January 2012. This outlined the range of methods designed to engage with local stakeholders.

7.8 Regular liaison with the North Yorkshire County Council Scrutiny of Health Committee has taken place throughout the period of engagement and their advice sought on specific topics. The Chairman of the Committee has acted as independent chair for seven of the nine public open meetings and another Committee member has chaired the other two meetings.
7.9 The main components of the engagement process have included a mix of information-giving and opportunities for people to have a say:

- Meetings with key stakeholders including MPs, District Councils, Strategic Partnership Task and Finish Group, LinKs and regular briefings to a wider group of stakeholders including parish and town councils
- On-going programme of engagement with CCG constituent GP practices.
- An on-going programme of publicity using press releases, syndicated articles in publications such as North Yorkshire Now, the Strategic Partnership newsletter, etc.
- A programme of nine public open meetings across Hambleton and Richmondshire. These were split into an informal section where people could view a poster display and read a comprehensive information pack about the issues and current options, as well as informally talk to key clinicians from the CCG and trust, followed by a formal presentation given by the Shadow Accountable Officer of the CCG (a GP) or a deputy and a paediatrician. A Question and Answer session followed at each event with a broad range of clinical and managerial staff available to answer questions. (Total attendance – 533 including some staff and other regular attendees). A full list of meetings can be found in Appendix 3.
- “Micro-websites” within NHSNYY and STFT main sites to provide comprehensive information about options, including information packs, posters, frequently asked questions. Q&A sheets were produced following all of the nine public meetings and these were posted on the website.
- A questionnaire/survey available in hard copy at open meetings, via focus groups, and online, and distributed through Army Welfare Service, GateWAY (Gypsy and traveller empowerment working across Yorkshire) Richmondshire Homestart.
- A series of focus groups at local children’s centres, NCT meetings, etc to talk to mothers about the problems and suggested options and listen to their views.
- Posters and leaflets in GP surgeries.
- Leaflets distributed through Army Welfare Service, libraries, supermarkets.
- Regular meetings with Friarage hospital staff.
- Establishment of a Stakeholder Involvement Group, made up of representatives of the CCG, South Tees and Darlington acute trusts, Darlington CCG, Yorkshire Ambulance Trust, local authority, elected members, LinKs, and patient groups.
- “Talking heads” videos were used for clinicians to explain the issues and, for the first time, social media figured prominently in the approach taken, enabling as the CCG and STHFT to reach thousands of active campaigners, particularly in the early stages of the process.

7.10 There were a number of mechanisms for people to give their views about the potential changes:

- By emailing views to a general email address.
- Writing a letter to the CCG via a Freepost address.
- Attending one of nine public open meetings arranged during the pre-consultation period.
- Completing the CCG survey questionnaire – online or in hard copy.

7.11 The CCG used social media to give information about the engagement process. There has been very active use of this medium by a locally organised campaign group.

7.12 In addition, representatives from the CCG and STHFT responded to all requests from key stakeholders to attend meetings and were proactive in setting up meetings with others, such as the local LinKs and the Facebook Campaign.
7.13 The NCAT report and resultant options developed achieved a high profile across Hambleton and Richmondshire, with considerable coverage by the broadcast and print media locally and regionally from the end of January onwards.

7.14 An estimated 2000 people attended a rally and march organised by County Cllr John Blackie and the ‘Save Northallerton Friarage Hospital Children’s and Maternity Services’ on 26 May 2012. Following the march a petition containing over 10,000 signatures was presented to Simon Pleydell, Chief Executive of STFT to pass to the CCG.

7.15 There have been regular briefing meetings for staff within the Trust hosted by the Divisional Manager (Women & Children) for staff working paediatric and obstetric services, Chief Executive Open meetings for staff at FHN, internal trust-wide briefings and a questionnaire on MLUs to staff at both JCUH and FHN.

Summary of issues from the engagement
7.16 The engagement process confirmed the value placed on services at the Friarage Hospital. This strength of feeling was no surprise to the CCG or Trust. A previous review of services (Friarage Clinical Futures) attracted over a thousand residents to open meetings across Hambleton and Richmondshire in 2004/5. The overwhelming view was that people wanted to be able to continue to access the current level of service at FHN; the choice offered by Darlington and other hospitals was frequently raised by the CCG but people were not as enthusiastic about this option, possibly due to no affinity or use.

7.17 In the public meetings, maternity services attracted more attention than paediatric services – with a frequently expressed wish for babies to be born in North Yorkshire. The main concern for paediatric services came from parents whose children have open access to paediatric services wanting to know how changes would affect them.

7.18 The most widespread concerns expressed in the engagement process relate to distances, transport, travelling time and cost of travel with fears expressed for a woman in labour or families having to transport a sick child. These views were expressed at all public meetings, stakeholder meetings and have also come through in the survey. People from all areas were concerned at additional travelling times and distance, particularly for people in the Richmondshire Dales. Examples of personal stories/experiences were cited where people considered additional travelling would have been unsafe. The safety of transferring children and women in labour between hospital sites was also a frequent concern.

7.19 The capacity of the ambulance service and the JCUH site to cope with increased numbers of patients needing to travel to JCUH was frequently mentioned as a concern – coupled with a general concern about ambulance service performance.

7.20 There was a wish to understand why issues could not be solved by greater cross site working between JCUH and FHN, and questions as to why services could not be moved from JCUH to FHN.

7.21 There were concerns about the capacity at JCUH should services transfer and whether the services would be able to cope – those who had direct experience of the SCBU at FHN wanted to understand why so many Teesside families were using this service and whether this means there is a lack of capacity at JCUH.

Using the findings from the engagement process
7.22 The CCG was clear that it wanted an open and honest dialogue with members of the public and patients. It was keen to take its statutory duty to consult beyond the minimum required and make it a genuine conversation with local communities. We have detailed
below what people told us through the consultation process and our response to concerns or questions raised.

<table>
<thead>
<tr>
<th>Patients and members of the public told us</th>
<th>Our response</th>
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<tr>
<td>Local people have confidence in and value children’s and maternity services at the Friarage Hospital.</td>
<td>STFT is nationally recognised as one of the leading healthcare providers in England for the quality of its services, as reflected by the fact that for 12 years running it has been one of the CHKS “Top 40 Hospitals”. It is no surprise to us that people value the services that are currently being provided and recognise the all round excellent clinical care. We do not have concerns about the quality of the services, but the future sustainability of children’s and maternity services over the next few years if nothing changes. The concerns were first highlighted by the clinicians at the Friarage Hospital who provide these services and are very proud of them. An independent review was completed by NCAT who supported the concerns of local clinicians and recognised there is a need to change the service model.</td>
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<td>People value close proximity of services above quality and safety.</td>
<td>As a commissioner we have to place the greatest emphasis on safety and quality and as a newly emerging and clinically led organisation, the CCG would be negligent in commissioning unsafe services. We feel the underlying concern here is about the ability to access services locally. As part of the work and through the Equality and Transport Assessment we will look to develop the correct infrastructure to support patients to have improved access to services.</td>
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<td>There are some concerns about a midwifery-led service, e.g. the safety of MLU Women being transferred while in labour due to unforeseen complications</td>
<td>It would be a fundamental requirement of any newly commissioned service that strict criteria be put in place to ensure that only MLU Women assessed as being “low risk” can be admitted to a midwifery-led unit and also that the unit is staffed by highly skilled, trained midwives. Once admitted, careful and continual observations for signs of complications and early transfer to a consultant-led unit would allow the risks to both the expectant mothers and their babies to be mitigated. There is no evidence regionally or nationally that maternity led units are any less safe than a consultant led service. The CCG will work with all providers to ensure robust criteria, policies and procedures are developed to ensure the highest quality of care and safety is achieved. The CCG will audit services on a regular basis to ensure standards are maintained.</td>
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<td>People are concerned at the potential impact on the ambulance trust and other acute trusts if services are moved from the Friarage Hospital.</td>
<td>We have met regularly with the Yorkshire Ambulance Trust to discuss the options being considered and have explored with them the impact of each of the service redesigns and the costs. We will continue to work closely with them on the shortlisted options and they will provide detailed and costed solutions to meet the needs of the commissioner and provider.</td>
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1 CHKS is part of Capita plc’s health division, an independent provider of healthcare intelligence and quality improvement services.
Whilst many people do not want to see any change, there is some recognition that the services do need to change in the future.

The way health care is delivered is changing all the time because of new technology, new drug treatments and changing practice based on clinical evidence. Many ways of delivering care which were the norm as recently as five/ten years’ ago are now seen as out-dated. Better child health and treatment means fewer children need to be in hospital overnight and the ones who do are often very poorly and need to be in a unit which is more specialised. We recognise that parents and children prefer to be at home with better support in the community if this is clinically appropriate.

There is concern that a gradual erosion of services at the hospital will lead to closure.

The CCG, as a group of all local GPs, recognises that there is a need for the way children’s and maternity services are provided to change, so they remain safe and sustainable for the future, they are determined that the Friarage Hospital will continue to have a strong and vibrant future as the front door to healthcare in Hambleton and Richmondshire.

Parents with “open access” facility for their children would like enhanced community services and hand-held records/personal care plan.

A meeting in July 2012 was held during the engagement period with parents whose children have complex health needs. They considered that having a much better service in the local community, for example being able to administer intravenous treatment for cystic fibrosis, would provide a much higher quality of care for their children than having to bring them into hospital for the same treatment. Hand-held records would mean that wherever they needed to access treatment clinicians would easily be able to decide on the most appropriate care and this would make care plans available to all carers.

GPs told us

They have been as fully involved in the CCGs work on the future of children’s and maternity services as they would have wanted to be.

All 24 GP practices in the Hambleton, Richmondshire District Council areas and in the Whitby area are part of Hambleton, Richmondshire and Whitby Clinical Commissioning Group. During the entire engagement process they have been kept informed and involved in the process.

They wish to be part of the option appraisal process

The GP practices take their new responsibilities as commissioners under the new Health and Social Care Act very seriously. Whilst the shadow governing body (the decision-making body for the CCG) has delegated power to make decisions on behalf of those practices, there was a unanimous view that GPs wanted to be part of the process for appraising the various options for the future.

The majority do not consider additional investment should be made in children’s and maternity services at the expense of other services

The CCG has a statutory duty to balance its books, and has inherited a considerable financial challenge from the local primary care trust. This means that from time to time difficult choices have to be made. As there is no “new” money coming into the NHS because of the national requirement to save £20bn over the next two years, any additional investment in children’s and maternity services would be at the expense of other services. With an estimated cost of £2.7 million to bring
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<th>The majority consider that a children’s assessment unit should be open 7 days a week.</th>
<th>STFT have suggested that a children’s short stay assessment unit would operate five days a week, Monday to Friday. However, local GPs consider that there is a need for such a unit to be open on a daily basis, opening for 12 or 13 hours a day during the week and reduced hours over the weekend. If this option were to be recommended, GPs as commissioners would agree the optimal times for opening and commission the service based on those. This will need to be determined through an activity demand review looking at times the services are accessed currently.</th>
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<td>They recognise many standards expected for acute services are not deliverable within the realistic budget of a small hospital.</td>
<td>Small hospitals are much more susceptible to any changing patterns of healthcare as they have to operate with much smaller teams. Staff within those teams are unlikely to have the breadth of specialist knowledge found in larger hospitals, and there is a danger that they would not see enough patients to keep up their skills. This impacts on the standards which they are able to achieve.</td>
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<td>They strongly support the Friarage as the front door into local healthcare for the people of Hambleton and Richmondshire and key to their vision of healthcare going forward.</td>
<td>As stated above, GPs are committed to developing the Friarage Hospital as a strong, vibrant centre for hospital-based care in Hambleton and Richmondshire. All parties are keen to continue to develop the vision for services at the site and look to use the site to support improved local care and deliver integrated models of care with community staff to support care outside of hospital and reduce both admissions and lengths of stay in hospital.</td>
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<td>Whilst some Richmondshire GPs may decide to refer children to Darlington, should the Friarage no longer have inpatient facilities, they may continue to refer patients to a children’s assessment centre at the Friarage Hospital if they knew that the child would be seen by a consultant the same day.</td>
<td>The facility for a poorly child to be assessed by a consultant paediatrician is an important factor in getting the right treatment at the right time and getting the child quickly back on the road to recovery. GPs will offer patients choice of service and be clear about the benefits and alternatives locally and available within one hour, this will be based on the suitability of the services compared to the needs of the child. Ultimately the choice will be made by the parents. We are extremely privileged within this area to be supported by a potential of four providers: Durham and Darlington NHS foundation Trust, South Tees NHS Foundation Trust, York hospitals NHS Foundation Trust and Harrogate and District NHS Foundation Trust all of whom have strong reputations and provide high quality services.</td>
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children’s and maternity services up to the required staffing levels to meet new standards of care, and no guarantee that STFT would be able to recruit to the new posts, GPs say that they cannot justify such a large expenditure. It amounts to over 55 Community Nurses or 370 Joint Operations.

Whilst every patient is important, the job of commissioners is to ensure that the whole registered population has access to appropriate care within the resources available. As a responsible commissioner we need to consider the scale of impact and the appropriateness of the decision in respect of individuals versus a larger population.
**Key stakeholders told us**

**Concerns around travel and transport were amongst the most significant raised by key stakeholders and members of public during the engagement period.**

The CCG recognises the very real difficulties presented by our very large geographical catchment area. There are many sparsely populated rural areas where some people live quite long distances – and travel times – from hospitals.

People living in Northallerton and Thirsk would be the most affected by additional travelling times. However, both towns are within 30/35 minutes of reaching an alternative hospital or hospitals. Access by ambulance to Darlington from the Richmondshire Dales is only a matter of 3-4 minutes longer than travelling to Northallerton, and transport links along the A1 are easier in bad weather. Public transport links from the Richmond and Catterick areas are also better to Darlington.

If the service models for children’s services do change, very few children would need to travel to a different hospital that is further away from where they live. Expectant mothers would continue to receive their antenatal and postnatal care at the Friarage Hospital as now, so for most journeys to hospital there would be no change from now.

All hospitals can be accessed by 100% of the population of Hambleton and Richmondshire within one hour travel time and 98% of the population of Hambleton and Richmondshire within 45 minutes travel time. It should also be noted that for a number of patients their nearest hospital is actually closer than the Friarage Hospital.

We need to share with the public the performance and range of service available to them as there are a number of perceptions about the different providers and this has not always been shown to be based on actual experiences. This will be done through the consultation process.

Where those from deprived areas could also be disadvantaged through extended travel, we will develop subsidised travel schemes to ensure they are not disadvantaged.

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**Concerns about vulnerable children**

There is concern that a gradual erosion of services at the hospital will lead to closure.

As above, whilst local GPs who represent the CCG recognise that there is a need for the way children’s and maternity services are provided to change, so they remain safe and sustainable for the future, they are determined that the Friarage Hospital will continue to have a strong and vibrant future as the front door to secondary and tertiary healthcare in Hambleton and Richmondshire. The CCG and trust will make a decision on opening hours relating to demand and activity assessment.

The CCG and STFT fully recognise the importance of working together to ensure that vulnerable children continue to have joined-up services which protect their interests. They intend to make it a priority to put in place a robust implementation plan to ensure systems and communications meet the needs of this very important client group.
Below are details on how people’s views have been taken into account by the CCG as part of the engagement process:

<table>
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<tr>
<th>Option appraisal</th>
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<tr>
<td>Refinement of the seven original options by eliminating those which would result in no paediatric services and no obstetric deliveries at the Friarage Hospital.</td>
<td>The CCG governing body would not appraise any option which would result in children’s and maternity services being completely closed at the Friarage Hospital in Northallerton. These options are not considered to be acceptable. We will also be developing a vision for the Friarage Hospital which will be shared with the public and detail the long term future of the hospital and community service across Hambleton and Richmondshire.</td>
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<tr>
<td>Clarification and refinement of the operating hours and criteria for accepting children onto assessment unit.</td>
<td>The CCG will make a decision on the operating hours and criteria for accepting children onto an assessment unit, once it has completed a detailed assessment of the times the current activity presents. This will be completed through the consultation period and The CCG will always look to align demand to access times.</td>
</tr>
<tr>
<td>Clarification of the care pathways which would support children who have open access to children’s services, including development of hand held records and a detailed care plan for each child.</td>
<td>The CCG and STFT are already working on arrangements to improve services for children who have an open access facility. These will be fed into our commissioning arrangements for 2012-2017 which is currently being developed. A meeting in July 2012 was held during the engagement period with parents whose children have complex health needs. Hand-held records would mean that wherever they needed to access treatment clinicians would easily be able to decide on the most appropriate care and this would make care plans available to all carers.</td>
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<tr>
<td>Compilation of detailed information on travel distance and time as part of the impact assessment, recognising the importance of this issue in securing access to services in rural areas</td>
<td>We have completed a detailed travel assessment which is explained within Section 13 The Implications and Impact Assessment of Viable Options and is also included in full within the appendices. The travel assessment highlights that some patients will travel less and some more. All of our population can access services within one hour and 98% of the public can access an acute provider within 45 minutes. We will also offer a taxi subsidy and additional patient transport services through the existing ambulance providers and through working with the voluntary sector.</td>
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<tr>
<td>Consideration of ways to improve transport services including ambulance provision.</td>
<td>We have worked closely with NEAS/YAS throughout the pre-consultation process to explore who we can lesson any of the implications where patients will be required to travel further to access hospital services. In the main this only adds an additional 4 minutes to the average car journey however for those in deprived areas and without access to a car this could have quite considerable implications. We are exploring the provision of additional capacity for both ambulance services, patient transport services, voluntary transport services and taxi services for those who could be disadvantaged.</td>
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<tr>
<td><strong>Accommodation for parents living a long distance from The James Cook University Hospital so they can stay with sick children sent there.</strong></td>
<td>STFT would be responsible for ensuring that appropriate accommodation is made available at The James Cook University Hospital for parents to stay with their children.</td>
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<tr>
<td><strong>All “open access” children to have a personalised clear care plan, with hand held records so that wherever they are seen clinicians will have access to their details</strong></td>
<td>See above – this has been answered in other sections of this table.</td>
</tr>
<tr>
<td><strong>Consideration of enhanced nursing of “open access” children in the community rather than bringing them into hospital.</strong></td>
<td>Parents of children with open access to services have said that they would consider enhanced community nursing would give them a better quality of service in the future.</td>
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<td><strong>Consideration of which specialist out-patient services could be brought into the community, e.g. diabetic and epilepsy care.</strong></td>
<td>STFT have said that they would consider introducing additional specialist clinics in the community. The CCG will consider which services would benefit best from additional community out-patient clinics.</td>
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<tr>
<td><strong>Quality</strong></td>
<td></td>
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<tr>
<td><strong>Detailed risk analysis on the transfer of patients.</strong></td>
<td>A detailed risk assessment has been completed for all of the options. The risk assessments and mitigations for the preferred options have been included within this document within Section 13 The Implications and Impact Assessment of Viable Options. During the consultation period we will complete more detailed analysis of the risk profiling of the options.</td>
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<tr>
<td><strong>Feedback to STHFT on perceived poor quality issues at The James Cook University Hospital.</strong></td>
<td>Despite STFT being in the top 40 CKHS hospitals for its quality standards, and feedback in the CCGs survey that 65% of patients using The JCUH stating that the care was good or excellent, there is a clear perception from people we spoke to in focus groups, some people attending the meetings, and some people responding to the survey that the care provided in The JCUH is inferior to that provided at the FHN. All feedback from the survey and focus groups will be giving to STFT to help them improve the patient experience and tackle the gap between the views of service users and the perception of non-service users.</td>
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8. Gathering evidence from different parts of the country

8.1 During the engagement period a fact finding exercise was conducted by the CCG, STFT and North Yorkshire OSC in order to leave “no stone unturned” in the efforts to find an innovative solution to the issues facing the Friarage hospital.

8.2 The objective of the fact finding exercise was to explore with other NHS organisations the issues being faced in the delivery of paediatric and obstetric services and the arrangements in place or being considered for future service delivery. It had two elements as detailed in 8.3.

8.3 Visits to other hospitals to discuss different approaches to running paediatric and obstetric services. A survey by STFT (with OSC involvement) of 75 Hospital Trusts running small paediatric and maternity units

8.4 In addition a survey was also carried out in June/July 2012 by Richmondshire District Council of small hospitals with maternity units, the results of which were shared with the CCG and STFT in late July 2012.

8.5 This section provides a resume of the visits and surveys and concludes with a summary of the findings – notes of the visits to hospital sites, STFT Survey response, Richmondshire District Council Survey responses, Survey of Midwifery Staff and Straw Poll of users of FHN maternity services are provided in the appendices.

Hospital visits

8.6 The three main visits undertaken were to:

- NHS South Tyneside to discuss the background to a public consultation on reconfiguration paediatric services and the proposals for closure of two inpatient services and the creation a Short Stay Paediatric Assessment Units.

- Oxford University Hospitals NHS Trust (Horton General Hospital) to discuss with the Trust, GPs and local councillors the reconfiguration process undertaken and understand the operational arrangements subsequently put in place as a result of an Independent Reconfiguration Panel review.

- Wansbeck Hospital (Northumbria Healthcare NHSFT) to explore the use of Advanced Neonatal Nurse Practitioners (ANNPs) to support maternity services and Special Care Baby Unit at the hospital.

Commentary

South Tyneside

8.7 The consultation led by NHS South of Tyne and Wear during 2012 proposed the closure of inpatient paediatric services within Queen Elizabeth Hospital Gateshead and South Tyneside District Hospital, South Shields and the retention of a single, dedicated paediatric in-patient unit at Sunderland Royal Hospital with the proposed creation of paediatric assessment units within Queen Elizabeth and South Tyneside District Hospital. The drivers for this change set out in the consultation document “Getting Better Together” A Public Consultation 2012, Gateshead PCT, South Tyneside PCT, Sunderland Teaching PCT closely match the issues raised by medical staff at the Friarage Hospital i.e. that the current configuration of services was not sustainable because:
Advances in paediatric medicine mean that serious childhood illnesses are very rare and children and young people seldom have to stay in hospital overnight. This means that, at times, fewer than half of the overnight beds for children in South of Tyne and Wear are occupied each night; children and young people suffer from more chronic illness now than in the past. These types of childhood illness can be managed safely and more appropriately in the child’s own home with support from healthcare staff. It is often the case that children attend hospital when they could have been treated closer to home by their own general practitioner (GP) or in a walk-in service - some of these children are admitted overnight when their medical needs could actually have been resolved without a hospital stay. In 2011/12, more than 12,000 children and young people were admitted to local hospitals. Many of them could have been managed in the community.

Smaller units are not able to employ a wide range of paediatric staff and some experience difficulty recruiting and retaining doctors and nurses. Children and young people who need an overnight stay can use services in Gateshead, Sunderland or South Tyneside. Spreading the paediatric expertise in this way means that the Trusts unable to provide the very high level of care required. Having three inpatient facilities in the area also results in a poor use of resources as beds are often unoccupied.

The South Tyneside area is not providing the type of services that acutely sick and injured children and their families need or offering the best care in the most cost effective way so that children and young people receive care closer to home or in their own home and fewer presenting at hospital and being admitted for overnight stays with more services available in the community.

The hospitals and the PCTs had concluded that paediatric assessment units were a sustainable and effective way of meeting the acute health needs of children – and had tested these proposals with the National Clinical Advisory Team – and were consulting on whether a 24 hour unit or one operating shorter hours was the best approach.

The visits highlighted that a principal concern was about middle grade paediatric staffing – currently and into the future. NHSNYY stated that they felt as doctor rota numbers reduced, retaining a 24 hour assessment unit might become unsustainable in the future – and NCAT had raised this concern with the NHSNYY.

There was the opportunity to discuss with those involved in the consultation why changes to paediatric services were being proposed but not to maternity services.

Overall, the visit highlighted that:

- the hospitals involved in the proposed change have three tiers of medical cover and propose to keep their medical cover unchanged (which is why a 24 hour assessment unit is feasible). They are therefore already in a stronger position than FHN which has no middle grades but are still concerned about the sustainability of their services;

- as a result competent paediatric input for SCBU can continue to be provided but if it is not possible to maintain 24 hour assessment units in the future, this may result in a need to reconsider maternity services;

- there had been a conscious decision to limit the engagement and consultation process to paediatric services so that progress could be made with paediatric reconfiguration. Commissioners were however raising issues about maternity services with the Trust;
• despite the very different geography of the South Tyneside area the issues raised by the public were very similar to those in Hambleton and Richmondshire with a strong emphasis on increased travel times.

Oxford University Hospitals NHS Trust (Horton General Hospital, Banbury)

8.11 As part of strategic service planning for the Trust, proposals for children’s and maternity services at Horton were needed, prompted by the loss of training accreditation for paediatric middle grades and the growing difficult of obtaining non training grade doctors for these posts. A decision was taken to move to an ambulatory care model paediatrics, which in turn meant that it would not be possible to support the Special Care Baby Unit (SCBU) at Horton and consultant led obstetrics with the proposal being for a midwifery led unit.

8.12 The Trust led a consultation with limited commissioner involvement which resulted in an Independent Reconfiguration Panel (IRP) review (2008) which ruled that the Trust should not proceed with the original options. The Secretary of State upheld the IRP findings. The PCT then led the “Better Health Care” programme which reviewed the options and which resulted in a plan for:
• a consultant delivered paediatric service; and
• a second anaesthetic rota.

8.13 This plan was upheld by a clinical review panel in March 2010 and received the support of the NHSNYY clinical executive. NHSNYY provided £1.5 million of funding above tariff to support the changes with the Trust finding the balance of the total cost of £2.5 million. The visit highlighted:

• as with South Tyneside, great similarity in the issues driving consideration of service change (in a unit which is bigger than FHN) i.e. – problems with running a unit without a secure middle grade tier in paediatrics and, in obstetrics, the reduction in training posts and the difficulties of running a unit with relatively junior doctors;

• useful experience about consultant delivered paediatric services. The visit confirmed that the minimum number required to undertake routine work and on call for the two sites was 16 general paediatricians and as a result the Trust had set out to recruit to eleven new posts. STHT had done well in recruitment (the proximity to the two universities in Oxford and to London helped) but acknowledged that taking on eleven new consultants had been challenging – and that there was a risk that the process could have gone much less smoothly. Full recruitment took over a year to achieve once a firm approval to proceed had been given – (with locums being relied on as recruitment proceeded) and at the time of the visits the first of the new appointees had left. The staff attracted to the posts are often first time appointments into consultant posts (good practice now is for consultants to receive mentorship in the first substantive job in recognition of their need to develop their skills);

• there were issues about the maintenance of skills acknowledged, and about continuity of care particularly for children with chronic conditions who are frequent attenders to the hospital;

• the future of maternity services was again under active review. The need to move away from reliance on doctors in training for delivery of the service was a strong concern. Options being considered were a midwifery led service, no deliveries at Horton or consultant delivered service - this would require an establishment of 13 consultants with two consultants available (1 resident and 1 on-call). There were concerns on the part of the Oxford team about the maintenance of skills in particular
having delivery involvement and impact on gynaecology skills. The achievability of fulfilling job plans was questioned by the lead Oxford consultant present at the meeting.

Northumbria Health Care NHS Foundation Trust (Wansbeck Hospital, Ashington)

8.14 The hospital has consultant-led maternity services but has never had paediatric input – it has been in operation for 10 years. Initially there were junior doctors – it was two years before they went live with the current model which relies on Advance Neonatal Nurse Practitioners. It depends on support from the RVI neonatal consultants.

8.15 The unit is staffed with 6.3 wte ANNPs band 8a (8 members of staff), 2 wte band 6s and a band 3 health care assistant.

8.16 The consultants from RVI provide cover 9 to 5 Monday to Friday (but are not on site at Wansbeck) although there is a Monday morning ward round. There is always someone available by telephone or mobile for advice.

8.17 The ANNPs operate an on call system – 1 in the hospital and 1 on call as a second pair of hands (with payments for on call and time back for when they have to come in). Not all of the 6.3 whole time equivalents participate in on call – so it is a very onerous commitment for those who do.

8.18 The unit has experienced midwives – the post natal ward will look after all but tube feeding babies. If there is a sick baby out of hours a call is made to the RVI who send out a registrar and also to an ANNP on call (takes 15 minutes to get in. If the registrar cannot attend, the consultant on call at RVI may have to come (and he then has to cover his on call). They have considered telemedicine but consider that the hands free phone works just as well. The visit highlighted that:

- this model is dependent on a group of very experienced nurses who trained in tertiary units;
- replicating this model is not feasible. Wansbeck acknowledged that they have concerns about recruitment. It is 10 years since they last made an appointment of an ANNP and that person came with experience from Gateshead. There have been advertisements for neonatal staff but the unit has failed to appoint. Some applicants have withdrawn once they realise that there is no neonatal consultant on site. There are plans to “home-grow” ANNPs. Home-growing will require staff to gain experience in a tertiary unit. This is difficult in itself as the RVI does not use ANNPs and is part of different Trust. Midwives from North Tyneside rotate through Wansbeck – but many prefer to stay at North Tyneside because of transport/travel issues.
- there is also an issue about maintenance of skills. Staff from Wansbeck plan to spend a week a year in the RVI but have to compete with doctors in training there to get hands-on work. Also, staffing numbers are tight making release of staff difficult. They are developing a band 7 role to support the band 8a which will allow the current band 6s to move up to band 7 over time. They are advertising for training practitioners.
- the advice of the Wansbeck staff is that it would take 5 years to be confident about running the model that they operate (and this does not take into account time to select the people to train). No-one else in the country is operating in the same way as Wansbeck. Dumfries, Brighton and South Manchester have been to visit the unit and have expressed an interest but, whilst Brighton has nurse practitioners (10), they practice with direct medical cover.
STFT survey of trusts

8.19 A questionnaire was sent to 75 NHS Trusts and NHS Foundation Trusts which run paediatric units meeting the definition of “small” and “very small” as set out by the Royal College of Paediatricians and Child Health (RCPCH) in their “Facing the Future” document.

8.20 The survey was compiled with the involvement of the scrutiny officer for the North Yorkshire County Council Overview and Scrutiny of Health Committee (OSC). The purpose was to provide comparative data on how other Trusts organise their paediatric and maternity services, what changes to service configuration may have taken place and to help in thinking about the future by identifying options for service provision which may be under consideration in other communities.

8.21 It was sent to 75 NHS and NHS Foundation Trusts Chief Executives in England, Scotland, Ireland and Wales in May 2012, including those identified by the RCPCH as operating small and very small paediatric units. The College list included hospitals which operate units which are very much bigger than those at the Friarage Hospital. An undertaking was given to use the information provided in an anonymised form but permission has been given by some respondent to provide Trust specific information.

8.22 The initial response rate was low. Seven written responses were received and there were telephone responses from three organisations:

Issues highlighted by responses

8.23 Regardless of the difference in size between most of the respondent units and the Friarage the responses do illustrate the issues facing paediatric and maternity services providers and the extent of change being implemented or planned as a response.

Consultant delivered services

8.24 Two hospitals (Furness General Hospital and Royal Free NHS Trust) had moved to consultant delivered paediatric services as a result of difficulties with medical staffing (largely middle grade). Royal Free responded to proposals for service reconfiguration being put forward by the local NHS because of difficulties in sustaining services by moving to a consultant delivered paediatric service with 15 plus whole time equivalent consultants. They are now in the process of considering whether continuing to offer a 24 hour seven day a week service is viable. Doncaster and Bassetlaw are in the process of implementing a change to a consultant delivered service.

Cross trust reconfiguration

8.25 Service reconfiguration had taken place at two sites:

The Chief Executive of South Manchester NHS Foundation Trust referred us to the “Making it Better” consultation which has reconfigured maternity, neonatal and paediatric services across Greater Manchester and which resulted in the closure of four maternity, paediatric and neonatal units in Trafford and Rochdale (with day time services for paediatric remaining) and closure of maternity units in Bury and Salford. At the time of the “Making it Better” consultation, doctors, nurses and midwives believed that organised changes in the way NHS services were provided were required urgently. The alternative was that they would evolve in other, probably less safe and efficient ways. They put forward the following case for change to improve services for children, young people, families and babies:

- The consultation information sets out that the NHS in Greater Manchester did not provide enough healthcare services outside of hospitals for children, young people, parents and babies, such as children’s community nursing services and that:
• There is evidence that better healthcare can be delivered in fewer, larger, more specialised units.
• Healthcare staff need a ‘critical mass’ of patients to care for to ensure they keep up their skills.
• In Greater Manchester, we don’t need as many hospitals providing overnight care because children and young people spend less time in hospital now and many conditions can be managed at home or in community settings.
• The overnight hospital services for children, young people, parents and babies are currently spread too thinly across Greater Manchester to provide the best quality care.
• Previously, some wards and units had to close temporarily due to staffing pressures.
• Women want more choice about the setting for the birth of their babies.
• The reconfiguration process was extremely prolonged but has now been implemented.

8.26 Maidstone and Tunbridge Wells FT has moved from two paediatric and maternity units to one inpatient paediatric unit (with an assessment unit on a second site) and one consultant led obstetric unit with a midwifery led unit at the second site. They cite the principal reason for changing the service as being the viability of middle grade cover and the effect of this on the safety and sustainability of the services – and have experienced “extreme difficulty in the recruitment of high calibre doctors with skills, experience and communication skills”. Since centralizing they are fully recruited for the first time in 10 years.

8.27 There are discussions and consultation about reconfiguration currently underway at four sites:

St Helens and Knowsley is involved in the strategic review of children’s services being undertaken by NHS Mersey. There have been previous reviews of services across this area and in planning their new paediatric unit which opened in 2012 the Trust explicitly acknowledged that the possibility of a radical reconfiguration of services between hospital sites had to be taken into account.

Ealing Hospitals NHS Trust is involved in the “Shaping a Healthier Future” review being undertaken by North West London with options being considered which would result in the centralisation of their paediatric inpatient and consultant led obstetric services to an alternative site. This exercise reflects circumstances which are very specific to London but also in the case for change note reflects the issues being discussed in relation to Northallerton ie: “pregnancies are becoming more complicated …babies born outside normal working hours are at higher risk of dying. This is associated with a lack of access to senior staff at these times….we don’t have enough senior doctors to provide round the clock care for children in hospital. These issues won’t be solved by training and hiring more doctors. Those doctors need experience of dealing with complications regularly so they can provide the best specialist care. If they do not see enough patients they lose these skills and cannot provide such high quality care. If spread across many hospitals, doctors will not get that experience”. The document also highlights that there are difficulties in recruiting and keeping clinical staff and if the best places to work and train are not offered, staff will not stay and patients will not get the best care… and if there are not enough senior staff, supervision of training staff will not be possible and trainees will be withdrawn from the hospital. The extent of clinical concern about the implications if there is no change is emphasised.

Furness General Hospital (University Hospitals of Morcambe Bay NHS FT) responded to the survey highlighting that paediatric and obstetric services are under review. Published information relating to this site includes an external review commissioned by the local CCG states: “The difficulties of staffing the paediatric department have been evident for several
years and this is due to a variety of external factors which are common to many small and/or isolated units across the UK. Those that impact directly are the shortage of sub-consultant grade staff to fill rotas and a withdrawal of most trainees from the hospital, largely because of lack of training opportunities. The report concludes that either a consultant delivered service (with eleven paediatric consultants) or an “eight till late” service is the way forward and that, in obstetrics, consideration should be given to a low risk only delivery service.

Doncaster and Bassetlaw NHS Foundation Trust has been through a clinical review process which considered the closure of the inpatient paediatric unit and consultant led maternity service and the establishment of a paediatric assessment unit and midwifery led unit, with the reasons for the proposed change including paediatric and obstetric workforce pressures with a reduction in training numbers and an increasing sub-specialisation in neonatology having a direct impact on ability to provide the correct level of medical support at middle grade level to sustain out-of-hours cover at a small unit, and a concern that the low volumes of children admitted to the inpatient unit introduce a risk that the paediatricians’ skills will, over time, become eroded especially in relation to dealing with acutely-ill children. Combined with the difficulties that this Trust was experiencing in attracting middle grades to substantive posts, this challenged the future sustainability of paediatrics. The Trust has subsequently reconsidered this change and has been pursuing a plan which moves to a consultant delivered paediatric services, and is also considering options for its maternity services.

General findings
8.28 All the respondents have more consultant and trainee resource than the FHN and are generally dealing with higher numbers of admissions and deliveries. There are three tiers of medical staff working in paediatrics and obstetrics (including the middle grade paediatric tier which is absent at the FHN and which is one of the principal concerns about the sustainability of the service) at all of the hospitals which responded with the exception of three units which have moved to consultant-delivered paediatric services because of difficulties with middle grade cover.

8.29 None of the units responding were reliant on nurse practitioners in neonates or paediatrics for delivery of service, which is one of the options, that STHFT had examined for the future operation of the unit to help address issues about middle grade staff. However there were nurse practitioners contributing to the teams in some hospitals. One respondent had explicitly considered using ANNPs as an alternative to trainee medical staff but had rejected this, based on its own research because of the difficulty of training and retaining staff.

8.30 The position with recruitment and retention of staff was mixed. As above, problems with medical staffing had led two units to move to or consider a radical change in the staffing model; only one unit reported no problems. Of the others the comments included - “had extreme difficulty” in recruiting substantive medical staff and paediatric middle grades; another has great difficulty with paediatric juniors and difficulty with paediatric consultants; one had recruited to paediatric posts but with a small field of applicants.

Richmondshire District Council survey of small hospitals
8.31 A survey conducted by the District Council contains useful, complementary information on small units – there is some overlap in respondents with the STHFT survey. This information has been put into the public domain by the Council.

8.32 The responses include those from Scottish units which are very small and very remote and operate quite exceptional systems (Western Isles and Caithness).
**Paediatric services**

8.33 The paediatric units which responded all had in place a middle grade tier of staff with the exception of two units - Furness General, which (as above) has moved to a consultant-delivered service but are currently reviewing its viability, and Erne Hospital in Enniskillen. Of the hospitals with middle grade cover:

**Withybush** acknowledge that there are occasions when they cannot provide middle grade cover and therefore a paediatric consultant has to be resident. This happens on a regular basis (there are five consultants).

**Furness General Hospital** acknowledges the difficulty of recruiting paediatric staff. Dumfries and Galloway has 7 middle grade posts established and five vacancies – consultants are working as middle grades and they are using locums.

**Border and Melrose** has 5 middle grade posts, of which 3 are vacant. They are considering how they move away from reliance on trainees through increased use of advanced nurse practitioners (they are already working a system whereby they have consultants resident on call until 9pm).

**St Mary’s Isle of Wight** relies on non-training posts (presumably because they are not recognised for training because of the size if the unit).

**Scarborough** report that they do not have enough middle grades to provide cover 24 hours/365 days a year and that “we are still actively looking at a solution to provide safe cover at all times that is sustainable”.

**Doncaster and Bassetlaw** should have seven middle grades at Bassetlaw but have only filled four posts. This is the main driver for their move to a consultant-delivered service which they recognise will result in difficulty maintaining skills and retaining staff.

**Yeovil** reports no problems with middle grades.

**Causeway Londonderry** has 2.5 middle grades and it is not clear how they maintain 24 hour cover as their consultants are not resident.

**Withybush, Haverford West** are in the process of reorganising services with two neighbouring hospitals. There has been a highly contentious engagement process about the future of this hospital.

**Obstetric services**

**Western Isles** acknowledges that the obstetric unit may have to convert to a midwifery led unit when the lead obstetrician retires in two years-time; Caithness is having difficulty recruiting to their consultant only service.

**Dumfries and Galloway** acknowledges that consultant expansion is not viable (it has 200 deliveries more that the Friarage) and that it will look to expand speciality doctor posts (non-training) as a way of surviving – whether such staff are available is not explored.

**Borders** reports that training posts for obstetrics will reduce and that more funding will be required to increase the number of consultants and change in job plans – although how 24 hour cover will then be achieved is unclear.
Doncaster and Bassetlaw’s response seems to acknowledge that difficulties with training numbers will lead to one alternative to their current obstetric system being a consultant-delivered service.

Research into midwifery led units (MLUs)
8.34 In addition to the joint visits and the survey work undertaken by the Trust which explored how other Trusts approach delivery of paediatric and obstetric services, staff from the FHN Midwifery steering Group have carried out research specifically aimed at establishing whether a midwifery led unit would be a viable means of delivering maternity services at FHN.

National data
8.35 In 2011, a national birthplace study was conducted by the NHS National Institute for Health Research which found:

- 24% of Trusts had a FMLU
- Incidence of perinatal outcome was low in all settings including FMLUs. However, the incidence of adverse perinatal outcome was increased in planned home births.
- Instrumental and interventions was significantly lower in home, FMLU and alongside Midwifery led units (AMU)
- FMLU women are considerably more likely to have a "Normal" physiological birth
- Women delivering in a FMLU or at home have substantially higher breastfeeding rates
- Transfer rates of 36% for nulliparous women (women who have never given birth) in FMLU births, 45% for nulliparous women in home births and 9-13% in multiparous women (women who have previously given birth).
- Cost savings for women in non-obstetric unit settings were £367 per home birth and £182 per FMLU birth.
- Intrapartum (during delivery) transfer was a major consideration when making a decision on place of birth especially around transfer distance in rural areas.

8.36 This led staff within the unit to seek further information about considerations for a FMLU:

- Number of women eligible for FMLU/home birth
- Facilities at JCUH
- Facilities at FHN
- Information for women
- Training for staff
- Staffing models
- Cost
- Sustainability
- Identification of numbers of women eligible for FMLU/Home delivery
- Staff views on FMLU care/home births
- Women’s views on FMLU care
- Identification of facilities required.
- Formulation of guidance on admission and transfer criteria and processes
- Staffing models and costs

8.37 From the maternity information system used at FHN it was estimated that approximately 500 women in 2011 delivered low dependency and would therefore be eligible for delivery within a FMLU. However, women's choice must be considered and this will be influenced by a number of factors such as place of residence, distance to consultant obstetric services, reputation of the unit, facilities available and transfer in labour.
Staff views
8.38 A questionnaire was distributed to all midwives working within FHN maternity unit. There was a 34% return rate (see Appendices).

- 99% felt it was important or very important to have a FMLU if consultant maternity services were not provided
- 91% would promote women to deliver in a FMLU
- 57% would be interested in working in a FMLU, 19% unsure

Women’s views
8.39 A straw poll of all women from 36 weeks gestation who fulfil the low dependency criteria in the month of June was conducted by community midwives in their antenatal classes to give an idea of the uptake of a FMLU to the current population choosing to deliver at FHN. The results were that of 60 women responding, 52 said they would attend an MLU if it were available; 8 indicated that they would choose to go to another hospital with 2 of these saying they would choose Darlington and the James Cook University Hospital.

Visits
8.40 4 MLUs were visited. These were Perth, Kendall, Hexham and Huddersfield.

8.41 The findings are summarised below:
- Delivery rates ranged from 675 per year to 167 per year.
- Transfer rates ranged from 16% to 27%
- Breast feeding initiation rates ranged from 60%-80%
- Transfer to obstetric led unit (OLU) ranged from 6 miles to 25 miles

8.42 Most units also provided consultant obstetric ante natal outpatient clinics on site as well as other services including breast feeding groups/workshops, parent education, 36 week ante natal visit.

8.43 A number of different staffing models were in place from independent FMLU staffing to a fully integrated community midwifery staffing model. The visit to Perth MLU was discussed illustrated a fully integrated staffing model and they felt that the main contributor to their success was the integration with the community staff. They all met every morning for half an hour to discuss workload in the unit and in the community so that all staff were aware of all issues.

8.44 As a result of the visits the FHN Midwifery Steering Group’s views were that:

- It is recommended that FMLU adopt a ‘home from home’ atmosphere and be as non-clinical as possible with a minimum of 5 en suite birthing/post natal rooms and facilities for partners to stay. Birthing pools should also be available (RCM 2010).There are currently 5 delivery rooms at FHN including 1 birthing pool.

- Following visits to a number of FMLUs, the steering group favour the option of `one stop’ rooms whereby the woman labours, delivers, recovers and remains post natally until discharge home. This concept has been running very successfully in the alongside midwifery led unit at JCUH for 6 years;

8.45 Four options for staffing were considered after the visits : the model favoured by the FHN midwifery steering group would be a mixed model of core FMLU staff supported by community midwives in order to maintain midwifery skills in intrapartum care, enable the provision of other services and also to maximise effective use of midwives. This will provide:

- Integration of the two teams
• Continuity of care for women within the community
• Ensure high risk women also received consistent care
• Flexibility of use of staff

8.46 In order to be viable (WHY) the FMLU would need to deliver a minimum of 300 deliveries per year. It would also need to compliant with CNST maternity standards for both midwifery staffing and clinical care.

Findings
8.47 The fact finding exercise has demonstrated very clearly that other hospitals, many larger than the Friarage Hospital and in a more robust position in terms of their medical staffing, are struggling with the same issues as have been raised by clinical staff working at the Friarage. It has also shown that the approaches to the future delivery of service which are under discussion or have been adopted elsewhere are very similar to those being considered for the Friarage.

Hospital visits and surveys
8.48 The issues faced at the FHN are occurring across the country in many hospitals of differing size and in very different geographic areas. Hospitals were at different points in dealing with these issues – some having already gone through reconfiguration or change in internal operational arrangements, others were still in the process and some were working through contingency plans to manage risks without substantial changes in the service offered to patients (the approach that South Tees Hospitals Trust has successfully adopted at FHN since the Clinical Futures Review carried out with Hambleton and Richmondshire PCT in 2005 and which clinical staff, the Trust Board and NCAT believe is no longer viable).

8.49 The approaches to achieving safe services for the future being adopted in those hospitals visited or surveyed which had reached the same conclusions about sustainability as South Tees and were, as a result, implementing or planning change are very much in line with the options initially identified by the paediatric and obstetric teams at FHN when the first discussions with the CCG took place in 2011. The visits have given the opportunity to fully explore ideas which were raised during engagement about consultant led services and the use of Advanced Neonatal Practitioners to support the operation of high risk maternity services in the absence of neonatal medical staff and ensure that these approaches have been taken into account in the development of options for the future. The research on and visits to midwifery led units has increased the confidence of maternity staff that freestanding midwifery led units can be a popular choice for women if fully integrated with community midwifery services and offering the right ethos.

Richmondshire District Council survey of small units findings
8.50 The responses to the Richmondshire District council survey illustrate:
• the widespread difficulty of obtaining middle grade cover in paediatrics;
• the fact that many obstetric units are already reliant on non-training posts so are less affected by proposed reductions in training numbers than the Friarage Hospital. Even so many are having to consider their future contingency plans – with an emphasis of recruitment of non-training grade staff, the future supply of which is very uncertain; that the future operation of many of these units is problematic. For example, Doncaster and Bassetlaw has undergone reviews of its paediatric and obstetric services and there is still discussion going on about future service models for Bassetlaw. Furness General Hospital has had a difficult time in respect of its services and is undergoing review as to the future delivery of both paediatric and obstetric services; Western Isles is considering changes to a midwifery led unit and Withybush is engaging on changes to its services.
Overall summary

8.51 The fact finding exercise and pre-consultation stage has demonstrated two key points. Firstly we have striven to achieve all of the expectations of the 4 reconfiguration tests set out in the NHS SCAP process and secondly we have taken into account all stakeholders feedback and concerns and for the shortlisted options are able to mitigate the associated risks of the service redesign.

8.52 It has demonstrated very clearly that other hospitals, many larger than the FHN, are struggling with the same issues. It has also shown that the approaches to the future delivery of service which are under discussion or have been adopted elsewhere are very similar to those being considered for the Friarage. However despite the intensive work on understand different models from around the country there do not appear to be successful models which we have not considered within our range of options. It did however highlight some of the risk associated with each model and the requirement for strong contingency plans to be should any delays occur through the public consultation process.

8.53 It also highlighted the need for strengthened community services to complement a paediatric assessment unit and some additional community support has been built into the assessment and outpatient models but this would need to come from the current financial envelop of the commissioner through a drive to reduce acute admissions and invest in more community resources.
9. Appraisal of shortlisted options

9.1 Each option considered in the business case could in theory deliver the objectives sought. In practice, the options carry differing levels of risk which will affect the Trust’s ability to provide safe and sustainable services.

9.2 As a general note; Yorkshire Ambulance Service advise that the impact on their capacity of options 2 and 3 models requiring change in service is very limited but that they will propose to the PCT and CCG that an additional ambulance be funded for an initial period (suggested a 3-6 month period when information can be gathered) to protect against any unexpected impact, whilst the actual implications of the changes are assessed.

Paediatric and maternity combined options:

Options 1 and 1a: continuation of inpatient paediatrics and continuation of high risk obstetrics

9.3 These options are considered together as the obstetric model is wholly dependent on the paediatric medical cover being sustainable and because the issues of consultant delivered services are common to both.

9.4 Options 1 and 1a rely on the recruitment and retention of medical staff and ANNPs. There is a very high level of risk that this recruitment will not be achievable. The principal barrier to recruitment is that paediatric appointees will need to be trained to cover paediatrics and neonates and obstetrics appointees’ obstetrics and gynaecology - training is increasingly specialised rather than generalist. The Trust can recruit to vacancies in paediatrics and obstetrics but recruitment in the North East is difficult and filling the multiple additional posts required for this model of service to work is not considered feasible. The requirement to be resident may not be a barrier to recruitment but, where consultant led services are in place, the feedback from these hospitals is that retention of staff is then problematic.

9.5 The lead in time for recruitment of the required medical staff (if obtainable) will be such that the service is likely to deteriorate to an unacceptable degree before change could be implemented - experience from Banbury (which operates in a much more favourable environment for both permanent and locum staff recruitment than Teesside and North Yorkshire), was that full recruitment took over a year to achieve once a firm approval to proceed had been given – and that was primarily for paediatric and anaesthetic recruitment. The Trust would need to recruit successfully in paediatrics, obstetric and anaesthetics for this option to be successful. The prospect of operating with locum cover whilst permanent recruitment is achieved raises very significant concerns about safety.

9.6 If recruitment were achievable, options 1 and 1a pose problems with the maintenance of skills because of low levels of activity and high numbers of staff whose job plans require a majority of their time to be spent working at night when there will be very low levels of activity. There is also the concern that staff attracted to the posts required are likely to be first time appointments into consultant jobs (this has been the experience at Banbury) and therefore limited in experience and developed skills (good practice now is for consultants to receive mentorship) – and, as above, highly likely to move on.

9.7 These options offer no advantage in patient safety or outcomes compared to the alternatives considered. There has been much concern expressed about the requirement to transfer patients between sites. It is the clinical view that continuing the services with the current unrestricted access poses a greater risk of harm to patients occurring during transfer as there is much greater unpredictability about the nature of patients presenting to
the Friarage than would be the case with either an assessment unit or a midwifery led unit where strict admission criteria apply.

9.8 These options require substantial recurrent investment – the viability of this investment is a matter for NHSNYY and CCG to consider as the option involves a very significant increase in costs. To put this into context this would be equivalent to 55 Community Nursing Staff or 370 joint replacements. There is also no evidence to show any increase in health need or expected demand.

9.9 The experience of patients and families using these services should be similar whichever option is adopted. Options 1 and 1a avoid the need for families to travel to JCUH if admission is required, which offers greater convenience, but patient experience data suggests that there are similar levels of satisfaction with the services offered on both sites once patients actually access the services. Experience at Banbury suggests however that there were issues raised by families with the continuity of care offered in their consultant delivered service because of the number of consultants working in the unit and their job plans which require the majority of their working time to be spent covering the ward at night – limiting the presence of each consultant in clinic and on the ward during the day when the majority of care is delivered.

9.10 The advantage and disadvantages are summarised below:

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<tr>
<th>Advantages</th>
<th>Disadvantages</th>
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<tbody>
<tr>
<td>• No visible change to service.</td>
<td>• Need additional investment of £2.7 million which given the financial position of the commissioner is not available and this would therefore mean a delay while we consult on where we would have to disinvest to accommodate the funding requirement. This could lead to the destabilisation of other services which are currently underfunded. For both of these areas there is growing health needs. Currently there is significant growth in terms of health need in these areas; therefore it is much harder to justify an increase of £2.7 million.</td>
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<tr>
<td>• No change to travel implications.</td>
<td>• Increase in middle grades, consultants and junior doctors which is challenging in terms of recruitment. Consultant recruitment is difficult if expansion takes place. Recruitment &amp; retention difficulties in non-consultant based service, service unsustainable.</td>
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<tr>
<td>• No public concerns around reconfiguring the service.</td>
<td>• Approval for further junior doctors and is not secure.</td>
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<tr>
<td>• Continued paediatric support to A&amp;E department.</td>
<td>• Junior grade cover by ANNP would not offer cover to paediatrics, only NICU</td>
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<tr>
<td>• Paediatric skills would be maintained in other specialties through continued exposure to children (e.g. anaesthetic and A&amp;E staff) – however, the experience is relatively limited due to the number of children seen.</td>
<td>• ANNP would need at least 2 year lead in time which leaves the service vulnerable in the interim period. Contingency plans would need to be developed.</td>
</tr>
<tr>
<td>• No change to travel times</td>
<td>• Difficulties in maintaining nursing staffing levels and managing sickness and absence due to small numbers of staff.</td>
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<td></td>
<td>• Difficulties in achieving the required skill set and competencies for the medical and nursing team due to low activity numbers and range of patients seen.</td>
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Option 2: paediatric assessment unit model with a midwifery led unit

9.11 The see and treat service proposed shares the advantage of the outpatient model in that it allows cost effective compliance with RCPCH standards without a reliance on extensive recruitment; it reduces (rather than removes) the need for paediatric cover out of hours as cover for the inpatient ward is no longer required but the assessment unit needs to be covered 10am to 10pm; it therefore makes more effective use of medical and nursing resources than operating a poorly utilised ward which releases resources for the and the delivery of specialist clinics, and enhanced community services which represent an improvement on the service currently offered.

9.12 This model would offer a greater degree of access to services than is proposed under the outpatient model and would entail fewer admissions to other units as a result of the assessment service. Some children who would previously have been admitted to FHN will need to be admitted to other units, but, as with the outpatient model there will be an increase in access to service and a daily emergency clinic which is not currently offered. The service would be safer than that currently provided as JCUH has more extensive facilities and access to more sub speciality skills than are delivered or deliverable at FHN.

9.13 During the engagement process, the risk of harm to children requiring transfer from FHN to JCUH was frequently raised. The aim of the assessment service is to ensure that transfers are kept to a minimum and therefore strict selection criteria will apply. With these criteria in place the likelihood of very sick children requiring transfer to an inpatient unit is considered to be lower than for a consultant delivered service to which very sick patients will be brought, and who are therefore more likely to require transfer.

9.14 This offers better local access to services at FHN than option 3, but by having a daily time cut off for services is potentially confusing for families. This model is therefore very reliant on excellent communication with GPs who should be the first point of advice for a sick child, and with the public about the operation of the service and the circumstances in which children should and should not present to FHN.

9.15 There is a question of sustainability due to the number accessing an assessment unit if the uptake of services is as low as projected in the business case. The sustainability issues do not arise from issues about maintenance of skills given the proposed job plans of consultants working in the unit but there is a question of the value for money that the model may offer if the projections of attendances in the most likely and worst case models are correct and the added value of offering an assessment service if GPs and families chose to go elsewhere. There is a risk that if the numbers using the assessment service are low, over time a move to a more limited outpatient based service will need public discussion.

9.16 This option addresses the problems of achieving sustainable medical cover for the obstetric service as the midwifery led model is not dependent on medical staff other than for outpatient care. If there are no deliveries at FHN, there will be re-deployment of medical staff into a larger pool of staff at JCUH, which should make both recruitment and retention easier, which will help the Trust to provide a sustainable obstetric service for Hambleton and Richmondshire in to the future.
9.17 There is a low risk associated with recruitment and retention of midwives to run this service based on the views of midwives currently working within the Trust about the attractiveness of this model of service.

9.18 The principal risks to the safety and sustainability of this option arise from lack of certainty about uptake. Around 500 women will be eligible to deliver in the unit, but experience from other units suggests that the uptake will be lower – and that after an initially positive response numbers tend to decline. If this is the case and the number of deliveries falls to 300 or fewer – less than one a day, the maintenance of skills will become an issue (rotation between FHN and JCUH can address this to some extent but a reasonable level of hands on experience within the MLU itself is needed). An MLU operating at this level of activity still requires the same level of staffing as a busier unit and can offer an unrewarding environment in which to work.

9.19 A midwifery led unit will result in a requirement for additional capacity to be created at JCUH if in quality of patient experience is to be assured. In 2009 high risk deliveries were accommodated at JCUH at very short notice – and could be again - but for the change to be sustainable permanent extra physical capacity is required. A step increase in physical capacity at JCUH is desirable irrespective of a move to a FMLU given the rise in the birth rate that has been experienced at JCUH in recent years and the pressure that this creates on space. A programme of reconfiguration of existing accommodation has been developed which demonstrates that it is feasible. The capital investment required to support these changes can be accommodated within the Trust’s medium term financial plan. Should the assumptions contained within the business case of the number of additional deliveries occurring at JCUH be wrong, there will be enough flexibility within the planned expansion to deal with higher volumes. There is a considerable lead-in time to provide all the additional space required and the risk of this is reflected in the risk assessment.

9.20 As with all the options considered, FMLUs are within the mainstream of practice and are a safe alternative to consultant led or delivered services and offer a very high level of patient satisfaction. There was concern expressed during the engagement process about issues of longer journeys to hospital (which is addressed above) and transfer between units – there will be an increased frequency of transfer but the risk of harm occurring as result is very low.

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<tr>
<th>Advantages</th>
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<tr>
<td>Meets RCPCH standards cost effectively.</td>
<td>Public concern about reconfiguration.</td>
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<tr>
<td>Opportunities for improved community service delivery.</td>
<td>Travel to other providers would be required when child needed inpatient care.</td>
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<tr>
<td>Options for enhanced specialist services delivered at FHN.</td>
<td>Transportation to other providers however for deprived families incurring additional travels costs we can develop travel subsidy programmes to mitigate this. It is very small numbers also as outpatients will still be delivered locally and it is only for inpatient stays and high risk births.</td>
</tr>
<tr>
<td>Opportunities for new services to support care outside of hospital such as open access IV therapies delivered at home by community services.</td>
<td>Potential initial confusion regarding opening times by service users. This will be mitigated through clear guidance.</td>
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<tr>
<td>Addresses lack of senior cover at night.</td>
<td>There are low numbers of low risk births anticipated to take place in the MLU (less than one per day) therefore need to understand long term viability will be dependent on patient choice</td>
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<tr>
<td>Offers more efficient use of the resources through improved utilisation of staff</td>
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<tr>
<td>In patient services would be offered at other providers and there is significant choice in providers within one hour travel time by car.</td>
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<tr>
<td>Develops sustainable paediatric and maternity services locally.</td>
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<tr>
<td>Maintains local services.</td>
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<tr>
<td>Improves local choice as there are consultant led units but there are no</td>
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midwifery led units and they offer a less 'medicalised' model of care for those who want a more intimate experience.

- Strengthens national direction of travel for more care for children to be delivered in the home setting.
- See and treat service in the area will result in fewer children requiring transfer to another provider.

Option 3: outpatient service with midwifery led unit

9.21 This option removes the requirement for paediatric cover out of hours and hence addresses the principle sustainability and governance issues facing the service. It supports compliance with RCPCH standards without extensive recruitment. It offers job plans which are likely to be attractive in a difficult recruitment environment without the onerous on-call of the current service or the requirement for residency needed under option 1 and 1a. It offers more opportunities for working on both hospital sites than the current service and for the development of sub specialty interests. This will support staff retention, strengthening the sustainability of services at both FHN and JCUH. This way of working also reduces the problems of achieving cover for a small nursing team.

9.22 The outpatient model makes more effective use of medical and nursing resources than operating a poorly utilised ward. This releases resources for the delivery of specialist clinics, and enhanced community services which represent an improvement on the service currently offered. There will however also be an increase in access to services compared to the current service through the provision of a daily “urgent” clinic for the assessment of children who are unwell but do not need admission.

9.23 This model would offer more restricted access to non elective services both in the children’s unit and in A&E than is currently provided at FHN and will require children to be admitted to other hospitals who would currently be admitted to FHN.

9.24 The service would be safe and safer than that currently provided or offered under option 1 and 1a as children will be admitted to JCUH which has more extensive facilities and access to more sub specialist skills than are delivered or deliverable at FHN. This will mean the right patient in the right place at the right time rather than children being admitted to FHN, retained for some time and then transferred on as happens now and as is likely under option 1 an 1a.

9.25 The risk to patients arising from an incident occurring en route to hospital was debated as this was raised frequently during the engagement process. The view is that children face risks now in travelling to both FHN and JCUH but that the incidence of serious harm occurring is rare – evidence as to whether longer journeys increase the risk of incidents occurring or affect outcomes is being sought. Overall, the service for children will be safer and this is reflected in the risk assessment.

9.26 This option addresses the problems of achieving sustainable medical cover for the obstetric service as the midwifery led model is not dependent on medical staff other than for outpatient care. If there are no high risk deliveries at FHN, there will be re-deployment of medical staff into a larger pool of staff at JCUH, which should make both recruitment and retention easier, which will help the Trust to provide a sustainable obstetric service for Hamilton and Richmondshire in to the future.
9.27 There is a low risk associated with recruitment and retention of midwives to run this service based on the views of midwives currently working within the Trust about the attractiveness of this model of service.

9.28 The principal risks to the safety and sustainability of this option arise from lack of certainty about uptake. Around 500 women will be eligible to deliver in the unit, but experience from other units suggests that the uptake will be lower – and that after an initially positive response numbers tend to decline. If this is the case and the number of deliveries falls to 300 or fewer – less than one a day, the maintenance of skills will become an issue (rotation between FHN and JCUH can address this to some extent but a reasonable level of hands on experience within the FMLU itself is needed). An FMLU operating at this level of activity becomes very poor value for money and an unrewarding environment in which to work.

9.29 A midwifery led unit will result in a requirement for additional capacity to be created at JCUH if quality of patient experience is to be assured. In 2009 high risk deliveries were accommodated at JCUH at very short notice – and could be again - but for the change to be sustainable permanent extra physical capacity is required. A step increase in physical capacity at JCUH is desirable irrespective of a move to a FMLU given the rise in the birth rate that has been experienced at JCUH in recent years and the pressure that this creates on space. A programme of reconfiguration of existing accommodation has been developed which demonstrates that it is feasible. The capital investment required to support these changes can be accommodated within the Trust’s medium term financial plan. Should the assumptions contained within the business case of the number of additional deliveries occurring at JCUH be wrong, there will be enough flexibility within the planned expansion to deal with higher volumes. There is a considerable lead-in time to provide all the additional space required and the risk of this is reflected in the risk assessment.

9.30 As with all the options considered, FMLUs are within the mainstream of practice and are a safe alternative to consultant led or delivered services and offer a very high level of patient satisfaction. There was concern expressed during the engagement process about issues of longer journeys to hospital (which is addressed above) and transfer between units – there will be an increased frequency of transfer but the risk of harm occurring as result is very low.

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Meets RCPCH standards cost effectively.</td>
<td>• Public concerns about reconfiguration of services.</td>
</tr>
<tr>
<td>• Opportunities for improved community service delivery.</td>
<td>• Travel to other providers would be required when child needed inpatient care and for women requiring consultant led obstetric services.</td>
</tr>
<tr>
<td>• Options for enhanced specialist services delivered at FHN.</td>
<td>• Transportation to other providers.</td>
</tr>
<tr>
<td>• Reduce the requirement for consultant paediatric cover out of hours as ward cover not required.</td>
<td>•</td>
</tr>
<tr>
<td>• More efficient use of medical and nursing resources.</td>
<td></td>
</tr>
<tr>
<td>• Inpatient service at other providers will be more sustainable and offer appropriate medical cover and skill set.</td>
<td></td>
</tr>
</tbody>
</table>
10. Implications and Impact Assessment of Viable Options

Economic impact of changes to maternity and paediatric services

10.1 There was a query during the engagement process as to whether the CCG or Trust would conduct an impact assessment to assess the effect on the economy of the Hambleton and Richmondshire area of changes to paediatric and maternity services.

10.2 The work done on economic impact by the NHS is largely concerned with assessing the comparative impact of investment in different therapies or services in terms of clinical outcomes of these interventions or therapies. One piece of published research reported that “Several studies of economic contributions of rural health services have taken place in North America (Doeksen, Schott 2003, Kleinholz, Doeksen 1991, Eilrich, St. Clair & Doeksen 2004). Doeksen and Schott (2003) estimated that almost one in five local jobs in Atoka County, Oklahoma, was directly or indirectly related to the presence of the health sector.”

10.3 They suggested that change in the size or structure of the health sector in a community would affect economic viability. However, other studies have shown minimal effects following hospital closure (Probst et al. 1999, Stensland, Mueller & Sutton 2002). For instance, Pearson and Tajalli (2003) used pre- and post-hospital closure data for 24 USA communities and 24 controls and found no evidence of short or long term harm to community economies.

10.4 Holmes et al (2006) differentiated between the impact of closure of one hospital in a community and closure of the only hospital. Losing the sole hospital in a county resulted in decreased income and employment.” (More than health: the added value of health services in remote Scotland and Australia” M. Prior, J. Farmer, D.J. Godden, J. Taylor, November 2010.

10.5 Whilst there is limited research, what there is seems to be equivocal in the fact that the extent of change under consideration is likely to have limited economic impact. The key facts relating to the economic impact are summarised below:

10.6 The biggest economic impact of these services is likely to be in providing direct employment. However, the impact on local employment will be minimal. There will be small reduction in the number of funded posts, dependent on the option chosen:

- Outpatient only paediatric services – 11.25 wte fewer whole time equivalent whole time equivalent posts than at present
- Paediatric Assessment unit (7.33 wte fewer)
- MLU (3.6 wte fewer)

10.7 The distribution of staff between FHN and JCUH would change but there is no evidence that staff move out of the Hambleton and Richmondshire areas when their job plans change.

10.8 Health Services can have an indirect effect on the local economy through the need for goods and services. We have no information to hand on what proportion of the non pay spend at FHN on paediatric and maternity services is through local businesses but the impact of the proposed changes will be very limited given that under any of the options the majority of the service remains local – and paediatric and obstetrics are small elements of the overall expenditure by the Trust on health services at FHN. Also, many goods and services are purchased on a Trust wide basis so a change of location between hospitals does not mean a loss of business to a supplier. In the short term, the Trust will need to spend money on changes to buildings at JCUH which could result in expenditure with local contractors – we know that a partner for construction sources much of its workforce locally.
10.9 Using health services may involve expenditure (because of travel costs). If a greater proportion of income is spent in these costs- there may be less discretionary expenditure on other things. As a result of the changes proposed, there may be increased expenditure on travelling for some families where the distance to be travelled increases –up to 1,000 children a year now admitted to FHN may have to be admitted to JCUH or another hospital of their choice (which may involve a shorter journey than to FHN in some cases) and up to 1250 women who deliver now at FHN may have to deliver elsewhere. On average the journey times may increase by 22 minutes for paediatrics and 15 minutes for obstetrics. Most people travel by car so there will be a small additional petrol cost. As the majority of journeys undertaken are for outpatient attendances or community midwifery attendances which are unaffected by the change, the impact of this extra expenditure on the economy is minimal. We estimate this to be around £20,000 per annum more may be spent on travel.

Workforce
10.10 The issues about recruitment and retention of staff have been extensively discussion in Section 1. The principal issues arise with Option 1 and 1a which requires significant expansion of the consultant medical workforce and recruitment of ANNPs. Based on experience from Banbury, the minimum lead-in time for recruitment is 1 year for consultant staff for consultant delivered services. For ANNPs, recruitment is very uncertain and a minimum lead-in time of 2 years for training is required. It is not anticipated to be a significant issue for options 2 and 3.

Estates
10.11 There are limited estates implications arising from Options 1 as the estate will be used in the same way. Existing facilities are of good quality and function. The exception is the obstetric theatre at FHN which if it is to remain in prolonged use will require improved air handling equipment. For options 2 and 3 there is a significant estates implications. There are currently 4300 deliveries per annum and an upward trend in deliveries at the JCUH hospital site. The existing facilities were built in the late 1980s and have been modernised since but are at the limit of their capacity for the volume of activity now being experienced.

10.12 An initial scoping exercise to consider the options for expansion of facilities has been carried out – this assumes that capacity for 1,000 additional deliveries per annum will be required. This has been scoped in more detail in STFT’s Business Case which is included Appendix 6. This will remain a Trust issue to scope and fund but we have been assured there is sufficient capital available but it remains subject to board approval.

Ambulance services
10.13 There have been a number of discussions with Yorkshire Ambulance Service about the options under consideration and the protocols which would need to apply in the event of an assessment unit, outpatient paediatric service, midwifery led unit of outpatient obstetric service at FHN. YAS have mapped journey times and assessed the likely impact on the service. Their advice to commissioners is that the changes will have limited impact but that they would propose providing an additional ambulance for twelve months following the implementation of changes whilst the actual impact of changes is measured, as a safety net  

10.14 Commissioning more service capacity from both CDDFT and STHFT will almost certainly affect the Yorkshire Ambulance Service and North East Ambulance Service (NEAS). YAS have proposed a 5 day or 7 day 12 hour additional cover resource either across a three month or a six month period. Options costed range of between £41k - £114k with a proposal to review the impact at the end of the particular period. Some lead in time will be required for this to be operational. There was confidence that this could be in place within a 3 month period if required.
**Investment**

10.15 Option 1 requires significant investment and is the most expensive of the options. This would require additional funding and as there are no available resources, it would require the diversion of resources from other services. The funding requirement just to understand the scale of the requirement is equivalent to 55 District Nurses funded for one year or 370 joint replacements.

10.16 Options 2 and 3 require capital investment by the Trust. An assessment has been made of the Trust’s ability to support the required investment and the Trust confirm that it can do this but this would significantly reduce availability to commit to any further capital expenditure beyond that already built into the Trusts plans.

We will work with the ambulance trust to consider other areas for efficiencies within the system to offset these additional costs.

**Implementation timetable**

10.17 For option 1, recruitment will be an ongoing challenge and it is deemed that to recruit to the required level will be a minimum of one year and this is likely to be far longer given the recruitment challenges experience. For options 2 and 3, it is proposed that, from approval to proceed, any change to paediatric services would require three months of communication and education with GPs and the public to ensure that the nature of the change was fully understood. For maternity services, the feasibility studies carried out by the Trust suggest that it will take 21 months to complete the changes to accommodation proposed at JCUH. Short term arrangements can be made which would allow the new service model to be implemented at FHN prior to building work being completed at JCUH but this requires further development work by the trust before a firm programme for implementation can be determined. If STFT repeats the actions it took in 2009 when the Maternity unit was temporarily closed and makes short term arrangements to accommodate the additional activity from FHN. This can then be achieved in less than three months.

**Equality Impact Assessments (including impact due to socio-economic deprivation)**

10.18 This section describes the process and outcomes of an Equality Impact Assessment (EIA) for the proposed models of care under consideration, undertaken by the CCG. Further work will be required to understand the impact that any potential changes might have and any adverse effects on particular groups of the local population. This will be completed once the results of pre-consultation are finalised.

10.19 This assessment is part of a statutory obligation in The Race Relations (Amendment) Act 2000, Disability Discrimination Act 2005 and the Equality Act 2006 to assess the impact of its policies, strategies and services on the population affected by them to ensure that no group suffers detriment as a result and that positive action to improve community cohesion is taken wherever possible. This EIA, like all others, considers the possible impact of the proposed models of care on the local population according to nine protected characteristics - age, disability, race, religion and beliefs, marriage and civil partnerships, gender, sexual orientation, transgender, pregnancy and maternity. Additionally, issues of socio-economic deprivation have been considered because deprivation is a determinant of health and leads to health inequalities as well. Potential impacts on human rights have also been considered.

10.20 The EIA therefore aims to:

- assess whether the proposed models of care options are likely to have any adverse effects on any of these groups
- Alert commissioners and providers of the need to monitor the impact on these groups and make changes to mitigate any inequality.
10.21 The impacts of the following three options have been considered as part of the EIA:

- Option 1 – In patient, out-patient and community paediatric service with increased workforce AND low and high risk obstetrics
- Option 2 – Paediatric Assessment Service (i.e. no in-patient beds), outpatients and community paediatrics AND low risk obstetrics only (midwife-led unit)
- Option 3 – Paediatric outpatient and community service (i.e. no in-patient beds or paediatric assessment unit) AND low risk obstetrics only (midwife-led unit)

**Method**

10.22 NHS North Yorkshire and York’s (given the CCG is in shadow form) and South Tees Hospitals EIA processes have been used to develop this EIA. A screening impact assessment was carried out against all the protected groups including people from more deprived populations. The screening impact assessment looks at positive and negative potential impacts. Impacts from staff working in the units and from the community engagement process have been used, as well as those generated by the Hambleton, Richmondshire and Whitby CCG project group. For those groups that are affected, more in depth analysis to understand the impacts has been recommended. From these impact assessments, we would expect action plans to be developed to reduce the impacts where possible.

**Screening impact assessment**

<table>
<thead>
<tr>
<th>Protected Characteristics</th>
<th>How might this change affect the various groups</th>
<th>Is there likely to be a differential impact?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Option 1</td>
</tr>
<tr>
<td><strong>Gender (including Gender reassignment, pregnancy and breastfeeding)</strong></td>
<td>The maternity options that are being considered means that women are affected by any change more than men. However, all options affect women as a group equally. No specific issues have been identified in respect of transgender groups. All options affect pregnancy and maternity. However, all options affect this group as whole equally.</td>
<td>No</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td>No specific issues have been identified in respect of ethnicity groups.</td>
<td>No</td>
</tr>
<tr>
<td><strong>Disability</strong></td>
<td>People with children who have disabilities who access the current services more frequently than other children will be adversely affected. They may need to travel more frequently than other children and their families accessing the service.</td>
<td>No</td>
</tr>
<tr>
<td><strong>Sexual orientation</strong></td>
<td>No specific issues have been identified in respect of sexual orientation.</td>
<td>No</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td>The paediatric service options that are being considered mean that children are affected by any change more than other age groups. However, all options affect children as a group equally. Equally, maternity service changes affect women of child bearing age (generally regarded as 15-44 yrs) more than other ages. Certain risk factors for high risk pregnancies may be age related e.g. young or old maternal age, multiparity, pre-existing health conditions.</td>
<td>No</td>
</tr>
</tbody>
</table>
such as high blood pressure, diabetes which are associated with age. This would mean that certain age-related factors may determine whether a woman can access any low-risk maternity unit.

| Religion/belief | No specific issues have been identified in respect of religion or belief. | No | No | No |
| Marriage and Civil Partnership | No specific issues have been identified in respect of marriage and civil partnerships. | No | No | No |
| Human Rights | No specific issues have been identified in respect of human rights. | No | No | No |
| Deprivation | Any increased travel time will impact of costs to the family which will impact relatively more in families who are more deprived. Certain risk factors for high risk pregnancies may be associated with deprivation status e.g. teenage pregnancy, multiparity, pre-existing health conditions, such as high blood pressure, diabetes; obesity; smoking; higher alcohol use. This would mean that certain deprivation-associated factors may determine whether a woman can access any low-risk maternity unit. Increased outpatient services around Catterick may reduce the impact of some of the proposed changes, and may increase access to services for communities from more deprived areas. Socioeconomic factors play a part in health outcomes (see needs assessment). However, many of the other risks are not directly affected by the proposed service changes as they relate to wider determinants. | No | Yes | Yes |

Recommendations for the CCG based on the EIA

<table>
<thead>
<tr>
<th>Protected Characteristics</th>
<th>Recommendations</th>
</tr>
</thead>
</table>
| Disability               | • The consultation should specifically engage with families of children who have disabilities, particularly those with open access to the paediatric ward  
  • Actions should be taken to reduce any potential differential impact on this group  
  **BOTH OF THE RECOMMENDATIONS HAVE BEEN ACTIONED ALREADY.** |
| Age                      | • The consultation needs to make clear that older women who are pregnant are less likely to be able to access any mid-wife led unit, and therefore have reduced choice and potential increased travel time. However there are clinical safety reasons why high risk pregnancies need to be managed in a consultant led unit.  
  **THIS WILL BE MADE CLEAR THROUGH THE CONSULTATION PROCESS.** |
| Deprivation              | • The travel impact assessment report should include deprivation as part of its criteria for assessment.  
  • Actions should be taken to lessen any impact that increased travel may have on this group  
  • Although generally child and maternal health is good, risk factors for poor child health (and actions to reduce them) need to be taken into consideration in any service change.  
  • Any increase in access to services in more deprived areas should be encouraged (e.g. Catterick). |
BOTH OF THE RECOMMENDATIONS HAVE BEEN ACTIONED. WE HAVE COMPLETED A TRAVEL IMPACT ASSESSMENT AND FOR THE LAST TWO RECOMMENDATIONS ARE DEVELOPING PLANS FOR TRAVEL SUBSIDIES FOR LOCAL RESIDENTS FROM DEPRIVED AREAS WHO MAY BE FINANCIALLY DISADVANTAGED BY THE CHANGES. WE ARE ALSO LOOKING TO DEVELOP MORE REMOVE OUTPATIENTS CENTRES AND THIS WILL BE EXPLORED IN MORE DETAIL THROUGH THE CONSULTATION PROCESS.

Impact of changes to patient flow on travel times

10.23 In the patient engagement exercise participants told us that they place a high priority on travel distances and times. In order to assess the impact of any changes to patient flow upon travel time the Paediatric and Obstetric activity was analysed for every patient admitted to FHN over a 12 month period. This took into account patients and their families, and use of private cars, bus services and community car schemes. The assessment is summarised here and a full analysis is provided in Appendix 7.

10.24 For the purpose of the analysis it was assumed that urgent care patients would go to their nearest suitable service and also GP views, expressed at the target event on July 3rd 2012, were taken into account. Projections based on travel distance and time were also refined where populations were either equidistant to a number of hospital providers (i.e. Thirsk) or where there were established care pathways (i.e. Northallerton to JCUH).

10.25 It should be noted that the travel analysis of current FHN activity identified that a proportion of the local community were currently travelling further to access FHN in preference to their nearest hospital. This was the case for 27% of patients needing a paediatric admission and for 33% of total maternity deliveries. For the vast majority of this cohort (approximately 85%), the nearest hospital both in terms of distance and travel time would have been Darlington Memorial Hospital.

Car journey times

10.26 Intelligence from the NYCC Citizens’ Survey Panel and the Richmondshire District Council Overview and Scrutiny Committee Transport Review estimate that approximately 96% of total households across Hambleton and Richmondshire have access to a car with 85% car ownership in Richmondshire. 90% of people who responded to the patient engagement told us that they had access to a car.

10.27 An assessment of the time taken to travel to the various hospitals for the actual paediatric and maternity activity based on 30, 45 and 60 minute thresholds is shown in Table 6 below. The 30 and 60 minute thresholds are the national lower and upper time thresholds for the local population to access a hospital in England as calculated by the Department for Transport (2007 – 2011).

<table>
<thead>
<tr>
<th>Time thresholds (mins)</th>
<th>FHN</th>
<th>James Cook University Hospital</th>
<th>Darlington Memorial Hospital</th>
<th>Harrogate District Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;=30</td>
<td>96%</td>
<td>67%</td>
<td>67%</td>
<td>67%</td>
</tr>
<tr>
<td>&lt;=45</td>
<td>99%</td>
<td>98%</td>
<td>98%</td>
<td>98%</td>
</tr>
<tr>
<td>&lt;=60</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>
10.29 Whereas the percentage of people who can get to hospital within 30 minutes is significantly greater for FHN than other hospitals the percentage within 45 minutes is only 1% different. All options that do not maintain current services at FHM will incur additional car travel times.

**Impact on local area populations**

10.30 The Clinical Commissioning Group looked at which geographic areas would be most affected by service change, both in terms of car travel and access via public services and by Ambulance. These were identified as Northallerton, Hawes and Reeth.

10.31 Thirsk (all postcodes beginning YO7) is equidistance to York, Harrogate and James Cook University Hospital and although any service change option would incur some additional travel time (approximately 16 mins), travel times in any direction do not exceed 45 minutes.

**Northallerton and surrounding areas**

10.32 This impact of service changes at the FHN would be predominantly felt by people living in Northallerton, Appleton Wiske, Swainby, North Cowton, RAF Leeming and surrounding places within the DL6 and DL7 postcode district areas (approximately 570 patients). Their car journey time which ranged from 0-17 minutes would increase to a range of between 14 – 44 minutes.

10.33 There is a choice of five direct buses between Northallerton and DMH with a journey time of 55 minutes. Passengers would arrive at the hospital just before 9am and the last bus back is at 17:15. There is a choice of ten outward and nine return direct buses to and from JCUH. Journey time takes 1hr 30 mins and there is a change at Stokesley on all routes. First bus leaves Northallerton at 06:58 arriving at 8:30. Last bus leaves at 17:16.

10.34 Patients requiring a 999 ambulance response (from postcode pick up points beginning DL7 8**) would have an estimated average increased journey time of 33 minutes for transportation to JCUH. This would be the most significant change to current ambulance emergency response times compared to patients taken to FHN.

**Hawes and surrounding areas**

10.35 For those living in the Hawes and Aysgarth area (postcodes beginning with DL8 3**) the average car journey time increased by approximately 6 minutes.

10.36 Bus transport from Hawes to DMH is not direct (changing at Leyburn and Richmond) and takes 1hr 40 minutes. There are three or four changes to JCUH points and the journey takes time 4hrs 6 minutes so this would not be a journey a hospital visitor (or a patient) could feasibly make.

10.37 Patients requiring a 999 ambulance response currently have the longest 999 travel times to FHN of just over an hour. If service change options were implemented, 999 journey times for patients transported to DMH would increase by around 14 minutes (YAS estimated journey time as 1hr 22 minutes) and by around 2 minutes for patients transported to Lancaster Royal Infirmary.)

**Reeth and surrounding areas**

10.38 The population living in the Reeth area (postcodes beginning with DL11 6**) also currently have journey times >45 minutes but their journey times would be reduced if they were to travel to their nearest hospital (Darlington Memorial Hospital).
10.39 Bus transport from Reeth to DMH is not direct (changing at Richmond) and takes 1hr 10 minutes. There are three or four changes to JCUH and the journey takes 2hrs 45 minutes so this would not be a journey a hospital visitor (or a patient) could feasibly make.

10.40 Patients requiring a 999 ambulance response currently have the longest 999 travel times to FHN of just over an hour (similar to people living in the DL8 3** postcode district sector area). If service change options were implemented, 999 journey times for patients transported to DMH would fall to around 10 minutes.

Conclusions to the travel assessment

10.41 A proportion of patients currently travel further to access FHN than their nearest hospital, however there are also a great proportion of patients whose nearest hospital it accessed would also reduce their overall travel time.

10.42 If current services are moved from FHN:

- Car journey times will increase by four minutes overall.
- 98% of patients will be able to access other hospitals by car within 45 minutes. This only changes by 1% for the existing service. 100% of patients can access services with one hour. This is in line with guidance nationally and representative of travel times nationally for some rural communities.
- For patients without access to a car there will be significant access issues for those living in the Hawes, Reeth and surrounding areas.
- Consideration needs to be given to the expansion of Community Transport Schemes or Taxi subsidisation.
- 999 Ambulance journey times would increase, particularly for those living in the Northallerton area and arrangements need to be made to ensure Ambulances are available.

Assurance for the 4 reconfiguration test expectations

10.43 The CCG have ensured that the four reconfiguration tests have been achieved and the evidence is summarised below:

<table>
<thead>
<tr>
<th>Test Expectation</th>
<th>Summary of evidence submitted by local commissioners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support from Clinical/GP commissioners</td>
<td>Pre-consultation was led by CCG working closely with STNHSFT and other providers.</td>
</tr>
<tr>
<td>Evidence for this test could include:</td>
<td>• Regular whole CCG meetings, locality meetings, letters, newsletter articles and social media have been used to ensure all clinical staff and GP are actively involved and we have had views and engagement from all practices across the locality. For details of the engagement methods used can be found in Section 7 – Pre-consultation, Engagement and National Research.</td>
</tr>
<tr>
<td>Evidence of engagement with Clinical/GP commissioners – either direct engagement with CCGs or at minimum with CCG group chairs, including on choice considerations.</td>
<td>• GP attendance at engagement meetings by local GPs can be found in Section 10 – GP Council of Members Appraisal of Options.</td>
</tr>
<tr>
<td>Evidence of robust plans for on-going engagement with</td>
<td>• GP on line survey demonstrated 84% felt fully engaged with the process, and the majority recognised standards expected for acute services were not deliverable within a realistic budget in a small hospital can be found in Section 10 – GP Council of Members Appraisal of Options.</td>
</tr>
<tr>
<td>Evidence of involvement of Clinical/GP commissioners in consideration of the evidence against the other tests by schemes/PCTs.</td>
<td>• GP practices and the GP Council participated in the option appraisal and final CCG recommendation to the PCT Cluster Board can be found in Section 10 – GP Council of Members Appraisal of Options.</td>
</tr>
<tr>
<td>Evidence of robust plans for on-going engagement with</td>
<td>• The clinical community along with local politicians have attended a number of hospital site visits nationally to explore a range of service models and to develop a more detailed shared learning. This information form the visits can be found in section 7 – Pre-Consultation, Engagement and National Research.</td>
</tr>
</tbody>
</table>
Strengthened public and patient engagement & role of LAs

Evidence of engagement/consultation activities with relevant patient groups including LINks and with the public both prior to decisions being made and for the subsequent period of implementation up to now, including on choice considerations.

• Evidence of the effectiveness of engagement/consultation activities.  
  o An explanation of how the view of the people who were consulted were taken into account when the decision was made;  
  o How feedback influenced the decision taken – whether anything was commissioned differently as a result of the feedback received;  
  o The main issues considered on which it was not possible to act, and the reasons why.  
  o How the above information was fed back to those involved.

• Evidence of robust plans for on-going engagement with relevant patient groups including LINks, and with the public.

• Evidence of engagement with OSCs, including where appropriate Section 244 consultation on substantial variations or developments of health services.

• Evidence of OSC support for proposed changes including where relevant the outcome of referrals to the Secretary of State and associated Independent Reconfiguration Panel review.

• Evidence of engagement with Directors of Adult Social Care and/or Directors of Children’s Services.

A robust public engagement exercise was undertaken from April to June 2012. This included:

• 9 public meetings  
• 16 Focus groups  
• Community meetings with LA groups, the LINK, the Facebook campaign group, friends of the hospital etc.  
• Extensive media briefings and radio and TV interviews  
• On line public survey. (480 responses)  
• Regular briefings with the Overview and Scrutiny Committee of North Yorkshire County Council, attendance at the Health and Wellbeing board and the Children’s Trust Board.  
• Regular meetings with local politicians/NYCC senior leaders.

We have detailed all of the engagement completed within section 10 and this also outlines the summary of feedback received and our commissioning response with suggested mitigations for risks or concerns raised by the public or key stakeholders.

The outcomes of the feedback have been fed into the report to develop mitigating actions to address these concerns. The key themes were:

Patients and members of the public told us

• Local people have confidence in and value children’s and maternity services at the Friarage Hospital.
• People value close proximity of services above quality and safety.
• There are some concerns about a midwifery-led service, e.g. the safety of women transferred while in labour due to unforeseen complications.
• People are concerned at the potential impact on the ambulance trust and other acute trusts if services are moved from the Friarage Hospital.
• Whilst many people do not want to see any change, there is some recognition that the services do need to change in the future.
• There is concern that a gradual erosion of services at the hospital will lead to closure.
• Parents with “open access” facility for their children would like enhanced community services and hand-held records/personal care plan.

GPs told us

• They have been as fully involved in the CCG’s work on the future of children’s and maternity services as they would have wanted to be.
• They wish to be part of the option appraisal process.
• They don’t consider additional investment should be made in children’s and maternity services at the expense of other services.
• The majority considering that a children’s assessment unit should be open 7 days a week.
• They recognise many standards expected for acute services are not deliverable within the realistic budget of a small hospital.
• They strongly support the Friarage as the front door into local healthcare for the people of Hambleton and Richmondshire and key to their vision of healthcare going forward.
• Whilst some Richmondshire GPs may decide to refer children to Darlington, should the Friarage no longer have inpatient facilities, they may continue to refer patients to a children’s assessment centre at the Friarage Hospital if they knew that the child would be seen by a consultant the same day.

Key stakeholders told us

• They have concerns there would be an adverse impact on patients having to travel further if services are moved.
• There is concern that a gradual erosion of services at the hospital will lead to closure.
• That communications and systems around protecting vulnerable
children should be reviewed, future-proofed and fit for purpose.

A major concern related to the future of the Friarage Hospital. A piece of work will begin in the autumn "Creating a positive future for the Communities Hospitals and Services Across Hambleton and Richmondshire" that will build on the CCG strategic vision and work with our local stakeholders to develop a sustainable blueprint for the hospital, and will address concerns about the future of both acute and sub-acute services.

**Clarity on the clinical evidence base for this test could include:** Evidence of internal up-to-date review of the clinical evidence base, including choice considerations.

- Evidence of independent external review of the clinical evidence base (likely to be an NCAT review in most cases).
- Evidence of support for the service model from senior clinicians whose services will be affected by the reconfiguration.
- Evidence of engagement with GP commissioners on the outcome of internal and independent external reviews of the clinical evidence base.
- Evidence of plans for future reviews of the clinical evidence base at appropriate intervals.

**Consistency with current and prospective choice**

This test should be embedded within the other three tests and this is reflected above. Choice in this context should explicitly recognise the need to balance access and evidence on patient safety and improved outcomes for

NCAT were in December 2011 invited to do an initial assessment of the clinical case for change prior to the decision to begin the pre-consultation phase. Their report confirms the case for change and recommended the inclusion of maternity services in the pre-consultation phase of the project. The summary of the NCAT findings is:

- The Trust proceeds with its work to redesign the paediatric service.
- The Commissioners and the Foundation Trust start a process of public engagement as soon as possible.
- The Commissioners and the Foundation Trust consider the consequences for the maternity services at FHN and look to develop a sustainable vision for maternity services on the FHN site in keeping with the above conclusions.
- The Commissioners and the Foundation Trust, in consultation with the public describe a vision of children’s and maternity services which will be centred at FHN.
- The Commissioners and the Foundation Trust should approach the local authority and patient groups to consider the need to set up a working group with the aim of improving transport services between the two hospitals of FHN and JCUH.
- The Commissioners and the Foundation Trust should approach Yorkshire Ambulance Service and the North East Ambulance Service to discuss the needs for ambulance service provision in the light of the above future service redesign.
- The Foundation Trust should consider the requirements for parental accommodation at JCUH.
- South Tees Hospitals NHS Foundation Trust should ensure there are good and close working relationships between the community and acute paediatricians.
- The Clinical Commissioning Group should lead the work required to develop clinical pathways in liaison with trust paediatricians and other key stakeholders.

The initial concerns about the sustainability of the present services were raised with the CCG by the senior medical staff at STHT.

STHT and the CCG have acted on the NCAT recommendations and have jointly undertaken a review of the most recent evidence and recommendations from the Royal Colleges and an extensive set of visits and questionnaires to other providers across the country facing similar issues this is clearly detailed within Section 8 the Case for Change and evidence of strong clinical engagement from GPs can be found in Section 10 – GP Council of Members Appraisal of Options.

The proposals seek to ensure safe sustainable services are provided for the residents of Hambleton and Richmondshire into the future. The preferred option will improve quality and safety by allowing staff to maintain and enhance their skills. Recruitment and retention will be maximised. This proposal increases choice for patients. Currently for midwifery services there is not an option of a less medicalised model enabled by a midwifery led unit; it is only a consultant led model. The consultant based model will still be available of four providers all within one hour drive by car but we will enhance the option locally of a midwifery led unit for low risk.

However a small group of patients will have to travel further for those services.
more centralised specialist services and should not be restricted to choice of provider. (although some will also have shorter travel times to their closest provider). Further work will be completed during the public consultation process to use the information we already have about the impact on specific patient groups to identify in detail what needs to be done to enhance community transport. The range of specialist paediatric outpatients at the Friarage will be increased and should in turn increase patient choice. Development of an enhanced paediatric community team will give patients the chance to have treatments at home rather than in a hospital setting. A midwifery led unit will give patients the choice of a less medicalised model of care for low risk births than is available at present in the locality.

Risk assessment
10.44 Risk Assessments provide an opportunity to consider the likelihood and potential impact of all the elements of a proposed service reconfiguration. Both STFT and the CCG have undertaken risk assessments to diagnose the associated risks and mitigations relating to the options summarised. The South Tees one can be found with the business case in the appendices. The CCG Risk assessment process is outlined below. It is important each organisation completes a separate risk assessment as the risks can be very different for commissioners and providers.

The CCG’s risk assessment
10.45 The CCG and PCT have consistent method of quantifying risk, the results of which can be processed to produce the acceptability of the risk(s) and follow a Risk Matrix methodology to designate each risk with a rating of Low, Moderate, High or Extremely High. Together the CCG/GP Council of Members has assessed the risks by defining the likelihood of the risk occurring or re-occurring (on a score of 1 to 5) and its severity (also on a score of 1 to 5). These are defined as follows:

<table>
<thead>
<tr>
<th>Likelihood</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remote/Rare</td>
<td>1</td>
</tr>
<tr>
<td>Unlikely</td>
<td>2</td>
</tr>
<tr>
<td>Possible</td>
<td>3</td>
</tr>
<tr>
<td>Likely</td>
<td>4</td>
</tr>
<tr>
<td>Certain</td>
<td>5</td>
</tr>
<tr>
<td>Minor</td>
<td>2</td>
</tr>
<tr>
<td>Moderate</td>
<td>3</td>
</tr>
<tr>
<td>Insignificant</td>
<td>1</td>
</tr>
<tr>
<td>Minor</td>
<td>2</td>
</tr>
<tr>
<td>Moderate</td>
<td>3</td>
</tr>
</tbody>
</table>

Likelihood:
- **Remote/Rare** (score 1) only under exceptional circumstances
- **Unlikely** (score 2) not expected, but could happen eventually
- **Possible** (score 3) might happen/re-occur in the near future
- **Likely** (score 4) will probably occur if circumstances remain
- **Certain** (score 5) expected to occur in current circumstances
- **Insignificant** (score 1) e.g. negligible harm, no further clinical intervention, no noticeable disruption to service, very low financial loss (e.g. £10), no media attention/media enquiry only
- **Minor** (score 2) e.g. minor injury, very short term clinical intervention, minor disruption to specific service, low financial loss (e.g. £10 - £99), low key local media coverage
- **Moderate** (score 3) e.g. lost time incident, longer term clinical intervention required, postponements or delays to treatment, medium financial losses (e.g. £100
10.46 When multiplied together, the scores give a risk rating of between 1 and 25 as detailed below. The acceptability of each risk will be assessed and will fall into one of 4 categories: Low, Moderate, High or Extremely High and will be colour coded accordingly.

<table>
<thead>
<tr>
<th>Severity</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major</td>
<td>(score 4) e.g. RIDDOR reportable incident, significant clinical deterioration requiring additional support, major disruption or postponement of services, major financial loss (e.g. £500 - £1,000), low key national media coverage</td>
</tr>
<tr>
<td>Catastrophic</td>
<td>(score 5) e.g. single/multiple fatality, permanent injury, long term ill health, severe clinical deterioration requiring long term intensive support, unexpected patient fatality, withdrawal of service for a significant period of time, considerable financial loss (e.g. &gt;£1,000), high profile national coverage (TV or national press)</td>
</tr>
</tbody>
</table>

**Severity:**

10.47 We have also considered the mitigating factors for each of the risk and then the risk is re-score based on the mitigations to be achieved. Below is the detailed risk assessment for the 3 preferred options chosen by the CCG and deemed as feasible options for shortlisting.
<table>
<thead>
<tr>
<th>Option 2</th>
<th>Short Stay Paediatric Assessment Unit with outpatients and community outreach with a midwifery led unit.</th>
<th>Lack of clinical continuity as consultants will work as a larger team across JCUH.</th>
<th>Financial viability of the option would require the divestment of some other services. To understand the scale of the divestment this would be equivalent to 55 Community Nurses or 370 joint replacements. This scale of divestment would have serious ramifications across Hambleton and Richmondshire.</th>
<th>We would work with the providers to support continuation of care wherever possible paying careful attention not to compromise performance.</th>
<th>This could not be mitigated as the commissioner does not deliver an annual surplus and has a recurrent financial deficit.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>3(4\times4)=16</td>
<td>5(5\times5)=25</td>
<td>3(3\times4)=12</td>
<td>5(5\times5)=25</td>
</tr>
<tr>
<td></td>
<td>This option includes strengthening community services and to treat more children with complex needs at home. This retains a local assessment of acutely unwell children and allows for the introduction of new services such as IV therapies.</td>
<td>Concern remains around this model from both the public and the politicians, particularly around the perceived reduction of maternity services. This does however offer an enhancement to current choice for maternity services and ensure services remain local. This also ensures access to consultant pediatric opinion and short stay assessment locally of children who do not require or are unlikely to require an inpatient stay.</td>
<td>Recruitment and retention of staff of medical staff and other nursing staff.</td>
<td>Clear recruitment plans will be developed and it is expected that a joint rota is developed across the James Cook University Hospital site and the Friarage to develop a larger team with better cover arrangements. The likely delay is with recruitment timelines for suitable applicants.</td>
<td>3(3\times3)=9</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3(3\times4)=12</td>
<td>5(5\times5)=25</td>
<td>3(3\times3)=9</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Risk related to the transfer of patients and expectant mothers within the episode of care</td>
<td>Policies will be developed to ensure the highest safety standards are maintained and where applicable patients will be escorted by appropriate clinically trained staff. If a problem occurs during labour patients will be transferred to a Consultant Unit where there is direct access to Obstetricians, Anaesthetists, Neonatologists and other specialist care including epidurals are available. Transfer will be by ambulance and a midwife will travel with the patient, transfer time will be approximately 33 minutes. It is expected a transfer rate for women in labour would be less than 5%.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

97
We will work with providers to ensure financial and contractual implications and detail of each model are carefully scoped in details.

We will work with the existing provider (South Tees) to agree contingency arrangements.

Agree with key providers bed capacity is available or can be made available to support increased activity at CCDHT / STNHISFT.

Ensure strong leadership for the new unit and ensure strong GP engagement and support locally through highlighting the service and its benefits.

Policies will be developed to ensure the highest safety standards are maintained and where applicable patients will be escorted by appropriate clinically trained staff. If a problem occurs during labour patients will be transferred to a Consultant Unit where there is direct access to Obstetricians, Anaesthetists, Neonatologists and other specialist care including epidurals are available. Transfer will be by ambulance and a midwife will travel with the patient, transfer time will be approximately 33 minutes. It is expected a transfer rate for women in labour would be less than 5%.

Concern remains around this model from both the public and the politicians, particularly around the perceived reduction of maternity services. This does however offer an enhancement to current choice for maternity services and ensure services remain local and ensures outpatients can continue to be delivered locally.

Risk related to the transfer of patients and expectant mothers within the episode of care

Transfer will be by ambulance and a midwife will travel with the patient, transfer time will be approximately 33 minutes. It is expected a transfer rate for women in labour would be less than 5%.

Concern remains around this model from both the public and the politicians, particularly around the perceived reduction of maternity services. This does however offer an enhancement to current choice for maternity services and ensure services remain local and ensures outpatients can continue to be delivered locally.

Commissioner clarity about funding and contractual arrangements

Commissioner clarity about funding and contractual arrangements

Commissioning assurance about contingency arrangements throughout the period until the potential services become active to maintain existing services

Assurance around bed capacity from the provider trusts.

Sustainability of the maternity led unit given there is expected to be one birth per day based on current modeling work of low risk births.

This option includes strengthening community services and to treat more children with complex needs at home. This retains a local assessment of acutely unwell children and allows for the introduction of new services such as IV therapies.

Paediatric outpatient services with midwifery led unit

Option 3
Risks relating to affordability and cost effectiveness

10.48 Consideration of the financial impact has been separated from the other prioritisation criteria for the purposes of this report. At the outset the commissioner has been clear that the future provision of paediatric and maternity services at the FHN is not about achieving savings – the issue is driven by the desire for clinicians to secure safe and sustainable services at the FHN for the future.

10.49 The financial impact for the commissioner is different from the issues for STFT who will have undertaken an assessment of what each option costs them to provide the service. The CCG on the other hand has a commissioning budget determined by a funding formula which it uses to purchase activity from providers. The most significant financial impact is the shift of resources in line with expected flows of patients and any additional investments which are required to support the changed flow of activity.

10.50 A full assessment of the additional costs needs to be undertaken – the CCG do not have sufficient information at the moment to cost the full implications or to determine the hours the services should operate and the contractual and referral criteria. We will be working with STFT over the next two weeks to begin the process of preparing more detailed specifications which can then be costed in detail.

10.51 The commissioners require much more detailed analysis of the financial impact of the options than the current information provided by STFT permits. The CCG have outlined some of the key issues below which need to be considered in terms of a full financial impact.

- Any financial impact will be regarded as significant in the current financial climate for the NHS.
- The contractual position for STFT generally exceeds the contract budget available through a mix of demand and case mix costs.
- The combination of current models of care, the poor financial climate, over activity on the contract and block contracts for community services means that there has been little opportunity to invest in community services that supports the delivery of care closer to home.
- The proposed changes to the national paediatric and maternity tariff may create a financial pressure.
• Impact on other commissioners – we believe this will be very small, the majority of activity at the FHN relates to Hambleton and Richmondshire.
• Detailed proposed care pathways are required to enable the activity assumptions outlined at the beginning of this report to be refined, applied to each option and costed.

10.52 Generally, the following principles will apply:

• The overall budget for paediatric and maternity services is all that is currently available pending announcements on available budgets or a significant shift in resources from one service to another
• Where activity moves to another provider the national tariff will apply
• Additional resources will be required for ambulance services and patient transport where there are significant changes in patient flow. This will deliver a cost pressure and we much explore where this can be re-cooped from in the longer term e.g. based on more efficient use of the patient transport contract or reduced transfers to JCUH through the effect of the SSPAU.
• The CCG expects improvements in community services and will expect to see resources in acute and community services used more effectively and apart from transport implications delivered within the current cost envelop.

Commissioning and contracting intentions
10.53 The CCG has outlined below the contractual and financial risks and will work with the current provider to develop a joint service offer. This will be developed within the next two weeks. The following appraisals and commissioning intentions are based upon existing information. Detailed economic evaluation and impact assessment of the preferred option will be required following agreement by the Board.

Option 1: Retain Current Obstetric and Paediatric Services with Enhanced Medical Cover

<table>
<thead>
<tr>
<th>Retain Paediatric Inpatient Services and Consultant Led Obstetric Service at FHN</th>
<th>Risks</th>
<th>Potential Financial Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paediatric Service</td>
<td>• Service not clinically sustainable.</td>
<td>• Add cost £1.6m for 10 additional WTE (based on S Tees costs) – cost pressure would need to be negotiated between commissioners and providers.</td>
</tr>
<tr>
<td></td>
<td>• Opportunity costs for remodelling service delivery.</td>
<td>• Planned spend for Paediatrics £2.364m therefore increase of 68% funding for no additional activity if the commissioner bore the full cost, which is not in accordance with PBR rules.</td>
</tr>
<tr>
<td></td>
<td>• Need to consider the view of the Competition and corporation panel (CCP) on the significant increase over tariff as they may view this proposal as inappropriate.</td>
<td>• Funding would need to be sourced from within existing CCG financial envelope</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Alternatively this would equate to double the 12/13 QIPP target</td>
</tr>
<tr>
<td>Retain Consultant Led Obstetric Service</td>
<td>• Service not clinically sustainable.</td>
<td>• Add £1.123m cost to increase staffing. Current planned spend £4.77m.</td>
</tr>
<tr>
<td></td>
<td>• Opportunity costs for remodelling service delivery.</td>
<td>• £1.23m additional funding - 24% (against 12/13 specialty level plan for Obstetrics and Midwifery) without an increase in activity.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Additional cost of both obstetrics and</td>
</tr>
</tbody>
</table>
paediatrics would equate to approximately an additional 55 district nurses or approximately 370 joint replacements.

- Funding would need to be sourced from within existing CCG financial envelope or additional QIPP schemes would need to be identified.

### Option 2: SSPAU and MLU

<table>
<thead>
<tr>
<th>SSPAU Commissioning and Contracting Intentions</th>
<th>Risks</th>
<th>Potential Financial Implications</th>
</tr>
</thead>
</table>
| • Commissioner will commission for services against good practice indicated in NHS Institute and Royal College guidance and KPIs.  
  • Agreed Assessment unit tariff to reflect level of intervention and zero length of stay.  
  • The expectations should be discharge rather than later admission.  
  • If admitted from SSPAU charge for admitted spell tariff only.  
  • Minimum 5 day assessment unit 10am -10pm subject to review at 3 months.  
  • Assess the demand for a 7 day service.  
  • Assume admission direct to unit not via A&E, SSPAU tariff only.  
  • Assume no additional OP activity generated – but relocating clinics from JCUH to FHN.  
  • All changes should be at worst financially cost neutral to commissioner  
  • Day-case facilities are child and young people appropriate.  
  • Appropriate overnight facilities are available for families at JCUH.  
  • Agreed admissions criteria for SSPAU should include open access for LTC children.  
  • SSPAU consultant waiting times to be reviewed and agreed.  
  • Actively promote sustainability of the service.  
  • Agree appropriate adjustments to NEL baseline to reflect proposed changes – this should be cost neutral to commissioner with providers. 1. Remove PAU activity, 2. Remove activity transferring to other providers (6 month review of actual performance and adjust if necessary).  
  • Work to be completed on funding to support a new community paediatric infrastructure, e.g. SCBU block contract to be reviewed with the intention of no additional cost.  
  • Commissioner will contract to reduce admissions and invest release resource into developing and enhancing children’s community services.  
  • To support discharge from SSPAU enhanced access to follow up. | • Increase in OP capacity may increase OP activity.  
  • A&E facilities at JCUH not to standard re separate entrance and facilities for paediatrics.  
  • Increase usage of ambulance to JCUH A&E – increased ambulance costs.  
  • SSPAU criteria too narrow therefore increase in IP admissions to JC and A&E.  
  • SSPAU criteria too broad generates additional charges in system and is a disincentive to collaboration on community paediatrics model.  
  • Specialist nursing generates additional activity in OP.  
  • A&E in hours/out of hours cover – may increase movement to other providers due to confusion  
  • Empty accommodation at FHN.  
  • Movement to JCUH for Paediatrics and SCBU could create delays in partnership working i.e. early support in reach into SCBU affected.  
  • Requires rapid access to diagnostics.  
  • Requires appropriate gatekeeping in A&E.  
  • Ambulance staff may divert straight to JCUH without clear algorithms and pathways agreed.  
  • Lack of access to senior decision making outside core working hours may result in increased admissions or delays in disc. | • Additional ambulance and taxi costs estimate of £20k taxi increase and £114k ambulance – subject to monitoring and review (combined costs for SSPAU and MLU). Through our QIPP plans we will seek to offset the transport related cost pressures through other programmes of work.  
  • Affordability assumption that activity will remain within current planned envelope.  
  • Guidance suggests low transfer to inpatient care, risk that this increased preventing release of funding for enhanced community services. |
required (e.g. telephone check, expanded community services).

- Timely access to senior decision making outside core working hours to be facilitated by telemedicine.

**MLU Commissioning and Contracting Intentions**

- Commissioner will commission for services against good practice indicated in NHS Institute and Royal College guidance and KPIs.
- Transfer from MLU to JCUH under PBR would be treated as one spell – therefore no additional costs to commissioner.
- No net increase in activity with proposed service.
- Promote sustainability of MLU; current projections would put them on the borderline of viability.
- Management of Gynaecology and early pregnancy, emergency unplanned attendances should not be affected.
- Funded at PBR tariff and rules.
- Possible increased transactional complexity under new PBR rules if increased no of women choose to deliver at other providers.
- Increase in ambulance costs.
- S Tees business case for capital spend not approved.
- IVF service transfer to FHN is politically sensitive.
- Service has low level of demand.
- Capacity available at South Tees.
- Additional ambulance and taxi costs cost pressures. Through our QIPP plans we will seek to offset the transport related cost pressures through other programmes of work.
- Likely to have a cost pressure due to new PBR tariffs (but this would happen anyway).

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**Option 3: Outpatient Paediatric Services and MLU**

<table>
<thead>
<tr>
<th>OP Only Commissioning and Contracting Intentions</th>
<th>Risks</th>
<th>Potential Financial Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Assume no additional OP activity generated – but relocating clinics from JCUH to FHN to offer expanded access.</td>
<td>• Increase in OP capacity / sub specialisation may increase OP activity.</td>
<td>• Additional ambulance and taxi costs estimate of £20k taxi increase and £114k ambulance – subject to monitoring and review. Through our QIPP plans we will seek to offset the transport related cost pressures through other programmes of work.</td>
</tr>
<tr>
<td>• All changes should be at worst financially cost neutral to commissioner.</td>
<td>• A&amp;E facilities at JCUH not to standard re separate entrance and facilities for paediatrics.</td>
<td>• Assumption that activity will remain within current envelope.</td>
</tr>
<tr>
<td>• Day case facilities are child and young people appropriate.</td>
<td>• Increase usage of ambulance to JCUH A&amp;E – increased ambulance cost.</td>
<td></td>
</tr>
<tr>
<td>• Appropriate overnight facilities should be available for families at JCUH.</td>
<td>• A&amp;E in hours/out of hours cover – may increase movement to other providers due to confusion.</td>
<td></td>
</tr>
<tr>
<td>• Work to be completed on funding to support a new community paediatric infrastructure, e.g. SCBU block contract to be reviewed with the intention of no additional cost.</td>
<td>• Empty accommodation at FHN.</td>
<td></td>
</tr>
<tr>
<td>• Commissioner will contract to reduce admissions and invest release resource into developing and enhancing children’s community services.</td>
<td>• Movement to JCUH for Paediatrics and SCBU could create delays in partnership working i.e. early support in reach into SCBU affected.</td>
<td></td>
</tr>
<tr>
<td>• Commissioner will work with the provider to review and agree revised tariffs to reflect short lengths of stay for NEL admissions at JCUH.</td>
<td>• Requires rapid access to diagnostics.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Requires appropriate gatekeeping in A&amp;E.</td>
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<td></td>
<td>• Requires additional GP assessment for urgent clinic criteria.</td>
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</tr>
<tr>
<td></td>
<td>• No open access for children with long term conditions at FHN.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Ambulance staff may divert straight to JCUH without clear algorithms and pathways agreed.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Urgent outpatient clinic increases OP activity without reducing referrals or admissions.</td>
<td></td>
</tr>
</tbody>
</table>
### Maternity Led Unit

- Transfer from MLU to JCUH under PBR would be treated as one spell – therefore no additional costs to commissioner.
- No net increase in activity with proposed service.
- Promote sustainability of MLU; current projections would put them on the borderline of viability.
- Management of Gynaecology and early pregnancy, emergency unplanned attendances should not be affected.
- Funded at PBR tariff and rules.

- Possible increased transactional complexity under new PBR rules if increased no of women choose to deliver at other providers.
- Increase in ambulance costs.
- S Tees business case for capital spend not approved.
- IVF service transfer to FHN is politically sensitive.
- Service has insufficient demand to be sustainable.
- Capacity not available at S Tees.

- Additional ambulance and taxi costs. Through our QIPP plans we will seek to offset the transport related cost pressures through other programmes of work.
- Likely to have a cost pressure due to new PBR tariffs (but this would happen anyway).
11. GP Council of Members Appraisal of the Options

11.1 The CCG is made up of a range of constituent GP practices and therefore all decision making is based on a federated approach by local GP within the CCG. The Hambleton, Richmondshire and Whitby Clinical Commissioning Group (HRW CCG) GP Council members were asked to appraise and score the service change options. The section below details the practices attending the meeting and those that delegated authority to a neighbouring practice. GP Council members unable to attend were contacted in order to check their acceptability of the outcome and any feedback they wished to share with GP Council practice members is documented.

Options appraisal process
11.2 In May 2012, the CCG Shadow Governing Body (SGB) held a development workshop to develop an options appraisal process, by which the SGB would make a recommendation to the NHSNYY Board on options for paediatric and maternity services at the Friarage Hospital Northallerton (FHN) and use for future CCG decision making.

11.3 The workshop was facilitated by public health. The activity involved members of the CCG SGB and support team. There were 14 members involved. The SGB requested that the options appraisal process should include criteria by which decisions can be made, and that those evaluation criteria would be weighted by the group in terms of importance. A consensus was reached and the criteria below were agreed:

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient safety</td>
<td>Maintains or improves patient safety (i.e. minimises harm)</td>
</tr>
<tr>
<td>Affordability</td>
<td>Affordable within the context of the overall budget</td>
</tr>
<tr>
<td>Clinical effectiveness</td>
<td>Achieves the desired clinical outcomes</td>
</tr>
<tr>
<td>Patient experience</td>
<td>Maintains or improves patient experience</td>
</tr>
<tr>
<td>Sustainability</td>
<td>Meets current and future demands (including effect on workforce, feasibility and adaptability)</td>
</tr>
<tr>
<td>Access</td>
<td>Closer to home where clinically appropriate</td>
</tr>
<tr>
<td>Cost effectiveness</td>
<td>Provides value for money</td>
</tr>
</tbody>
</table>

11.4 The criteria were weighted using the 'weighted pair’s model' where each criteria is given a relative score of importance compared to the criteria above score out of 100. The weighted scores are shown in the table below but did not exhibit much variation. However, patient safety was weighted the highest.

11.5 At the SGB development session in June 2012, there was further discussion on the prioritisation process. It was felt that the number of options was too high, and that a number of potential options would not meet some of the SGB member’s minimum criteria. Therefore it was decided to develop some filter questions, using the criteria already agreed, to explicitly articulate those minimum criteria. Safety had been highlighted as a key issue and there were some national standards that needed to be met. Also, any option had to be sustainable for at least five years. Finally, the members felt that any option that did not attempt to keep
clinically effective care closer to home should be dismissed. The following filter questions were developed and agreed at the meeting.

**Filter Questions and Scoring System**

- The option meets minimum safety requirements?  
  - No: Record why not, reject  
  - Yes

- The option is sustainable?  
  - Yes

- The option provides care closer to home where clinically appropriate?  
  - Yes: Full option appraisal

**Criteria**

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Comparison</th>
<th>Relative score</th>
<th>Weight (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Patient Safety</td>
<td>100</td>
<td>100</td>
<td>16%</td>
</tr>
<tr>
<td>B. Affordability</td>
<td>88.8</td>
<td>100</td>
<td>89%</td>
</tr>
<tr>
<td>C. Clinical Effectiveness</td>
<td>107.3</td>
<td>100</td>
<td>95%</td>
</tr>
<tr>
<td>D. Patient Experience</td>
<td>85</td>
<td>100</td>
<td>81%</td>
</tr>
<tr>
<td>E. Sustainability</td>
<td></td>
<td>117.7</td>
<td>95%</td>
</tr>
<tr>
<td>F. Equity of access</td>
<td></td>
<td>87.7</td>
<td>84%</td>
</tr>
<tr>
<td>G. Cost effectiveness</td>
<td></td>
<td>100</td>
<td>84%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>628</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Extraordinary GP Council of Members meeting (August 2012)**

11.6 At the meeting in August 2012 of the GP Council Members the options for both Paediatric and Maternity Services were discussed. Below is a summary of the key points raised relating to each of the option.
<table>
<thead>
<tr>
<th>Option</th>
<th>Commentary</th>
</tr>
</thead>
</table>
| Do nothing                                                           | GP Council Members were advised that the SGB had felt that the ‘do nothing’ option did not meet minimum safety requirements based on advice from the National Clinical Advisory Team and was not sustainable. This option was discounted.  

**THIS OPTION NOT TO BE PROGRESSED FURTHER.** |
| Run a five-day working ward                                           | The GP Council Members felt that the five day ward offers no benefit – either the ward remains open, with significant investment required or there should be a transition to an alternative model. This option is likely to be confusing for patients and difficult and potentially unsafe to operate. It was felt this option did not address all of the issues with recruitment and skills retention.  

**THIS OPTION NOT TO BE PROGRESSED FURTHER.** |
| Develop the Friarage as a ‘small and remote unit’                    | This was not supported based on the national definitions by the RCPCH of a small and remote unit because the Friarage did not fulfil the criteria for small and remote.  

**THIS OPTION NOT TO BE PROGRESSED FURTHER.** |
| Do not provide a children’s service at the Friarage Hospital.         | They also agreed that having no paediatric or maternity service at the Friarage was not acceptable. It is not an option that the Hambleton Richmondshire and Whitby Commissioning Group wish to pursue. They also agreed that it was not possible to have high risk maternity without full paediatric 24 hr service available.  

**THIS OPTION NOT TO BE PROGRESSED FURTHER.** |
| Option 1 Invest in current service to ensure meets requirements       | It was noted that the investment gap to fund the recruitment of 12 WTE Consultant Paediatricians of £2.7 million. Clinicians would be resident at FHN and rotate through James Cook University Hospital (JCUH). The South Tees Hospitals NHS Foundation Trust (STHFT) maintain that even if the funding were available, recruitment would be difficult as low activity rates meant clinicians wouldn’t necessarily see this as a good training opportunity providing the necessary experience. For the CCG to invest in this option there would need to decommission other services.  

**THIS OPTION NOT TO BE PROGRESSED FURTHER.** |
| Option 2 Short Stay Paediatric Assessment Unit                        | GP Council members debated the option to provide an assessment unit in principle, as this has not currently been financially modelled or the referral criteria agreed. The GPs outlines this would be required at the next stage. It was envisaged that there would be a core of between 4-5 Consultant Paediatricians at FHN completing an on-call rota at JCUH. There was a query as to whether the proposed Assessment Unit raised any medical-legal issues. The consensus view was that there was no GP responsibility once a child was accepted by clinicians at the Unit. |
There was support for a 7 day Assessment Unit with an extension of the opening hours to those being proposed by STHFT. It was suggested that the last admission could be 19:30 with the Unit closing at 23:00. Given the relatively low activity, it was questioned why a Consultant Paediatrician couldn’t see a child later than 19:30 or be available by phone. The CCG might wish to commission a 5 or 7 day outpatient service with access to a Consultant Paediatrician. Many routine interventions currently provided at FHN could be treated by an enhanced community nursing team. There were very few community services for children and young people with complex conditions e.g. antibiotics for those with cystic fibrosis.

It was acknowledge clear acceptance criteria for low risk would be required for expectant mothers who were suitable. It was acknowledged that a low-risk admission could become a high-risk case (i.e. a prolapsed or a sudden abruption) that required a transfer would be very rare and that midwives would be able to predict mothers that would fall into a higher risk category over the pregnancy duration. National data does not reflect any difference in safety of a midwife led unit compared to a consultant led unit. This service would need support to develop given the low level of births anticipated and would need GP support to develop.

Council members questioned the need for an urgent outpatient clinic at Catterick as had been proposed by STHFT. This may be intended to retain flows to JCUH for patients needing admission but with the projected patient flows to Darlington Memorial Hospital, an outpatient service at Catterick (or Thirsk) may prove to be a better option if that is something the CCG wished to commission.

GP Council members questioned whether this option would place any additional pressure on Out of Hours GP Services. The general view was that there would be little pressure on GPs as there were few overnight stays and mothers were discharged quickly.

With reference to the ambulance service if was agreed work was required with the NEAS/YAS to ensure enough capacity was in place to support. Discussions are continuing with the ambulance service.

**Scoring the options**

11.7 Thirteen of the twenty-two member practices attended the meeting, 1 practice delegated authority to another practice, 3 practices in Whitby whose patients are not affected by the change abstained and 5 practices who did not attend were contacted by telephone following the event to see if their views were consistent with the outcome. 86% of member practices contributed to the process either through representation at the meeting, by giving delegated authority or by concurring with the outcome. More details and commentary on this can be found in Appendix 8.
11.8 GP Council Members agreed with the prioritisation process that had been developed and agreed to score the three remaining options. Practices had been given prior information on all the options, and were given the opportunity to go through the criteria and discuss the impact on each of the options before submitting scores. Thirteen of GP Council members were present at the meeting and the following collated weighted scores were recorded for the top three options. Most support was given to option 2 which will provide a short stay paediatric assessment unit and a midwifery led unit. The weight scores are summarised below:

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Option 1 – Invest in existing service and continue to provide a consultant led service for paediatrics and maternity for both outpatients and inpatient stays</th>
<th>Option 2 – provide a Short Stay Paediatric Assessment Unit, Outpatients and a Midwifery Led Unit</th>
<th>Option 3 – Paediatric Outpatients only and midwifery led unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Safety</td>
<td>19.11</td>
<td>15.61</td>
<td>10.35</td>
</tr>
<tr>
<td>Affordability</td>
<td>4.39</td>
<td>15.28</td>
<td>15.42</td>
</tr>
<tr>
<td>Clinical Effectiveness</td>
<td>16.10</td>
<td>15.03</td>
<td>12.45</td>
</tr>
<tr>
<td>Patient Experience</td>
<td>14.91</td>
<td>12.52</td>
<td>7.23</td>
</tr>
<tr>
<td>Sustainability</td>
<td>5.62</td>
<td>14.73</td>
<td>15.80</td>
</tr>
<tr>
<td>Equity of access</td>
<td>15.85</td>
<td>13.59</td>
<td>7.79</td>
</tr>
<tr>
<td>Cost effectiveness</td>
<td>5.20</td>
<td>13.92</td>
<td>12.92</td>
</tr>
<tr>
<td>Total weighted score</td>
<td>81.17</td>
<td>100.68</td>
<td>81.97</td>
</tr>
</tbody>
</table>

Option 2 was scored the highest, with Option 3 next and Option 1 last (however Options 1 and 3 scored very similar results).

**Public consultation mandate**

11.9 After ascertaining that the 13 Council members present had a mandate to vote on the number of options that the CCG would recommend taking to formal public consultation, the voting results were as follows:
<table>
<thead>
<tr>
<th>Motion</th>
<th>Votes Cast</th>
<th>Abstentions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consult on the single highest scoring option</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Consult on the two highest scoring options</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Consult on all three options</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>
12. Recommendations and Next Steps

12.1 The recommendation to the Board is that a service model based on an SSPAU and midwifery led service should be explored as an option through public consultation but the risks of a requirement for future change if up-take is low must be made clear during consultation to encourage continued public debate about which models best address issues of safety, sustainability and patient preference.

Phase 1 - approvals process

12.2 For the public consultation process the CCG will be a shorter, user friendly version of the business case which will be developed following the decisions made by the Governing body and following the North Yorkshire Health Overview and Scrutiny Committee on the 7th September. A final decision regarding the process and content of public consultation will be taken by NHSNYY Board on the 25th September 2012. This decision will be submitted to NHS North for approval prior to commencement of any public engagement exercise. The quality assurance of the process and proposals will be achieved using the NHS Yorkshire and the Humber SCAP (including NCAT & Gateway Review Teams).

Phase 2 - public consultation

12.3 Subject to approval the approach to public consultation will follow the Department of Health Guidance and the rights and responsibilities enshrined in the NHS Constitution. Cabinet Office guidelines recommend a period of 12 weeks for consultation of this nature. The consultation objectives are:

- To consult on the proposals with a range of internal and external stakeholders
- To meet obligations to consult with staff and external stakeholders about potential changes
- The meeting the four tests set out by the Secretary of State for Health
- To provide a channel for staff and external stakeholders views to inform the decision making process

12.4 Key stakeholders within the consultation process will reflect the current stakeholders and specifically include:

- NHS Commissioning staff
- NHS provider staff
- NHS staff side representatives
- The councils’ official decision making bodies
- North Yorkshire Health Overview and Scrutiny
- Local Councils
- Officers with relevant specialist knowledge
- Clinicians
- Patient groups
- Statutory NHS organisations
- Community groups and organisations
- Voluntary groups and organisations
- Campaign and special interest groups
- The media
- LINks
- Health and Wellbeing Board
- Clinical Commissioning Groups in North Yorkshire and York
- Local health representative committees including LMC, LOC, LPC
- Relevant area based organisations
The outcome of public consultation

12.5 This consultation is expected to commence in November 2012 and continue for 12 weeks. Following the close of public consultation in February 2013 a period of analysis will take place and a report will be prepared for consideration by the NHSNYY Board. A period of briefing will take place for key stakeholders thereafter.

Phase 3 - implementation

12.6 Changes to the services provided at the Friarage Hospital Northallerton do not have a scheduled start date as no decisions have been made. Any change will require a process to be developed which engages clinicians and managers in planning the transition. The governance arrangements will seek to assure local stakeholders that:

- Any service changes are being made in a way which maintains the safety of patients
- Any service changes are compliant with the decisions being made, following the public consultation process
- Plans are put in place to ensure that during the transition period any service changes do not adversely affect performance
- There will be a communication campaign to ensure that all stakeholders, including staff, patients and public groups are aware of any service changes before they are made.

12.7 Throughout each phase of this project the CCG and Providers will continue to work together to:

- Fully understand the clinical pathways for each of the proposed models ensuring that the views of the public are considered
- Fully understand the financial implications
- Work to mitigate the profiled risks for each option
- Develop a strategy to ensure that the Friarage Hospital in Northallerton is able to deliver the best health outcomes possible for local people.
Appendices (available separately)

Appendix 1A: Project Charter for the Project Group

Appendix 1B: Terms of Reference for the Stakeholder Group

Appendix 1C Terms of Reference for the NCAT

Appendix 2: Health Needs Assessment

Appendix 3: NCAT Report December 2011

Appendix 4: Engagement Report

Appendix 5: Gathering evidence from different parts of the country.

Appendix 6: South Tees NHS Foundation Trust Business Case

Appendix 7: Travel Impact Assessment

Appendix 8: GP Council Commentary

Appendix 9: Gateway Review