Children’s and maternity services at The Friarage Hospital

Assessment of Future Services
February 2014
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Acknowledgements

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Finally, the CCG would like to thank both the County Councils and the District Councils for their continued support, input and feedback.
## Glossary of Terms

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<th>Term</th>
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<tr>
<td>Acute Care</td>
<td>Medical or surgical treatment usually provided in a general hospital.</td>
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<tr>
<td>Advanced Neonatal Nurse Practitioner / Advanced Paediatric Nurse Practitioner / Extended Scope Practitioner</td>
<td>These staff provide high quality, safe and effective evidence-based care to neo-natal and paediatric patients and their families as an advanced level practitioner. These nurses are able to autonomously deliver complex high level interventions, diagnose and initiate treatment plans, responses to treatment and provide on-going management of care.</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 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) took 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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<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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<td>Term</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 and 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.</td>
</tr>
<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 in-patient procedure.</td>
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<tr>
<td>Emergency</td>
<td>An urgent unplanned episode of care.</td>
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<tr>
<td>Gateway</td>
<td>The Gateway review process was developed by the Office of Government Commerce (OGC) and involves series of short, focused, independent peer reviews at key stages of a project or programme.</td>
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<tr>
<td>General Practitioner (GP)</td>
<td>A doctor who has a medical practice (general practice) in which he/she treats all illnesses. Usually referred to as a GP and sometimes known as a Family Doctor.</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. Chairman, Clinical Chief Officer).</td>
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<tr>
<td>Independent Contractors</td>
<td>A term used in 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 in 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 and Local Authority Social Services department.</td>
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<tr>
<td>Integrated Health &amp; Social Services</td>
<td>Bringing together the 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><strong>Intermediate Care</strong></td>
<td>Short term intervention (usually up to six weeks) by a multidisciplinary 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><strong>Local Health Economy</strong></td>
<td>This term refers to the different parts of the NHS working together within a geographical area. It includes GP practices and other primary care contractors (e.g. pharmacies, optometrists).</td>
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<tr>
<td><strong>Long-term Conditions</strong></td>
<td>Conditions (e.g. 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><strong>Managed Care</strong></td>
<td>Patients with complex needs are identified and supported by skilled practitioners working for an integrated care system.</td>
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<tr>
<td><strong>Minor injuries</strong></td>
<td>Examples are cuts, bruises, scalds and sprains. The role of a minor injury unit or service would be to provide treatment for such minor injuries.</td>
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<tr>
<td><strong>Models of Care</strong></td>
<td>Guidance on ways of treating patients that are based on clinical evidence.</td>
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<tr>
<td><strong>National Clinical Advisory Team (NCAT)</strong></td>
<td>The NCAT are part of the Department of Health and provide clinical experts to support advise and guide the local NHS on service reconfiguration proposals to ensure safe effective and accessible services for patients.</td>
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<tr>
<td><strong>NHS Foundation Trust</strong></td>
<td>Public bodies providing NHS hospitals, community and mental health care and ambulance services.</td>
</tr>
<tr>
<td><strong>Out of Hours Services</strong></td>
<td>Medical cover provided outside the normal working hours of community health care professionals, usually from 6pm-8am Monday – Friday and 24 hours during weekends and Bank Holidays.</td>
</tr>
<tr>
<td><strong>Neonatal practitioner</strong></td>
<td>Healthcare professional caring for the health of new born babies.</td>
</tr>
<tr>
<td><strong>Obstetrician</strong></td>
<td>Senior doctor/consultant working in the field of medicine concerned with the care of women during pregnancy, childbirth and the period following birth.</td>
</tr>
<tr>
<td><strong>Obstetrics</strong></td>
<td>The field of medicine concerned with the care of women during pregnancy, childbirth and the period following birth.</td>
</tr>
<tr>
<td><strong>Open access</strong></td>
<td>Facility offered to those children where parents can phone the ward and self-refer directly, without going through the GP or A&amp;E.</td>
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<tr>
<td>Overview and Scrutiny Committees</td>
<td>The role of overview and scrutiny differs from authority to authority and can usually be ascertained with reference to the Council’s Constitution. This is often undertaken by questioning executive councillors, council employees and representatives of other organisations such as NHS on decisions made and policies being pursued in the local area. This kind of formal holding to account usually happens “in committee”.</td>
</tr>
<tr>
<td>Paediatrician</td>
<td>Senior doctor/consultant working in the field of child healthcare.</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>General medicine relating to child healthcare.</td>
</tr>
<tr>
<td>Payment by Results</td>
<td>This term refers to the flow of money in the NHS in England. Under payment by results, the money received by NHS Trusts directly relates to the number 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 and ophthalmic practitioners together with district nurses and health visitors, with administrative support.</td>
</tr>
<tr>
<td>Primary Care Services</td>
<td>Care provided by GPs and other healthcare workers in the community.</td>
</tr>
<tr>
<td>Primary Care Trusts (PCTs)</td>
<td>Former free-standing statutory NHS bodies with responsibility for delivering health care and health improvements to their local areas. They commissioned or directly provided a range of community health services as part of their functions. They were formally abolished on 31 March 2013 and their commissioning role was 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>
</tr>
<tr>
<td>Risk</td>
<td>The possibility exposure to some form of loss or damage.</td>
</tr>
<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>
</tr>
<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,</td>
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washing, dressing, housework and help with eating.

| Specialist | Someone devoted to the care of a particular part of the body, or a particular aspect of diagnosis, |
| Specialist Services | Advice guidance and assessment provided by professionals with particular expertise. |
| Stakeholder | Organisations and individuals with an interest in the activities of an organisation. |
| **Tier 1** | These doctors can be newly qualified in the first year out of medical school up to four years after qualifying. They have skills in basic assessment and recognition of sick patients, resuscitation, cannulation, taking bloods and arterial gases etc. They have clinical skills relevant to all clinical practice. Those in year 3 and 4 will be starting to develop an interest in a specific field e.g. general practice, obstetrics & gynaecology or paediatrics. They are usually the first person who is called by nursing/ midwifery staff to see or assess patients except in an acute emergency. |
| **Tier 2** | These doctors are 5 – 9 years post qualification. They are working towards a specialty qualification in their desired field e.g. obstetrics & gynaecology, paediatrics. They are either working towards or completed all their specialist examinations. They have gained experience in a specific field (e.g. obstetrics & gynaecology, paediatrics) and are able to develop more complex management plans and perform specific roles relating to the job e.g. operative delivery in obstetrics, placement of umbilical catheter in babies for neonatal doctors or in paediatrics perform lumbar punctures in children. They supervise and teach the level one doctors, but are still under the supervision of a consultant. They are able to liaise with other specialities and are closely involved in the multidisciplinary team management of complex patients. |
Executive Summary

In July 2011, South Tees Hospitals NHS Foundation Trust (STHFT) approached NHS Hambleton, Richmondshire and Whitby Clinical Commissioning Group (CCG), which was then in Shadow Form, regarding concerns about the future sustainability of paediatric services at The Friarage Hospital, Northallerton.

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 for change. 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 faced and also to include in that conversation, the future of maternity services at The Friarage Hospital, as this is fundamentally linked to the paediatric service in terms of sustainability. These conversations took place from April to June 2012 as part of a pre-engagement phase and again from September to November 2013 as part of a formal public consultation.

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

This report details the clinical case for change, the results of the public engagement, 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.

The process is as follows:

- This paper outlines the preferred clinical option chosen by the GP Council of Members of the CCG and a recommendation for implementation.
- The CCG will make a formal recommendation to our Governing Body to consider.
- The NHS England Area Team will confirm that they are assured that the process followed has been as robust as possible.

There is a strong clinical case for change of the services. This is detailed below:

The clinical case for change

The Friarage Hospital is a small hospital. The Royal College of Paediatrics and Child Health (RCPCH) classify it as a small paediatric unit. The maternity unit has 1250 deliveries per year which makes it one of only eight units in England 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 The Friarage Hospital is now 0.7 of a day. A review of some of the cases treated has demonstrated that many of these children could have been supported by
a Paediatric Short Stay Assessment Unity (PSSAU) 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, 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 pregnancies (twins, triplets etc.). Many of these women already deliver their babies at The 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.), instead of having generalist skills. Replacing the current The Friarage Hospital 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. Clinicians and managers from the CCG and STHT investigated a wide range of small paediatric and maternity units throughout the UK to seek out models 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 by The Friarage Hospital are replicated across the country. Some solutions requiring significant investment are unaffordable financially but also do not deliver a sustainable model for the future.

**To leave no stone unturned**
The CCG has striven to find a way forward for children’s and maternity service at The Friarage Hospital that balances the need to improve safety and sustainability with keeping services as local as possible. There isn’t an easy solution. Local politicians and the Rt. Hon William Hague MP, tasked the CCG to “leave no stone unturned”. The Secretary of State also asked the CCG to be open to new ideas during the consultation phase.
The CCG as a commissioning organisation has a duty to commission services that are “safe and sustainable”. What safety means is that children and mothers, who use those services, can be sure that they have the best chances of survival and being as healthy as possible after being in hospital. Sustainability means that services are not built around the skills and attributes of particular people so that when those individuals aren’t available for any reason the service can be safely delivered by other people who are easy to find and have the right skills.

The CCG has turned very stone. It has examined each option found during its research and those recommended by others. Each option was examined carefully and with an open mind, and included discussions with local commissioners and providers of those service models. However, the CCG have been unable to find a model that allows services to be delivered on the same footprint as before without continuing and unacceptable compromises on safety and sustainability, or unaffordable investment.

**Impact assessments**
These are detailed in the main document. Travel was an issue raised by the public on many occasions. Analysis of the data shows all residents will be able to access a consultant led in-patient 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 NHS Foundation Trust, York
- County Durham and Darlington NHS Foundation Trust, Darlington
- Harrogate and District NHS Foundation Trust, Harrogate
- The James Cook University Hospital, Middlesbrough

A plan to strengthen community transport to support those most disadvantaged by any changes has been developed. We have worked with the Yorkshire Ambulance Service (YAS) to develop detailed proposals to support a Midwifery Led Unit and will implement both a taxi utilisation scheme and a shuttle bus between The Friarage Hospital, Northallerton and The James Cook University Hospital, Middlesbrough.

**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 CCGs 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.
Option appraisal
The CCG went through a rigorous option appraisal exercise during which the original two options discussed through the public consultation were reviewed and we received a further three options from the public. The total options reviewed were:

Option 1 - Paediatric Short Stay Assessment Unit (PSSAU) and midwifery led maternity service with full outpatient services and enhanced community service provision.

Option 2 - Paediatric outpatient services and enhanced community services and a Midwifery Led Unit (MLU). Similar costs to Option 1.

Option 3 – A Consultant Led Unit and 7 day week PSSAU with overnight beds proposed by Andrew Newton

Option 4 – MLU option with PSSAU managed by senior nursing team proposed by David Williamson

Option 5 – Consultant led option proposed by Richmondshire District Council

Assurance Process
The CCG has ensured a robust assurance process is in place. This is summarised below:

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.
4. A full Service Change Assurance Process (SCAP) has been adhered to.
5. Sought independent information for the NHS Deanery for Paediatrics for Health Education North East regarding middle grades to verify future provision of Tier 1 and Tier 2.
6. Held two Clinical Review Meetings with the authors of the additional options (option 3, 4 and 5) with local clinicians and commissioners and published transcripts of the meetings to assess the viability of each option.
7. Requested an independent review completed by NHS England Regional Analytical Team of the infant mortality data to review the appropriateness of comparisons between The Friarage Hospital and South Tees Hospitals NHS Foundation Trust data sets (Appendix 4).
8. NCAT assessment of the 3 additional options (23 December 2013).
9. Council of Members (CoM) approved the weighted criteria and decision making process to be adopted and this has been used consistently throughout the whole process.
10. Each of the practices have held a meeting in their surgery and reviewed all of the options against the weighted criteria and decision making framework.
11. On the 7 February 2014 a Council of Members meeting was held where each of the practices delegated responsibility to one representative from their practice to attend the CoM meeting and present their views and scores for each of the options and investment areas.
Recommendations
The Governing Body (GB) of the CCG is requested to approve Option 1 and in doing so:

- Agree that the clinical case for change has been strongly made and other options have been considered.

- Agree the views of the public have been sought and all mediums used to ensure a fair and transparent process has been adopted and that the impact on vulnerable groups and those with health inequality needs can be mitigated.

- Endorse the outcome of the GP Council of Members meeting and the preferred option from the public consultation.

- Approve the overall investment of £625,000. This is made up of £286,000 extra investment in the paediatric service to allow the PSSAU to be open 7 days a week rather than 5, and to offer an out of hours taxi service for paediatric patients. An additional £339,000 investment will both support the changes but also improve access to urgent care and transport services for the wider population for Hambleton and Richmondshire, by providing another 24/7 ambulance in the Northallerton area and a shuttle bus between The Friarage and The James Cook sites benefitting staff and patients.

- Agree all investment areas will be formally reviewed by the Governing Body at 6 months post-implementation.

- Agree the implementation timeframes of 6 months for the new services to commence in October 2014.
1. Background

Our mission is “to commission (buy) first class healthcare which improves the health and wellbeing of everyone living in Hambleton, Richmondshire and Whitby and the surrounding areas.” Our patients are at the heart of everything we do and ensuring local services are safe and sustainable is our number one priority.

As a Clinical Commissioning Group (CCG), we are driven by our values:

- Integrity
- Energy
- Transparency
- Focus

The CCG also has a legal duty under the NHS Constitution to commission high quality, safe services. With this in mind, it has been leading a review of paediatric and maternity services at The Friarage Hospital, Northallerton. The need for this review was identified in early 2011 when staff from South Tees Hospitals NHS Foundation Trust (STHFT) told us about their concerns for the future safety of these services. Doctors and nurses at The Friarage Hospital are concerned that they will not be able to retain their clinical skills (and develop new ones) because there are not enough mums-to-be and children using the services currently.

The CCG has worked closely with STHFT and other local stakeholders over the past two years to look at the issues facing The Friarage Hospital and how we can address them.

As part of this process, the CCG sought guidance from a group of independent health experts called the National Clinical Advisory Team (NCAT) in 2011. NCAT assessed the services at The Friarage Hospital and agreed that the concerns around safety and sustainability were real issues in both paediatric and maternity services and that the CCG needed to address them.

The CCG is committed to involving people in its plans as early as possible and in the spring of 2012, it held a three month engagement exercise to talk to local people about the issues faced by The Friarage Hospital and the possible options for the future.

At this stage, seven options were discussed with the public and their feedback used to develop them in more detail and provide insight into the views of local people.

The feedback from the public was analysed along with the clinical evidence and guidance, and the lessons learned from visiting other hospitals around the country to look at how other services operated. The Council of Members (a representative from each of the 22 GP practices in our area) then carried out a detailed appraisal of each option.
From this exercise, the following three options were shortlisted:

• Option A - Sustaining a 24 hour consultant led paediatric service and maternity unit (essentially keeping services the same by investing £2.7m in more consultants or senior doctors).

• Option B - Providing a Paediatric Short Stay Assessment Unit (PSSAU) and Midwifery Led Unit (MLU) with full outpatient services and enhanced services in the community.

• Option C - Providing paediatric outpatient services and Midwifery Led Unit (MLU) and enhanced services in the community.

The GP Council of Members firmly supported option B as their preferred option.

Following this process, the Board of NHS North Yorkshire and York (the statutory NHS body at the time) decided we should consult on options B and C only, after discounting option A from the consultation process because it was unsustainable and unaffordable.

This view was supported by the Independent Reconfiguration Panel (IRP) who carried out an initial review of the process. They gave the CCG the go-ahead to begin formal public consultation and this was launched on 2 September 2013. It ran for 12 weeks and closed on 25 November 2013. The IRP also requested that the CCG work closely with the local stakeholders and population as part of the consultation process and invite new options and not limit respondents to those listed. They also asked the CCG to clearly articulate in the documentation why an option to invest in a consultant delivered service had been discounted from the consultation.

During the consultation, the CCG has therefore asked for people’s views on the two options that it believes will ensure paediatric and maternity services will be safe and sustainable for the future and also requested new options be presented as part of the consultation. An explanation about why the option to invest in a consultant delivered service was discounted from the process was included in the consultation document and supporting documents on line and discussed openly during the conversations with the public.

The CCG and STHFT also continued to look at other models used around the country to see if there was an alternative solution that had not yet been considered. This research did not identify any appropriate solutions or alternative ways of addressing the concerns faced at The Friarage Hospital that met with the CCGs criteria – meeting safety requirements, sustainability or providing care close to home, therefore none were deemed to be models that could be taken forward.

Three additional options were received from two members of the public and from the Richmondshire District Council. These will be explained in more detail in Chapter 5 and all of the options are included in Appendix 1.

The CCG has also engaged widely with those patient groups who will be most impacted by the changes. 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 following discharge as this facilitates early discharge from hospital.

The CCG has worked with primary and secondary care clinicians, community nursing teams and patients’ families to develop ways to better support them and deliver care close to home.

The proposals (which are covered in more detail in Chapter 5) explored include additional:

- transport options for travel between The James Cook University Hospital, Middlesbrough and The Friarage Hospital, Northallerton.
- community paediatric nursing and enhanced access to primary care
- investment in remote technologies to support Open Access families.

During this public consultation period the CCG engaged widely with all key stakeholders including all of the District and local Councils and this is outlined in more detail in the consultation and engagement section in Chapter 4.

After the consultation formally closed, the CCG hosted two meetings with clinicians and the authors of the new options in order to explore their feasibility and to work with the authors to determine what can be implemented in a safe and sustainable way. The clinical review meetings will be described in later sections of this report and a full transcript is available via the CCG website to ensure full transparency in the decision making process.

As part of the assessment process, NCAT have reviewed all of the options and provided an independent clinical review report. This report will be explained and outlined in Chapter 6.

The Council of Members then carried out a detailed appraisal of each of the options including the three new options. This report includes the assessment of each of these options and additional information related to the assessment process.

Throughout this process the CCG has operated in an open and transparent way and have looked to engage widely with the public and key stakeholders in order that they fully understand the challenges and the risks associated with the current service model.
2. Current Service Model

STHFT offers paediatric and maternity services at both The James Cook University Hospital in Middlesbrough and The Friarage Hospital in Northallerton – the two hospitals are 22 miles apart, an average journey time of 36 minutes. The Friarage Hospital predominantly serves the populations of the districts of Hambleton and Richmondshire in North Yorkshire.

The Friarage Hospital, Northallerton is one of the smallest in the country. At present, it has a paediatric outpatient and in-patient (overnight stay) service which includes a 14-bed children's ward. It also provides a maternity service in the community and in the hospital. This includes antenatal and postnatal clinics, a labour and postnatal ward and a 10-cot special care baby unit. The hospital is owned and run by South Tees Hospitals NHS Foundation Trust (STHFT).

There is also 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.

Practices offer some enhanced services as part of local schemes and also other services which are currently commissioned by the NHS England Area Team.

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 The Friarage Hospital. The service is provided mainly, although not entirely, by local GPs.

Midwives from STHFT work in general practices to provide antenatal care and there are well organised children's safeguarding arrangements.

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.

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)
- Musculo-skeletal conditions specific to childhood
- Complex conditions
- Sensory impairment
- Significant communication disorders
- Autism Spectrum Disorder (ASD)
- Multi agency planning and
- Paediatric consultation for the specialist children’s service team

Additionally the CCG commissions Health Visiting and School Nursing services for this locality via Harrogate and District NHS Foundation Trust.

**Health Needs Assessment and Activity Modelling**

As part of the review of services, we completed in the pre-engagement phase a full health needs assessment and activity modelling. We have repeated this assessment for the public consultation phase, so the CCG can be assured that during the last twelve months, there have been no significant changes which need to be taken account of as part of this reconfiguration of services. The conclusion is that whilst there have been some minor changes to activity modelling they are not indicative of an upward trend. In summary, however the key points worthy of note 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.

- Future military population numbers provided through MoD briefings have consistently said that re-basing planning suggests no significant impact on the overall numbers of serving personnel and families based at units/stations in North Yorkshire and across the North. However as a CCG we do not feel we are in a position to be conclusive that this would apply to the demographic profile. With rebasing from British Forces Germany - 36,000 Serving Personnel (SP) and families and draw-down from Afghanistan there may be some changes to that profile. Return from Germany is rolling out from now to 2017 with most going South but some coming to Catterick/NY so there is still a degree of uncertainty around precise numbers and Service Personnel/family profile. We have therefore assumed only a modest change.

- 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 other parts of North Yorkshire.

- Deprivation (which is associated with poorer health) is higher in parts of Richmond, Colburn and parts of Northallerton.
The Health Needs Assessment and the activity modelling work can be found in Appendix 2.

**Integrated Care for Maternity and Paediatric Services**

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 The James Cook University Hospital offers a level of specialist care which is not available at the smaller The Friarage Hospital (including neonatal intensive care and paediatric intensive care facilities). In some instances children and women requiring the services offered at The James Cook University Hospital will be directed there for their care, or in some cases, to other specialist hospitals e.g. Newcastle.

The issues facing paediatric and maternity services at The Friarage Hospital are complex. (Paediatric and maternity services are linked, and cannot be run safely and independently of each other.) These issues are explained in great detail in our Public Consultation Document included in Appendix 3 and also in Chapter 3 – Case for Change.

Current activity at The Friarage Hospital, in terms of children being treated as in-patients is shown below:

- Around 5 children a day are admitted acutely to the children’s ward.
- The majority of children with major injuries or in need of emergency care are already taken to The James Cook University Hospital or an equivalent major centre so they can be cared for by the most experienced teams.
- The paediatric ward has 14 beds and a 69% average occupancy during the day and 31% at night.

Fewer babies are being born there:

- Around three or four babies are born a day which equates to 1,260 babies a year. This figure is not likely to increase in the next few years and means The Friarage Hospital has one of the smallest maternity units in the country.
- The Special Care Baby Unit (SCBU) has 10 special care baby cots and supports 156 babies per year.
- On average there are 13,750 antenatal and postnatal appointments at The Friarage Hospital locally and would continue to be provided from The Friarage Hospital and/or local GPs practice.
- Whilst the overall numbers of births will remain the same, more and more mothers need specialist care during their deliveries - a figure which is likely to increase over the next few years.

These issues mean that we need to consider making changes because:

- The safety and clinical quality of services is our number one priority – both now and to safeguard standards for the future.
• The CCG cannot allow a situation where the quality of services at the local hospital depends on what day of the week it is, what time of day or night it is, or which staff are available.

• It is important that the most senior, experienced and specialist staff are on hand at a hospital 24 hours a day, seven days a week for the patients who need them. To achieve this we need to concentrate teams of highly trained professionals at fewer, larger hospitals to make services safer and better.

• At the same time, we need to provide the right balance of services in the community and closer to patients’ homes. In particular, we need to provide preventative and supportive care to patients so they are healthier and less likely to be admitted to hospital.
3. Case for Change

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. NHS England has recently launched their “The NHS Belongs to The People – A Call to Action” campaign, which allows the general public to have a say in the future of the NHS whilst ensuring that any ideas identified are sustainable whilst also still respecting the values which underpin the NHS. The CCG has adhered to these principles and has looked to develop a sustainable service through strong partnership working with both local providers and the public.

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 more acutely.

**National context and standards for paediatric services**

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 paediatric 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.

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.

The national direction of travel for patients with long term conditions is to be supported in the community and therefore 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 stays.

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.

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 in-patient 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.

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).

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.

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/year (1456 non-elective admissions)
2. Small >1501 – 2500 emergency admissions/year
3. Medium 2501 – 5000 emergency admissions/year
4. Large >5000 emergency admissions/year

The RCPCH clearly state that it is these very small and small units that have no middle grade rota could risk closure. However, remote very small/small units should consider conversion to a Paediatric Short Stay Assessment Unit (PSSAU).

The RCPCH identified that within the UK this would affect 48 of the current 218 paediatric units, 32 of which would need to consider creating a PSSAU taking into account the issues of politics, history and public opinion. A PSSAU could be a long day service up to a 23 hour service but should cover times of peak demand.

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 the 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.

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).
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 are the correct training skills, and competencies that those staff should have to ensure any presenting child can be given the assurance of the 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.

Standard 8 of RCPCH recommends that a minimum of 10 Whole Time Equivalent (WTE) should be on any rota tier. The EWTD mandated a working week of no more than 48 hours. As a result the Academy of Medical Royal Colleges (AMRC) 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. NHS Health Education North East confirmed this is not an option - See Appendix 4.

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. British Association of Perinatal Medicine (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 those staff members may not have the expertise, skill or experience required to provide appropriate services.

HRW CCG have questioned why STHFT has not developed these roles previously as part of planning for the future. In response the Trust states that they have tried to develop these roles within The James Cook Hospital and have struggled to find available nurses with the appropriate skills and competency to deliver the new role and work at the required levels. Developing and maintaining the skills within a competitive employment market has meant that they have then experienced difficulty in retaining skilled staff. There is therefore no specialist nursing workforce available within STHFT to utilise at The Friarage Hospital. It would take a further three to five years to develop for Tier 1 (replacing junior doctors) and 5-7 years for Tier 2 roles (replacing training grade doctors) and would remain subject to the ability to retain highly skilled nurses in a competitive employment market.

‘Facing the Future’ document also recommends that there is a clear need to enhance the role of primary care and has suggested this should be done by:

- Increasing the number of GPs trained in paediatric medicine - GP basic training to be expanded from 3 to 4 years to accommodate greater exposure to paediatric and children's health.
- Improve the access to specialist consultant opinion for GPs to enable better communication and swifter treatment should the need arise.

**National context and standards for maternity services**

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.

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

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.

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 The Friarage Hospital but there has been an increase at The James Cook University Hospital. 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

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).

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

The Royal College of Obstetricians and Gynaecologists (RCOG) in their paper High Quality Women’s Health Care (2011) identified some of drivers for high quality maternity services was to ensure that safe and effective care was delivered through increasing the need for 24/7 consultant presence in units and this can only be delivered through centralisation of key services. This is due to multiple reasons namely the European Working Time Directive (EWTD) and availability of consultants and middle grades doctors. These 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

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 currently not being met at either The Friarage Hospital or The James Cook University Hospital. In reconfiguring consultant led maternity services to the larger of the two sites the aim is to enable compliance to national standards. The full staffing requirements are included in Appendix 5 (Business Case section 5.31-5.36 inclusive).

In 2008, there were two key publications – Safe Births: Everybody’s Responsibility (Kings Fund) and Towards Better Births (Health Commissioning Consortium - HCC) – that both set out the need to focus on the main factors to achieve safe, sustainable and equitable maternity services for women.

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.

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 Royal College of Midwives (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 High Dependency Units.
In Obstetrics and Gynaecology, the target for future workforce determines that 3000-3300 consultants are needed with the current present configuration of hospitals and standards for delivery suite presence. Currently there is a total workforce of 2186. The consequence of this has been units such as The Friarage Hospital, rely on doctors in training to provide the majority of out of hours care; there are ongoing recruitment and retention issues along with a failure to meet professional and service/safety standards.

In addition, there is also a drive to recognise consultants as either obstetricians or gynaecologists because of the demand on labour wards and the need for compensatory rest, which results in the gynaecology sub-speciality being depleted if colleagues fulfil both roles - this adds a further complexity for small units requiring dual roles.

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. The North East midwifery shortfall is 4%, whereas Yorkshire & 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.

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.

The public are rightly focused on outcomes of care: What does all this mean for them and how do improvements in staffing ratios actually lead to improvements in care for individuals and reductions in harm and death? Despite agreement by the clinical community that improving consultant presence on labour wards reduces harm, evidence to support this view is limited as little research has been published in this area. Some unpublished data exists but because of small numbers involved publishing would make this patient identifiable so therefore it remains confidential. However a study published in the BMJ in 2010 demonstrates that the risk of death due to a baby receiving too little oxygen during labour (intrapartum anoxia) and delivery is reduced by 25% (x1 in 4) if they are delivered when the unit was fully staffed by consultants on a 24/7 basis.

The table over the page shows how the outcomes differ:-
About 1 in 4 deaths from intrapartum anoxia at term could be prevented if all women attempting vaginal birth had the same risk of this event as women delivering during the normal working week. *Pasupathy et al. BMJ 2010*

**Local context for both maternity and paediatric services**

The paediatric unit and the maternity unit at The Friarage Hospital are amongst the smallest in the country – with 1400 non-elective admissions per annum, the paediatric unit is classified by the Royal College of Paediatrics and Child Health (RCPCH) in their report "Facing the Future" (2011) as 'small', one of the units which would need to change or close because of changes in child health, reduction in the utilisation of in-patient units and changes in workforce training.

There are 1250 deliveries on average a year in the maternity unit – only eight units in England deliver fewer than 1500 babies per annum.

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 tier (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 highlighted by the local consultants as a clinical safety issue.

The principal concern about the paediatric service is therefore, that at night cover for the paediatric ward is provided by junior medical staff and nurses without any more senior doctor being available within the hospital. In maternity, the overnight medical cover, from 22.00 – 08.00 hours, 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 The Friarage Hospital have to be able to provide skilled care to sick children and neonates; obstetricians have to be
obstetrics 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;

• If there is a poorly child on the children’s ward who needs expert intervention at the same time as a baby is in distress during delivery on the labour ward there is only one doctor available with the necessary skills, increasing the risks to both of serious avoidable harm.

• 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 of sufficient quality; 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 Friarage Hospital 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.

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 the maintenance of skills and there remains an issue at both sites in relation to staffing levels. The scenarios detailed below provide an example of the difference in care across the two sites. Where rotation is possible, the Trust has rotated staff. The issue however is that there are simply not enough consultants at The Friarage Hospital, The James Cook University Hospital or nationally. The solution is to centralise rotas.

### Scenario one

Joshua is one year old and has a fever, headache and vomiting. His GP makes a diagnosis of likely meningitis and refers him to Friarage Hospital where he is admitted to the children’s Ward. The hospital is close by and Josh is there in 20 minutes. He is seen by a junior doctor training to be a GP and a junior staff nurse. They are worried about Josh and call for the Consultant from home. The Consultant comes in and starts to treat him, it’s hard to put in a drip and he isn’t breathing very well. The junior doctor phones for the Consultant Anaesthetist to help, he is experienced with Adult care, but rarely treats children, although he has been on a special training course. The Anaesthetist is in theatre and can’t come immediately. It’s difficult because the Paediatrician feels that Josh needs to go to Intensive Care, but there is none available in the hospital. She needs to phone the Intensive Care Unit to handover and request a transfer team, but it is difficult for her to leave Josh’s side. She has to continue treating him until the Anaesthetist can come and help, only then can she phone the Intensive Care Unit and make a handover. They agree to come to Friarage to collect Josh, but won’t be there for two hours. In the meantime Josh is moved to the Adult Intensive Care Unit where he can wait. He receives treatment from the Paediatrician and Adult anaesthetist and Adult ICU nurses. The
adult staff have all attended training courses but have little practical experience in dealing with children.

The transfer team arrive and arrange transfer for Josh, he has been in hospital for three hours. It will take another hour to get him ready for transfer and then another hour to get to the Intensive Care Unit.

Scenario two

Joshua is one year old and has a fever, headache and vomiting. His GP makes a diagnosis of likely meningitis and refers him to James Cook University Hospital. The hospital is 40 minutes' drive away. He is seen on the Children's ward by a junior doctor who is training to be a Paediatrician, and an experienced trainee paediatrician, treatment is commenced immediately and the Consultant is called, who arrives in a few minutes. There are at least two experienced Paediatric nurses helping to stabilise Josh. The Consultant is worried about Josh's breathing so calls for a Consultant Paediatric Anaesthetist who attends in a few minutes. Together the team of 4 experienced doctors decide that Josh needs to go to the Paediatric Intensive Care Unit, which is located on the adjacent ward. He is moved around to the Unit, cared for by the 4 doctors and two nurses.

Josh has been in hospital for less than one hour.

In addition, The Friarage Hospital cannot take care of very sick children so they are transferred to The James Cook University Hospital PICU. Recognising early signs of deterioration can be clinically difficult for junior medical staff with minimal levels of paediatric experience. There is therefore a clinical risk those children may not be identified early enough and therefore could be at greater risk of death or significantly poorer chance of making a full recovery from their illness.

Finally, 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-specialty cannot be delivered and maintenance of skills is difficult.

The RCPCH has warned that it will be impossible to staff all the in-patient rotas that currently exist in a safe and sustainable way and comply with European Working Time Directive regulations. There are too few trainees to staff current rotas 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.

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). The 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 Ministry of Defence (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 Appendix 2.

Permission for middle grade allocation will only be given by the NHS Deanery for Paediatrics for Health Education North East, to units where there is considered enough exposure to a range of clinical activity and caseload variety. The Friarage Hospital is considered too small to provide this adequate training and therefore there is no prospect of any such allocation. 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.

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 and small in-patient units to Paediatric Short Stay Assessment Units (PSSAU’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. We have therefore developed options which centre on a Midwifery Led Unit (MLU) and a Paediatric Short Stay Assessment Unit (PSSAU) both of which are nationally recognised service models. In addition we have visited a range of hospitals offering the models outlined above to understand what the services they have offered and what are the risks and implications of introducing these new models. We have summarised this in Appendix 5 (Business Case Section “Gathering Evidence from Different Parts of the Country”).

National Clinical Advisory Team (NCAT)
The CCG asked NCAT to do an initial assessment of the case for change in December 2011 and then a formal review of the results of the engagement exercise and options for consultation in 21 August 2012 looking at compliance against the 4 reconfiguration tests.

NCAT then also reviewed the 3 additional options submitted during the consultation to give an external view of suitability for implementation as a robust clinical model. A copy of all the NCAT reports is included as Appendix 6. The key findings of the review in terms of the sustainability of current services at The Friarage Hospital are noted below:

- NCAT agreed with the conclusions reached by the clinicians from STHFT that their current service, which relies on the clinical staffing arrangements described above, is not sustainable particularly if 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 team 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 in-patient beds to The James Cook University Hospital in Middlesbrough.

• 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.

• 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.

• NCAT highlighted the challenge of clinical inter-relationship between paediatric and obstetric care. They felt that without consultant paediatric cover at The Friarage Hospital, Northallerton for the Special Care Baby Unity (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 Friarage Hospital was too small to maintain a 98 hour consultant presence on the labour ward and other models of care should be explored, including midwifery led delivery unit where the outcome for patients can be very good with the retention of outpatient based maternity services.

The findings of the NCAT review helped to develop the commissioning intentions and options described in the next section.

If the CCG fails to act The Trust believes:

• The service offered at The Friarage Hospital will compare less and less well with other hospitals and will be of lower quality than people should expect.
• We will fall short of the required clinical standards – which is a real safety issue.
• We risk more unplanned closures and more serious incidents.

NCAT confirmed that no change was not an option and this conclusion was subsequently accepted by the Independent Reconfiguration Panel in their letter dated the 22 February 2013. They suggested the CCG invite new options and not limit respondents to those listed within the public consultation. Throughout the public
consultation, the CCG has clearly articulated this request and has received three new options from the public which will be discussed in greater detail in Chapter 5.

The CCG invited NCAT to review the three new options submitted by the public as part of the public consultation process, to provide us with independent external clinical advice to aid our decision making process. The NCAT review of all options is included in Appendix 6.

**The options for consideration**

During the consultation period, we asked for views on the two options described below. In both options, maternity services are the same; however, the options for paediatric services are different.

We are proposing to open a Midwifery Led Unit (MLU) at The Friarage Hospital. MLUs are run by experienced midwives and are a safe local option for women who are medically fit, have had a normal pregnancy and are at low risk of complications.

If there were any complications during the birth, women would be transferred by ambulance to a consultant led unit, supported by their midwife. Women who are at high risk of complications would need to have their baby at a Consultant Led Unit, to ensure specialist doctors are available to provide supervision or medical intervention (such as caesarean deliveries). We have summarised the options for mums-to-be below:
There will be no change to ante-natal and post-natal care and the MLU option described above is the same in both of the options summarised below.

It is important to note with both Option 1 and Option 2 that the first point of contact for a parent with a sick child should always be the child’s GP. If a child needs medical attention when the GPs surgery is closed, parents now have available NHS 111 who will refer the child to the most appropriate place for their care.

**Option 1**

Option 1 is summarised below:
- Open a Midwifery Led Unit (MLU) As above
- Develop a Paediatric Short Stay Assessment Unit (PSSAU) at The Friarage Hospital.
- Continue to deliver community paediatric nursing and consultant paediatric outpatient service at The Friarage Hospital. More specialist in-patient paediatric services will be available at The James Cook University Hospital, Darlington Memorial Hospital, Harrogate District Hospital and York Hospital.

**Explanation**

Under Option 1, a PSSAU would be offered at The Friarage Hospital, based on Royal College of Paediatrics and Child Health (RCPCH) guidance, providing rapid access to treatment for children and ensuring we meet the 10 standards laid out by the RCPCH.

Working closely with local GPs, the PSSAU will help to reduce unnecessary hospital admissions and overnight stays. However, children who need to stay in hospital will be dealt with promptly and taken to the most appropriate place for their in-patient care. No in-patient (overnight) care would be available at The Friarage Hospital.

We believe a PSSAU would offer better access to services as children who need routine assessment, investigations, minor treatment and day surgery would still receive this local care. The unit would still only see, on average, three children a day but the unit would allow us to support care close to home for the majority of children.
If a child needs to be assessed by a paediatrician out of hours (when the PSSAU is closed) they will be referred to the nearest major centre for specialist care.

**Option 2**

Option 2 is summarised below:
- Open a Midwifery Led Unit (MLU) at The Friarage Hospital as above
- Continue to deliver community paediatric nursing and consultant paediatric outpatient services at The Friarage Hospital. More specialist in-patient paediatric services will be available at The James Cook University Hospital, Darlington Memorial Hospital, Harrogate District Hospital and York Hospital.

**Explanation**

The difference between the options is that Option 2 does not include the development of a Paediatric Short Stay Assessment Unit (PSSAU). Instead, an urgent clinic would be developed for assessing children who are unwell and require outpatient assessment only as there will be no observation area for children.

We would work with local GPs to ensure that clear pathways of care are in place so that children are seen at the right location to meet their needs. This model ensures children’s care is delivered by a wider range of specialists available in bigger centres of expertise and therefore able to deal with a wide range of conditions.

Children will be directed to consultants with the specialist skills they require enabling better quality of care to be delivered. All other care that cannot be delivered at an outpatient appointment would be delivered at another hospital such as The James Cook University Hospital, Darlington Memorial Hospital, Harrogate District Hospital and York Hospital. This option would mean more children being admitted to the surrounding hospitals rather than being initially assessed at the PSSAU.
Our preferred option
The CCG preferred option is Option 1. We believe it will keep as many services available locally as possible. It will also give us the opportunity to invest in community based services and deliver more care close to home. At the same time, it will ensure that specialist services are provided in the most appropriate place and by the most experienced clinicians, ensuring we meet national safety and sustainability standards. Option 1 is supported by all of our local GPs. The benefits of these changes for patients are:

• All patients can experience the same high standard of care, from the right healthcare professional with the right skills and experience to support their needs.

• Improving maternity and paediatric care will save lives. Centralising specialist services in our area means better outcomes for patients as specialists increase their skills and knowledge by dealing with larger numbers of similar complex cases.

• It is easier to attract and retain skilled staff if they are able to work in specialist centres, so we will avoid the problems of having to temporarily close services or divert patients at the last minute when staffing levels drop or where we have long-term vacancies which we cannot attract new staff into.

• Specialist services will safeguard the quality of care patients will receive today – and in the future.

• Taking action will avoid the problem developing into a crisis in the future where the unit needs to close in an unplanned way.
4. Public Consultation and Engagement Process

In law, an NHS organisation must involve patients and the public in the design and development of new initiatives and in any substantial development or variation in the provision, commissioning and decommissioning of a service.

NHS bodies have two legal duties to consult when proposing changes to the way local health services are provided, operated or developed. They are:

(A) The duty to consult with Local Authority Overview and Scrutiny Committees on proposals for substantial changes.

(B) The duty to consult and involve patients and the public in an ongoing way, not just when major changes are proposed.

HRW CCG sees this as much more than a legal duty and is therefore committed to ensuring we engage widely with our diverse population on all aspects of health, and have developed a wide range of public involvement mechanisms to ensure the conversations are ongoing and not a one off. This is integral to our organisational structures. Examples of this include:

- Appointment of three local people from our Patient Congress which is made up of our Health Engagement Network (HEN) and our GP Patient Participation Groups to attend our Governing Body. One from each of our three localities – Hambleton, Richmondshire and Whitby.
- Appointment of a HealthWatch Representative to attend our Governing Body.
- Established our Patient Congress which is held quarterly to hear the views of local people on all matters relating to health.
- Widely used social media, website and provide regular public updates.
- Commenced the Fit 4 the Future engagement on the future of services across Hambleton, Richmondshire and Whitby which has been well attended and supported.

Our aim is to support ongoing conversation with the public on the health issues and challenges we face as a CCG and ensure they contribute actively to the development of our future strategic plans, and can influence our priorities and direction of travel. These meetings have been well attended and we have strong dialogue with our local population.

In terms of engaging with the public, on the reconfiguration of maternity and paediatrics services, we undertook a public engagement exercise from March to July 2012 and a formal public consultation from September to November 2013. We have gathered a great wealth of information and the views of the public throughout these two phases, which are summarised below and includes details of each and the key themes which emerged from each of the phases.

Engagement Phase
In Spring 2012, The CCG held a three month engagement exercise to talk to the public about the issues facing maternity and children’s services at The Friarage Hospital and the possible options for the future. We held 9 public events and over
600 people filled in a survey to give us their views. We listened to what people told us during this public engagement exercise and a number of key points are summarised below. The full report can be found in Appendix 7.

The key issues raised during the engagement exercise are summarised below. The CCG responses to these concerns can be read in more detail in Chapter 5:

- **Long-term future of The Friarage Hospital** - During the engagement exercise, many people expressed concern about the long term future of The Friarage Hospital. The CCG is committed to the long term future of The Friarage Hospital and have reassured people that as a group of local GPs, we have a great regard for The Friarage Hospital and we have a very bright vision for its future.

- **Clinical Safety** - Local people expressed concerns during the pre-engagement phase that they do not believe the current services are clinically unsafe and in the public survey during the engagement process, people rated closeness of services above safety and quality. However, as a group of GPs responsible for commissioning these services, the CCG absolutely have to put the safety of our patients above everything else and we have clinical concerns that were supported by NCAT.

- **Families of children with Open Access** - Open Access is provided on a long-term basis to some children with complex health needs to provide speedy access to specialist paediatric care. It is also provided on a short term basis to children who have been discharged from hospital to allow many children to return to their own home sooner. Concerns were raised by parents of children with Open Access as to the model of care in the future. They were concerned about additional travel for outpatients and the receipt of ongoing care.

- **Transport** - We know that one of the issues people are worried about is transport. People told us that they were concerned about travelling times, the cost of travel and access to suitable transport options. Particular issues were raised about the ability of the ambulance to be able to respond to emergencies and to mothers-to-be at the new MLU, who change from low risk to high risk during labour. There were particular worries relating to the capacity of the ambulance services and current service standards. As equally important was the ability to access The James Cook University Hospital site with a range of issues relating to signage and car parking raised. This affected patients much more broadly than those accessing maternity and paediatrics and has been an ongoing theme locally.

- **Integration between health and social care** - Integration between health and social care services and this often causes duplication and delays in accessing vital equipment for families and there is not thought to be enough community nursing services of community nurses available at weekends.
Public Consultation Phase
The CCG produced a detailed public consultation document which summarised the journey so far, why we need to make changes and the options for the future. This document and fact sheets can be found at Appendix 3. The document and posters to promote the consultation were distributed and an email to key stakeholders was circulated. Printed copies of the documents were also distributed widely across key locations around Hambleton and Richmondshire, including:

- GP Surgeries
- Health Centres
- Children’s Centres
- Libraries
- Supermarkets and Village Stores
- Children’s’ Day Nurseries
- The Friarage Hospital
- Town Halls
- Parish Councils
- Schools (distributed by North Yorkshire County Council)

To support the consultation document, we also produced a range of ten factsheets on specific topics and a booklet of scenarios to bring to life the options for the future and a detailed Communications and Engagement Strategy which can be found in Appendix 8.

The communications and engagement activity undertaken included:

- 9 formal public engagement meetings across locality market towns - each independently chaired by the Chief Officer of Richmondshire CVS which were attended by over 293 people
- 18 stakeholder and local community meetings
- Staff briefings/ discussion groups
- Mother and child groups
- Public survey, which resulted in 76 responses
- Involvement of local GPs through email correspondence, newsletters and meetings
- 1500 copies of our consultation document were distributed
- A ten minute DVD to explain our consultation and encourage people to give their views which was shown in various locations around Hambleton and Richmondshire and was available on line to be viewed by the public.
- It is worthy of noting that every meeting request and media interview during this time was accepted

Our survey
We ran a survey, in both hard copy and on-line which was open for the full twelve weeks of the consultation. In total, 76 people completed the survey. A full breakdown of the survey results can be found on pages 22-39 of Consultation Feedback Report which can be found at Appendix 10. The CCG not only considered these survey responses in their decision making, but also any other views that had been put through various alternative channels.
Media coverage and activity
By adopting a proactive approach and working closely with our local newspapers, radio stations and TV channels we raised awareness of the consultation and encouraged people to get involved. A full breakdown of our extensive media activity can be found in section 6 of the Public Consultation Feedback Report in Appendix 9.

Online and social media activity
A comprehensive section was created on the CCG’s website which contained extensive information on the consultation and STHFT also mirrored our approach and presented the information on their website.

We used a number of social media channels including Facebook, Twitter and posting on sites such as NetMums to send regular updates about the consultation and to advertise the public consultation events.

Our Clinical Chief Officer, Dr Vicky Pleydell, also used her online blog to discuss some of the key issues coming from the public feedback. Her posts were shared widely. This innovative approach to engagement has proved particularly successful and we now have over 1,000 followers on Twitter, meaning our messages are reaching more and more people.

Engagement with key stakeholders
We ensured that there was continued engagement with a wide range of key stakeholders - these included:

- **Open Access children** - two open meetings were held with families of these children. A special consultation drop-in event was also arranged with these families and dialogue remains open with a small group.

- **Focus groups** - visits to numerous mother and toddler groups. Offers were also made to arrange follow-up visits. The CCG also attended a Birth and Beyond which is group of mothers who act as peer supporters on the Catterick Garrison and attendees gave feedback by filling in the questionnaire.

- **Health Overview and Scrutiny Committees** - continued close working with North Yorkshire County Council’s (NYCC) Health Overview and Scrutiny Committee, both before and throughout the consultation. The CCG has attended every committee meeting during the consultation period to both brief the committee on progress and to formally listen to their views. A copy of the consultation document was shared with all of our neighbouring scrutiny committees and The CCG attended meetings with Redcar and Cleveland Health Scrutiny Committee, Darlington Borough Council Joint Health Overview and Scrutiny Committee and Tees Valley Health Scrutiny Joint Committee to play our DVD and answer any questions about the impact potential changes would have on their local residents.

- **Local Authorities** - The CCG has made a clear commitment to partnership working and engaging with our partners in local authorities, including Darlington Borough Council and Middlesbrough Council. Attendance at public
meetings with Hambleton District Council, Richmondshire District Council and North Yorkshire County Council’s Richmondshire Area Committee to discuss the consultation and answer queries and concerns and listen to their views was undertaken by CCG Senior Managers and Clinical Colleagues from STHFT.

- **GPs and Practice Staff** – The CCG worked continually to keep all member GP practices informed and up to date throughout the consultation process. Briefings were given at the regular CCG locality meetings and Practice Development Events was highlighted in our Practice Newsletter and other email communications. GP practices also displayed posters and information leaflets to promote the consultation. The CCG has also met with the military practices located within the CCG boundaries and have discussed the implications of the proposed changes with them and sought their views and feedback.

- **Staff engagement** - staff were briefed and asked for their support in promoting the consultation. Access to relevant information was made available to ensure queries could be effectively answered. Staff were invited to attend the public events to provide support and to gain an understanding of the public’s reaction to the consultation and many did attend. STHFT held an open drop-in session at The Friarage Hospital where staff were invited to raise any issues of concern or ask questions. Appendix 9 shows the key themes discussed at the meetings and the questions that were raised.

**Key Themes Emerging from the Public Consultation**

During the nine public meetings, which were attended by some 293 members of the public, local authority members and other stakeholders, the following main issues were raised. It is interesting to note the consistency in responses between the pre-engagement and the public consultation, a couple of which are summarised below

- “I have to say that I support the changes. We cannot expect every service to be at every road end. It is clearly better for specialist services to be concentrated in centres of excellence like James Cook and for the Friarage to provide what it is good at.”
- “I have just read your documentation and congratulate you on an excellent argument. I personally favour Option 1 but would urge you to beg James Cook to provide improved signage and car parking.”

It is also worth noting that one respondent commented:

‘Forgive me for my confusion but did we not have a long process for consultation last year? What happened to all the results of the last consultation process?’

This was an interesting comment, following the number of responses received for the last public consultation compared to the engagement phase. Therefore when considering the themes below they have been reviewed alongside feedback from the earlier engagement phase. All themes will be addressed equal important. The themes are listed below:
• **Clinical Safety** – this was the biggest concern for those attending the consultations. This included increased travel distances and times, impacts of risks for patients, lack of public transport, and impact of bad weather on travelling. The transfer of patients, specifically mums in labour, was of widespread concern.

• **Transport (Ambulance and Shuttle Bus Support)** - there was a lot of concern over the availability of ambulance support should mums in labour need emergency transfer to The James Cook University Hospital. With regard to the Shuttle Bus Service, there was concern that the service which would be run 5 times a day would be inadequate and would put women at risk. There were also concerns raised over the current lack of parking at The James Cook University Hospital. The distance between the two hospitals sites also caused concerns and knowing available hospitals to access easily.

• **Future proofing The Friarage Hospital** – the responses from the local councils included comments relating to the future of The Friarage Hospital services and concern was raised over the number of local services lost within the town in recent times, such as the closure of the prison and therefore the impact on local jobs.

• **Capacity at other local hospitals** – concerns were raised over whether there was enough capacity available to manage the increased numbers of women who would need to use the hospitals to give birth and is there enough capacity for paediatric services, including SCBU. These hospitals included Darlington, Harrogate and York. The respondents also questioned the additional spend to accommodate changes at The James Cook University Hospital site.

• **Maintenance of a consultant led model for maternity and paediatrics services** - it was suggested that to avoid mums needing to travel whilst in labour, consultants could be rotated between the two hospital sites - this scenario could also help keep skills levels up across the two sites. It was also suggested this could be done for paediatrics also. In a number of the proposals there were comments relating to recruiting consultants with contractual terms limiting where they can live and enforcing rotation as part of the consultant contract. It was also felt the consultants could be supported with ANNPs, APNPs or middle grades which should be made available by NHS Health Education North East. It has also been suggested this could be provided for a cost of £200k as compared to the £2.7 million as detailed in the STHFT Business Case.

• **Patient Choice** – we were asked if STHFT will allow patient choice when a low risk birth changes to high risk during labour or a sick child needs emergency transfer.

It was raised by Richmondshire District Council that mothers-to-be from neighbouring CCGs could be encouraged to use The Friarage Hospital as opposed to The James Cook University Hospital to make the unit more viable.
• **Sustainability of a Midwifery Led Unit (MLU)** – Concerns were raised by a number of local councils, Royal College of Midwives and the public with regards to the sustainability of the MLU. This was in terms of both the availability of staff and in relation to the positive promotion of the MLU locally. Without this they were concerned that the numbers of people giving birth would be so low it would become unsustainable in the longer term.

• **Public consultation process** - concerns were raised about the costs of the consultation, whether this was ‘a done deal’ and the speed of implementation of the new models of services.

• **Unique solution** – Since the issue of safety and quality of these services was first raised with the public the CCG has been encouraged to find a unique solution to the challenges with maternity and paediatric services at The Friarage Hospital. During the consultation 3 proposals were put forward by respondents.

**The Public Consultation Survey Response Rate**

Despite the extensive promotion and effort to proactively inform our key stakeholders and target groups, formal response to the consultation was low (76 responses to the survey), especially when compared to the number of people who participated in the engagement exercise. Attendance at the public consultation events was also low in some areas although in others, Thirsk, Northallerton and Hawes, the turnout was higher.

As part of the legal advice the CCG sought on the consultation the specific issue of the low response rate was addressed. The advice received was that providing the process itself had been conducted lawfully, a low response did not invalidate it. We have however wanted to ensure we use all of the information received from both the engagement phase and the public consultation to ensure we are accurately responding to public views.

The preferred option from the public consultation feedback was Option one - a PSSAU with outpatient services, enhanced community services and a Midwifery Led Unit. There was strong support for extended hours of operation of the PSSAU (Monday to Friday 10am – 10pm) and the most important elements relating to the paediatric service were the availability of specialist care, distance from home to hospital and access to a high quality and safe service. It is worth noting that 17 respondents also stated they wanted the PSSAU unit to be open 7 days per week for 24 hours per day.

The public consultation response for maternity services highlights access to high quality and safe services, availability of specialist care and distance from home to hospital. We also asked whether local people would use the new standalone MLU and the response was overwhelmingly positive. The positive reasons for people wanting to use this service were care close to home, more personalised care and expert care from a midwife.
Conclusion
HRW CCG recognises that we have had a low response rate from the public consultation. The consultation was widely publicised. It may be that this reduction in interest during the consultation process can partly be explained by the success of the detailed and extensive engagement exercise just 12 months prior to the consultation.

We hope that many people may feel they have had their opportunity to comment and also now have a better level of understanding of the real concerns about safety and quality of the present service.

During the consultation, the clinicians present expressed very clearly and openly their concerns about the safety of the service and what that really means for children and mother and babies. We also addressed head on concerns about the general future of The Friarage Hospital itself, rather than about these services specifically and hopefully the CCGs and STHFTs absolute commitment to its future as a vibrant hospital served to allay those anxieties. It is also possible of course that people felt it was a “done deal” (as per one letter received) and they would be unable to influence it. We hope not. We are aware though that either or both interpretations are possible from the evidence.

However, to ensure we address all concerns raised now or previously we have therefore collated all of the feedback we have received and will act on this collectively. We also recognise there remain pockets of strong support locally for consultant led services for paediatrics and maternity.
5. Additional Options from the Public Consultation

One of the recommendations from the review by the Independent Reconfiguration Panel was to “invite new options and not limit respondents to those listed”. As a result, the CCG asked members of the public to put forward any suggestions for the future which have not yet been considered during the public consultation. The CCG received three submissions which are summarised below. The full documentation for all of these additional options can be found in Appendix 1 and they have been shared with the public via the CCG website.

Option 3 - Suggestions for Reconfiguration of Children’s Services at The Friarage Hospital

Submitted by Andrew Newton (father of a child with Open Access)

In summary this option suggests:
- PSSAU services should be 7 days per week in line with government policy
- Offer better support to people in their own home
- Provide a monitoring and observation unit 24/7 with beds for overnight stays
- Enhance to 24/7 community and paediatric nursing within Hambleton and Richmondshire
- Provide access to outpatients 7 days per week
- Develop the role of GP as Gatekeeper to support open access patients
- Enhance the use of telemedicine/technology
- 24/7 Paediatrics Services in the community to provide dressing changes, Nasal Gastric Tube (NG) refitting / replacement, blood tests, enemas, IV antibiotics and other treatments such as factor for haemophiliacs, patient assurance, oxygen monitoring, administering certain drugs and monitoring. This supports the agenda for care outside of hospital and closer to home.
- Outpatients via teleconferencing (this provides a video link between the patients and the clinician using videoconferencing equipment) and could be used to explore what could be delivered remotely with a nurse at The Friarage Hospital for a range of specialist clinics such as hand splint clinic, neurology, gastroenterology, spinal and Botox, ENT, oral surgery or others areas as deemed clinically appropriate.

Option 4 - Option for Maintaining 24 hour Consultant Cover at The Friarage Hospital

Submitted by David Williamson (Nurse and ‘Save our Friarage’ Facebook Campaigner)

In summary, this option suggests:
- Supportive of a MLU approach by the CCG
- Nurse led paediatric overnight model which in the view of the author is how the service is currently operated at night now
- The option suggested two nurses and one ‘on call’ Senior House Officer but no consultant out of hours to be based at The Friarage Hospital should be the future staffing model. In addition, the author proposed if a child deteriorates a
consultant at The James Cook University Hospital would be able to offer advice to the team at The Friarage Hospital.

- Staff rotation to be used to ensure the right nursing skills of staff are maintained between The James Cook University Hospital and The Friarage Hospital workforce.

**Option 5 - Our Model for the Future Provision of Children’s and Maternity Services**
Submitted by Richmondshire District Council

In summary, this option suggests:

- This option suggest the continuation of a consultant led unit for maternity and paediatric services, through the increased use of ANNPs/APNPs to cover the gaps in middle grades and through up-skilling midwives/paediatric teams so there is less demand on consultant time, when on call. The option also suggested continuing to offer overnight stays for paediatric children.
- Address skills mix and no middle grades through clinical research fellow from local universities and teaching hospitals/employ speciality doctors. Use advanced care nurse practitioners (ANNPs) in replacement for middle grade paediatric trainees and obstetric trainees. It is suggested that the present cadre of midwives and paediatric nurses working at the Friarage would readily step forward to be trained as ANNPs.
- Address on call issues through an employment strategy which makes it mandatory for all consultants to live within 20 minutes of The Friarage Hospital and/or integrated rotas between The James Cook University Hospital and Friarage Hospital sites
- Continue to provide a full A&E for major and minor illness and injury
- Develop and consider a Young Persons Unit, with the suggestion that this can be delivered with no additional cost
- Have a more relaxed approach to the Royal Colleges recommendations.
- Increase patient activity within the obstetric unit by 500 births a year by diverting births presently taking place at The James Cook University Hospital to The Friarage Hospital. It is hoped that increasing the number of births at The Friarage would improve sustainability and the skills and competencies of the doctors and nurses
- Suggested overall services would cost around £200k to deliver

The CCG is extremely grateful for the time and effort that the authors of the three proposals have spent in developing their submissions. It was also important to fully understand all of the options and we therefore held two meetings with the authors of these options which we called Clinical Review Meetings.

**Clinical Review Meetings**
The CCG hosted two meetings with the authors of the different options with the clinical teams from the Trust, on the 18 December 2013 and 27 January 2014.

The meetings were chaired by Henry Cronin, HRW CCG Chair, HealthWatch and The Rt. Honourable William Hague MP (who sent his apologies) were also invited to attend. HealthWatch attended both meetings.
The aim of the Clinical Review Meetings was to openly discuss with the authors their options in detail and for them to engage with STHFT clinical teams to see if they were viable options for the future. Both meetings were recorded and full transcripts are available on the CCG website and are included in Appendix 10.

Key Issues from Clinical Review Meetings

The tone of the meetings was positive and constructive and all the participants engaged positively in discussion and debate. The CCG outlined the requirement placed upon it to commission safe sustainable and affordable services. Each option was reviewed individually using a presentation summary and questions to prompt discussion. We have summarised below the key themes and clinical issues associated with each option:

Key themes and clinical issues for Option 3

This option was submitted by Andrew Newton. The key elements of the discussion are summarised below:

Nurse led observation unit (overnight)
The first point discussed for this option was whether an overnight nurse led observation unit could be delivered safely, whilst conforming to Royal College Guidance. Clinicians responded that this would not conform to Royal College Guidance for Paediatrics which states consultant cover must be available on site/on call. In effect, if this service was to have overnight beds, it would need to be a consultant led unit and therefore it was not felt to this was a viable option.

Opening hours and days of the PSSAU
The two options for both a 5 and a 7 day service for the PSSAU were discussed. The preference of the author was for 7 days per week and a 24/7 unit. Based on activity and demand, STHFT proposed a 12 hour (10am-10pm) day unit with last patients being admitted at 8pm to allow for continued observation. STHFT reported that there would be a significant increase in costs if the unit was provided 7 days per week and that they would provide a breakdown or costs and activity for the CCG in order for them to review. This information is included within the next section Chapter 5.

Provision of more outpatient services locally
There was general agreement about providing more outpatient services at The Friarage Hospital site and exploring the opportunities presented by the development of new technologies. STHFT agreed to develop a proposal on how this could be achieved. They also recognised they needed to develop partnership working between the tertiary hospitals in our region that provide outreach clinics at The James Cook University Hospital to investigate the feasibility of local clinics at The Friarage Hospital, in line with national strategy to provide more services 7 days a week.

Improving Access to Primary Care
There was also positive discussion about the role of the GP and how they can play a more prominent role in the care and support of children with complex needs. The paediatric team described how over the years due to the low levels of activity they
had been able to provide more enhanced care in a paternalistic way. They felt this care could be provided just as effectively by primary care and the CCG have commenced a GP Gateway programme which the author is involved with and which is being led by the CCG lead GP for Children’s Services, Dr Charles Parker. This programme will enhance access to primary care and work with families to share responsibility with the local GP.

**Enhancing Paediatric Community Nursing**
Finally, this proposal requested enhancement of the paediatric community nursing service. The CCG support this proposal as it chimes with the CCG Strategy to deliver care as close to home as possible. STHFT agreed to provide a detailed proposal detailing what additional services could be provided, and the additional costs of delivering this over 7 days rather than 5 as at present. This is included in Chapter 7.

**Summary**
In summary, the Clinical Review Group felt that many elements of this proposal could be incorporated into the preferred option of the CCG and recognised this will form part of our ongoing strategy and business planning.

**Key themes and clinical issues for Option 4**

**Risk Factors relating to Acutely Ill Children**
The group discussed the key differences between the roles and responsibilities of midwives and general nurses. Midwives are practitioners in their own right and are monitored and expected to enhance their training, in a different way to general nurses.

Pregnancy is recognised as a normal life event. Risk factors are assessed throughout the pregnancy, when in labour and post-natally. Pregnant women are not unwell. If they become unwell, they need to deliver in a consultant led unit. Monitoring the risk factors allows midwives to identify early signs of “illness” i.e when the pregnancy or labour is not progressing as planned and a transfer to a consultant led unit can be organised, long before complications arise. When a child is acutely ill risk factors cannot be used in the same way, as the child is already ill and therefore needs to be under consultant supervision, in case of further deterioration of their condition.

Nursing staff can and are rotated between the two sites.

The clinical team also felt the consultant opinion could not be provided from a remote team located at The James Cook University Hospital site, as they felt a consultant needed to be able to lay hands on a child, in order to complete a full and accurate assessment. The use of telemedicine, in an acute episode of care, was therefore discounted as an option to replace medical presence in the hospital. It was however felt that the clinicians could further develop the concept of telemedicine as part of a pilot scheme for children with long term illnesses, for their long term care and to access primary care. This should be developed gradually, across a range of specialities to build knowledge and learning, before this became part of mainstream
service, as it was too early to determine its clinical success. This could form part of the CCG commissioning strategy for children’s services into the future.

It was concluded the only way overnight services could be clinically safe, would be to have a consultant-led paediatric unit requiring 3 tiers of medical cover. NHS Health Education North East have confirmed they will not provide middle grades for The Friarage Hospital as they will not get the adequate training in order to maintain their skills – Appendix 4. The option of a continuation of a consultant led unit has been previously discounted by NCAT as a viable and sustainable option for a small unit like The Friarage Hospital.

Summary
The clinical team felt this proposal could not be developed into a feasible option. We also discussed that both the Royal Colleges and/or NCAT would be unlikely to support a nurse-led unit.

Key themes and clinical issues for Option 5

Unfortunately, Richmondshire District Council was unable to send a representative to the meeting on 18 December 2013, due to a funeral. The group decided to discuss the option in their absence but also arranged a further meeting on 27 January 2014 with the authors from Richmondshire District Council.

Cost of a Consultant Led Service
The CCG requested Richmondshire District Council provide further details on the cost assumptions of an enhanced consultant led service for an additional £200,000 investment. STHFT have provided a detailed analysis of costs required to provide a consultant delivered service which is compliant with national standards from the Royal Colleges and based on Agenda for Change pay bands and terms and conditions. This formed part the information presented to the CCG Shadow Governing Body and the PCT Board during the option appraisal process. Further evidence to understand the assumptions made within the proposed model to explain the significantly reduced costs would enhance the understanding of the proposals. The CCG have transparently shared all costed models.

Prospect of middle grade doctors at The Friarage Hospital
There are no middle grade doctors in paediatrics at The Friarage Hospital. Training places are not available because it is not considered to be a suitable environment in which to develop and enhance their skills because of the low number of patients seen. The numbers of trainees in both paediatrics ad obstetrics is reducing and STHFT are experiencing difficulty in covering its middle grade tier in obstetrics. A letter from NHS Health Education North East was requested and confirms that there are no plans to place training doctors in paediatrics at the hospital - see Appendix 4.

The author of this option also suggested that if middle grades were not an available the CCG and STHFT could explore speciality doctors and/or research fellows or Advanced Nurse Practitioners as a replacement for middle grade doctors in obstetrics or paediatrics.
Prospect of Specialist Doctors and Research Fellows
In terms of the non-training doctors STHFT explained, there were very few of these and they have had experience of using non-training doctors at The Friarage Hospital previously and it was extremely difficult to recruit and this results in the rotas being covered by locums of variable quality. Dr Roberts, Consultant Paediatrician explained that ‘having had previous experience of this, it would make me extremely wary of going down that line, as we want to be able to ensure that any service that is produced is a high quality service for children’. Also these doctors would be working alone out of hours with the consultant at home and would make supervision more of a challenge.

Development of Extended Scope Practitioners
The role of Extended Scope Practitioners (ESP), Advanced Nurse Practitioners (ANP) or Advanced Care Practitioners (ACP) as termed by the author of this option, was discussed. The terminology describing these roles is confusing and demonstrates the lack of consistent national qualification and competency standards. STHFT confirmed that they have developed the role of advanced neonatal nurse practitioners (ANNP) specifically working in the Tier 1 (junior doctor) neonatal rota at The James Cook University Hospital. In the last 10 years, they have trained 4 ANNP (2 have left) and are currently supporting another two trainees. Added to this they have also employed 2 ANNP, who had already undergone training elsewhere, who have been supported to get up to speed with the role at The James Cook University Hospital. They also had 1 ANNP at The Friarage Hospital but the role was unsuccessful, as it was difficult to maintain the drive and keep the skills, and the post-holder ceased functioning in the role. They are commencing further training for Tier 2 (middle grade) which requires the post-holder to have 3-5 years to gain the required skills and experience at Tier 1 to be considered for work towards Tier 2. It is not possible to build a safe and sustainable staffing model on staff, who have yet to be identified and then trained within the timescales required.

Retention remains an issue. The rota would require at least 6 Whole Time Equivalents with additional staff to cover sickness and absence leave. It is not possible to simply recruit staff, who already have this level of expertise. In other areas where these staff work at this level, they have been developed by their employing organisations. Choosing the correct person to undergo training is essential, this person should have sufficient experience and ability before being sent on the course. Most ANNP courses will have the clinical aspects completed within a year, with the second year devoted to a dissertation in order to complete the degree. Gaining enough clinical exposure in order to get used to what they will be doing in practice and ensuring they have enough support, usually takes the duration of the course and at The James Cook University Hospital, the practice is allowing them to consolidate for 6 months post course.

The above role would only prepare the staff to care for the sick neonate. Another tier to care for the paediatric child to maintain children’s services would be required. These practitioners would have to be trained paediatric nurses with experience who undertook a training programme to become an Advanced Paediatric Nurse Practitioner (APNP) - the Trust have a more limited development in this area and indeed, across the country the role is less developed in paediatrics. At The James...
Cook University Hospital they have 1 trained staff member who works in A&E. There are 2 APNPs undergoing training currently at The James Cook University Hospital.

**Provision of Paediatric Unit without Consultant Cover**

The author suggested that the CCG consider a consultant led maternity unit at The Friarage Hospital without paediatric consultant cover. This is similar to services currently provided at Wansbeck Hospital and Hayward’s Heath Hospital where they operate without a paediatric consultant and with only Advanced Neonatal Nurse Practitioners (ANNPs) taking the place of middle grades in the paediatric rota and that STHFT can identify potential candidates amongst their own nursing staff and call for volunteers and embark on a training programme immediately.

The Trust and the CCG do not understand how Wansbeck Hospital or Hayward Heath Hospital are able to provide the services safely and compliantly. The guidance nationally is very clear and this guidance must be adhered to by Foundation Trusts to meet the requirements of the NHS Clinical Negligence Schemes for Trusts (CNST). It is clearly spelt out that patients must have access to an appropriate level of skill. To clarify this, the appropriate skill is better articulated and explained not by the word, ‘Paediatric’ but by the term ‘Neonatology’.

Both of these services rely on a retrieval scheme (poorly babies treated by a medical team sent from a larger neighbouring hospital to transport the baby back). This can delay care to sick children. The Trust would remain non-compliant with national standards, assuming they were able to recruit and retain appropriate staff. When Trust clinicians visited these units concerns were raised over the future model given the anticipated retirement of key staff.

It was the view of the group that this model does not build safe and sustainable service.

**Patient Diversion Programme**

Richmondshire District Council suggested a patient diversion scheme. By encouraging more mums-to-be to use The Friarage Hospital and divert patients to this hospital and away from The James Cook University Hospital clinicians at The Friarage Hospital would see more patients and hence be able to maintain their skills.

The NHS Constitution grants the right for patients to have choice in services and choice in providers. As such, it is not possible to assign anyone to a particular service unless they choose to go. It is entirely their choice. A small number of patients who live closer to The James Cook University Hospital choose The Friarage Hospital currently. Another local commissioner has been asked to comment on the patient diversion programme. The CCG has enclosed a letter from South Tees CCG outlining their concerns in relation to any diversion of patients in Appendix 4.

Patients locally have the choice to give birth at any of the local hospitals listed below or further afield if they wish:

- County Durham and Darlington NHS Foundation Trust, Darlington
- York Hospitals NHS Foundation Trust, York
- Harrogate and District NHS Foundation Trust, Harrogate
- South Tees Hospital NHS Foundation Trust, Middlesbrough

The CCG cannot support a policy that dictates to the public which service they can access. The role of the CCG is to ensure that any service available to local patients is both safe and sustainable.

**Consultant Contracts**

Richmondshire District Council suggested that consultants should live within 20 minutes of the hospital and that this would enable a viable consultant led service to be retained. The consultant contract does not dictate where they need to live, it dictates their availability when on-call and the distance that they have to travel, so they can live anywhere in the country, as long as when they are on-call they are within a certain mileage of the hospital. If STHFT was to implement this restriction on where consultants can live, you can see from the map below how restrictive the zones that consultants can reside in are.

![Map of 20 Minutes Drivetimes from The Friarage Hospital and James Cook University Hospital](image)

STHFT confirmed adding a clause to specify where the consultant actually resided would be hard to enforce and could impact on the ability to recruit good consultants. Dr Ruth Roberts confirmed ‘If you look at the last four appointments we have made at The Friarage Hospital, three of those people and I am one of them, would not be working there if you had to enforce this’.

**Shared Rotas between The Friarage Hospital and The James Cook University Hospital**

The author also proposed a shared rota across The Friarage Hospital site and the James Cook University Hospital site. The Clinical Review Meeting discussed the
viability of this and it was felt this was not possible. Currently, neither The Friarage Hospital nor The James Cook University Hospital fully meets the national standards for consultant cover. The national standard for all general acute paediatric rotas are to have at least ten WTEs, all of whom need to be WTD compliant.

**The James Cook University Hospital for paediatrics has:**
- 9.8 consultants
- 9 x Tier 2 Middle grade rotas
- 8 x Tier 1

**Friarage Hospital for paediatrics has:**
- 5 consultants
- No middle grades at Friarage
- 6 x Tier 1

By combining the whole workforce of the two sites the service would become compliant for a single rota and The James Cook University Hospital site was the natural choice as it had the highest level of activity and staff and an established middle grade rota. The standards for maternity services are detailed below and the level of consultant obstetrician presence on a labour ward is dependent on the number of births each unit has annually. The current standards are summarised below:

- All centres should have a minimum of 40 - hours consultant presence
- Centres with 2500-4000 births should have 60 - hours consultant presence
- Centres with 4000-5000 births should have 98 - hours consultant presence
- Centres with >5000 births should have 168 - hours consultant presence

However, by 2014, units with between 2500-4000 births should have 98-hour consultant presence and units of +4000 births should have 168-hour presence. Summarised below are the number of hour’s consultant cover each unit has:

**The James Cook University Hospital** has 98 hours for on average 4400 births
**The Friarage Hospital has** 40 hours for on average 1250 births.

The CCG commissioning plan will ensure compliance for The James Cook University Hospital to have an aspiration to achieve 168 hours by 2015. There are a number of associated risks with this, which are the availability and cost of additional staff required.

There is therefore no further benefit to be gained from a further sharing of this rota. There is however benefit of centralising resources, so the consultants and middle grades from one location, on one rota and this will then ensure national standards and have the specialist skills to treat patients both now and in the future.

**South Tees Hospital NHS Foundation Trust Safety Record**
Finally, the author has questioned the difference in safety records of the two hospitals managed by STHFT relating to child mortality figures. The CCG have requested that NHS England Regional Analytics Team review the data. They have
completed this review and confirmed that the data sets cannot be reviewed in isolation due to case mix differences – see letter in Appendix 14.

Any child who is acutely unwell is transferred to The James Cook University Hospital site for the continuation of their care and therefore they treat more acute cases of child illness. In the sad scenario where a child dies, the death is more likely to be attributed to The James Cook University Hospital than The Friarage Hospital because they deal with more complex care because of the more specialised services they offer.

Therefore, comparing the two hospitals is not appropriate. The James Cook University Hospital should be compared to other tertiary centres and The Friarage Hospital to other similar sized hospitals.

Royal College of Paediatrics are concerned about overall outcomes across the UK compared to other parts of Europe. The comparison highlights the improvement in outcomes where services are centralised. This variation can be explained by the increased availability of a senior decision maker (consultant) with the right level of training in larger units who can appropriately identify early signs of significant and life threatening illness and act accordingly.

Summary

This option is similar to those considered during the engagement phase. When these options were assessed, the CCG supported by the external independent clinical advice from NCAT, agreed the clinical case for change was strong and excluded the possibility of a consultant led model. The concerns about quality and safety of the service remain. It was agreed this option meets neither of these requirements.

**NCAT Independent Review of Additional Options**

In addition, to the Clinical Review Meetings, the CCG asked the National Clinical Advisory Team (NCAT) to independently review all of the additional options.

NCAT has also carried out two previous reviews of the children’s and maternity services at The Friarage Hospital (included in Appendix 6 - NCAT reports dated 12 December 2011 and 21 August 2012). NCAT had given support for both the options put forward for public consultation by the CCG but preferred Option 1, as being most likely to meet local health needs.

The table below summarises the NCAT evaluation of options 3, 4 and 5:

<table>
<thead>
<tr>
<th>Option</th>
<th>Clinically Viable</th>
<th>Additional Comments</th>
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<tbody>
<tr>
<td>Option 3</td>
<td>Not counter to the options proposed by the CCG. Inpatient beds are not clinically</td>
<td>NCAT were supportive of the proposals to extend the range and reach of services to 7 days per week and to extend the community paediatric nursing. NCAT felt these could be done as part of the CCG preferred options. NCAT suggested this needed to form part of the annual planning and become part of the CCGs strategic plan.</td>
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</table>
NCAT did not however, feel the observation and monitoring unit on a 24/7 basis could be safe and sustainable, as outlined in previous reports. NCAT felt unable to support a proposal whereby children would be admitted onto the site out of hours or remain as in-patients overnight due to the lack of appropriately skilled staff in line with ‘Facing the Future’ report.

NCAT were also supportive that a Midwifery Led Unit could operate in a standalone way on the proviso that the unit appropriately risk stratified and only accepted low risk births. The MLU would need to have appropriate staff trained in resuscitation in case a baby was born flat or blue. It was important appropriate resuscitation takes place within the unit and that the mother and baby are then transferred.

<table>
<thead>
<tr>
<th>Option 4</th>
<th>Not thought to be clinically viable</th>
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<tr>
<td></td>
<td>The proposal suggests the withdrawal of consultant cover other than over the phone and NCAT feel this would increase clinical risk. The expectation is that children with the potential to deteriorate would be looked after by nurses and junior level paediatric trainees which would increase clinical risk. They were also concerned that Senior House Officers (SHO) working unsupervised on site would not have their training approved by the General Medical Council as they would fail to meet Royal College of Paediatrics and Child Health Standards. The present situation is thought to be untenable and unsafe by the present consultants, thus this proposed change would make matters worse by having consultants at greater distance, albeit over the phone, and could potentially cause more patient safety problems. For instance if there was a sudden deterioration in a child, which is not uncommon in this age group, they would require stabilisation before transfer by ambulance to The James Cook University Hospital. Presently the consultant at home on call would come in to assess and manage the child; this would be unlikely to happen if the consultant was on call at The James Cook University Hospital - this sort of patient would be much better off being in The James Cook University Hospital in the first place. This proposal was therefore not supported by NCAT.</td>
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<tr>
<td>Option 5</td>
<td>Not thought to be clinically viable</td>
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Essentially the Council is suggesting maintenance of the present consultant-led service. For the reasons as previously elaborated in NCAT’s reports there are a variety of challenges to this. NCAT has supported, and continues to support, the clinical case for change developed by HRW CCG.

NCAT believe that it is optimistic to believe a consultant led unit which is safe and sustainable can be provided for £200,000 over the current costs and support the CCG in their conclusion that in order to plan safely for the future, a consultant-led model in and out of hours with paediatric in-patient and obstetric unit is not the way forward.

NCAT also believe that increasing role of paediatric nurses, neonatal nurses or midwives with additional skills will be the way forward but acknowledge there are no nationally recognised training schemes and it would be very difficult to suddenly put in place this level of advanced nurse practitioners in either paediatrics or maternity.

Additionally other units, who have relied on ANNPs/APNPs, have also found there are recruitment and retention problems. At this point in the development of this particular professional group we feel that to plan a unit that relies on ANNPs/APNPs would not be wise as it may not be either safe or sustainable.

Likewise there are similar arguments to recruiting specialist doctors and research doctors to the middle grade rotas. For large teaching hospitals this can be an option but again there are often problems in planning and sustaining these rotas. Associate doctors in clinical positions are one option. In the past these were often overseas doctors who came to the UK to train but were unable to complete their consultant training for whatever reason. This cohort of doctors is now difficult to find.

NCAT further believe it would be very difficult to offer viable consultant contracts which restrict where they may reside within 20 minutes of the hospital and therefore believe this may impact negatively on recruitment and retention, and thereby the long term sustainability of the service. This coupled with the suggestion of rotation of consultants between the two
units would greatly restrict the area people can reside, in order to meet both requirements.

NCAT's main concern is always about the safety and quality of a service, recognising that, because of workforce issues, sustainability is very important. NCAT therefore do not think that presently the Richmondshire District Council has put forward a model yet which meets these criteria.

Having reviewed the options that emerged from the public consultation NCAT does not believe any of them are clinically viable however they do believe elements of option 3 can be incorporated into the CCGs preferred Option 1.

**Conclusion**
The CCG were extremely grateful for the additional options received from the local population and wanted to again convey our thanks to all the authors. The CCG and STHFT took time to review with the authors of the additional options each option carefully as part of a clinical review process, to explore and understand the viability of each option and then assess in line with the views of the local population and in line with the information from NCAT.
6. Equality Impact Assessment
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.

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.

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.

The impacts of the following five options have been considered as part of the EIA:

Option 1 – Paediatric Assessment Service (i.e. no in-patient beds), outpatients and community paediatrics AND low risk obstetrics only (midwife-led unit) proposed by HRW CCG

Option 2 – Paediatric outpatient and community service (i.e. no in-patient beds or paediatric assessment unit) AND low risk obstetrics only (midwife-led unit) proposed by HRW CCG

Option 3 – No Midwifery Led Unit and 7 day week PSSAU with overnight beds proposed by Andrew Newton

Option 4 – Midwifery led option with PSSAU managed by senior nursing team proposed by David Williamson

Option 5 – Consultant led option proposed by Richmondshire District Council

Method
HRW CCG and STHFT Equality Impact Assessment (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 have developed action plans to be developed to reduce the impacts where possible.

**Recommendations from the Equality Impact Assessment**

The CCG has acted on all recommendations from the Equality Impact Assessment which is included in Appendix 12.

The open access patient groups, who use The Friarage Hospital, formed a key stakeholder group. Prior to, and during the consultation period, a father of an open access child sat on our Governing Body and represented his local community of Hambleton. Meetings were held with the families of open access children and they were also sent regular updates on the progress of the public consultation. During this period, a detailed understanding of the needs of these children was developed, to enhance plans to support them into the future. The recurring themes from this engagement are summarised below:

- **Strengthen the role of the GP as primary provider of care.** In the past The Friarage Hospital Paediatricians have provided a very paternalistic care. They have been able to do so as there are a low number of children using The Friarage Hospital. What this has meant is that the important role of the GP has been overlooked and secondary care has provided both primary and secondary care input. Both families and clinicians recognised the need to change going forward and that in order to deliver care close to home the GP should take a more prominent role. Out of hours NHS111 and the GP Out of Hours Service should support parents’ choice in where and how to access appropriate care.

- **Strengthen role of Telemedicine and technology.** Many families expressed concern about increased travel and suggested this could be overcome through the use of telemedicine, which enables the patient and clinician to access each other remotely and thereby complete an outpatient appointment without the need to travel. This would be of particular benefit to those families who access more specialist care at outpatient clinics in Newcastle and Leeds. This could commence soon and start in one particular speciality and with a small number of families and then expand quickly as experience and confidence grew.

- **Enhance the paediatric community nursing cover.** Many of the hospital admissions which occur in this cohort of patients could be avoided through the provision of more community nursing provision particularly at weekends. The CCG will therefore look to invest in more paediatric community nursing to ensure 7 day per week cover and will support more services being provided in the community such as IV antibiotics, enemas etc. We are now getting all the community and acute paediatric nursing teams together and completing a full review of community activity and patient experience and will review opportunities for improvement and efficiencies to enhance patient care. The primary areas are long term conditions such as epilepsy, asthma and diabetes in the under 19s.
• **Enable health and social care to work more closely.** The parents told the CCG that there is much duplication between health and social care which operate in isolation. The Government is proposing radical changes to the entire system for Special Educational Needs and Disability (SEND) and the introduction of personal health budgets both of which will support better patients’ choice and empowerment.

This ambitious and transformative approach has resulted in the launch of the Children & Families Bill 2013, which is currently progressing through Parliament. The Bill will extend the SEND system from birth to 25, giving children, young people and their parents’ greater control and choice in decisions and ensuring needs are properly met. Accompanying the Bill is the Indicative Draft of the new (0-25) Special Educational Needs Code of Practice (2013), which sets out more detail around the Government’s plans as follows:

1. Children and young people to be at the heart of the system;
2. Close cooperation between all the services that support children and their families through the joint planning and commissioning of services.
3. Early identification of children and young people with SEND.
4. For children and young people with more complex needs, a coordinated assessment of needs and a new 0 to 25 Education, Health and Care Plan (EHC Plan), for the first time giving new rights and protections to 16-25 year olds in further education and training comparable to those in school. This will replace the current statementing process by 2014.
5. A clear focus on outcomes for children and young people with Education, Health and Care Plans, anticipating the education, health and care support they will need and planning for a clear pathway through education into adulthood, including finding paid employment, living independently and participating in their community.
6. Increased choice, opportunity and control for parents and young people including a greater range of schools and colleges for which they can express a preference and the offer of a personal budget for those with an EHC plan.
7. A clear and easy to understand ‘local offer’ of education, health and social care services to support children and young people with SEND and their families.

HRW CCG is working with the North Yorkshire County Council to support this initiative and our health teams are involved with the working groups to drive this initiative forward.

• **Provide outpatient appointments on a 7 day per week basis as per national directive to improve access and quality of services.** The CCG is currently working closely with STHFT to develop more services which will be available 7 days per week to ensure uniformity of safety and quality across 7 days. This is a complex programme of work involving all specialities and the support services such as diagnostics (e.g. x-ray and pathology). This will therefore form a key element of the development of contractual and business planning for the next two year cycle.
The EIA recommendations in relation to age, suggested that the CCG needed to make older women aware they may be unable to utilise the MLU on the grounds of clinical safety based on the fact that they are higher risk. This has been made clear throughout the public consultation process. Interestingly, the public consultation process found no difference in respondents aged 39 and under and those over 40 in terms of their support for the MLU.

Finally, the EIA recommend the CCG take a number of steps to avoid impact for those affected by deprivation. The following actions were suggested:

- 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.
- Encourage access to services to those living in more deprived areas (e.g. Catterick).

The CCG have completed a travel impact assessment and in summary have concluded:

- A proportion of patients currently travel further to access The Friarage Hospital than their nearest hospital. However if these people accessed their nearest hospital this would reduce their overall travel time.
- If current services are moved from The Friarage Hospital:
  - 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.
  - For patients without access to a car, there will be significant access issues for those living in the Hawes, Reeth and surrounding areas.
  - 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.

The full travel impact assessment can be found in Appendix 13. As a result of the impact of the changes on deprivation, the CCG will implement the following schemes to ensure access, by deprived groups, is not negatively impacted. These are summarised below:

- **Commission from Yorkshire Ambulance Service an additional ambulance to be stationed in Northallerton.** This will ensure a response within 8 minutes for both maternity and paediatric services. This will be carefully monitored during the first 12 months and subject to utilisation will be re-commissioned. This will ensure a dedicated ambulance 24/7 staffed by a Band 6 Paramedic and a Band 3 support. This resource will be utilised to improve access to urgent care for the Northallerton area as well as supporting the MLU to gain most benefit from the investment. The paramedic crew, to ensure value for money, will be based within a Northallerton practice in hours
providing support to local practices, and out of hours will be located in A&E at The Friarage Hospital to support triage and streaming of patients.

- **Commission a shuttle bus between The James Cook University Hospital site and The Friarage Hospital.** This will be available to all patients, patients’ families, friends and visitors and to staff from the hospital. It should also positively impact on concerns raised through the public consultation about parking at The James Cook University Hospital. The CCG will procure a provider once the Governing Body have approved investment. It is proposed that the shuttle bus will run daily between The James Cook University Hospital, Middlesbrough and The Friarage Hospital, Northallerton. There will be 5 x return journeys per day, with the first arriving at The James Cook University Hospital at 9.00am for out-patient appointments, and the last returning to The Friarage Hospital at 5.00pm.

- **A taxi subsidisation scheme.** This will be implemented to support any families with children, who are sent to The James Cook University Hospital A&E by ambulance and are unable to arrange or afford their journey home. This service will operate out of hours only.

In addition, to the new schemes outlined above, the CCG has also launched an innovative scheme, where patients who call 999 but are now deemed to be a medical emergency will be taken to their GP practice. This scheme has been very successful in improving patients care and speed of treatment but also in reducing inappropriate attendances to A&E but also in improving the CCG performance against national targets for ambulance response times. For 6 months the CCG has met the 8 minute response time for 75% of RED 1 (emergency) ambulance calls. This is a vast improvement of over 20% improvement in the last 12 months and ensure compliance to national targets. Patients are also seen and treated more locally by their own GP or out of hours GP, and patients in red emergencies now get a quicker response time, as ambulances are kept in area and therefore are available to respond to the next call.

In addition, the CCG will reduce the impact of deprivation through also providing improved access to local services and this will have the additional benefit of reducing travel implications. This will be achieved in two ways:

1. **Improved access to primary care services** – the CCG will look to improve access to primary care and extend the opening hours and times over the next three years, as part of a phased development programme in line with government strategy to nationally ensure services are 7 days per week and the same in hours as they are out of hours.

2. **Review community paediatric nursing** – The CCG will review paediatric community services and look to develop a 7 day a week service. This will ensure patients receive more services in their own home or local area. This will ensure access to services in the most deprived areas will be improved and should support improved child health.

**Conclusion**
The CCG therefore feels it has met all of the recommendations from the EIA.
7. Assurance Process

The CCG as part of the programme assurance have followed the Secretary of State’s Four Reconfiguration Tests in order to provide internal and external assurance and the evidence is summarised below:

<table>
<thead>
<tr>
<th>Test expectation</th>
<th>Summary of the evidence</th>
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<tbody>
<tr>
<td>Support from Clinical/GP commissioners</td>
<td>The public consultation was led by the CCG working closely with STHFT and other providers and the work has been managed through multi-agency project meetings. HRW CCG have also worked closely with the Clinical Networks and Clinical Senates, neighbouring CCGs and both community services and the Ambulance Trust and there is now widespread support for the reconfiguration. Regular CCG meetings, locality meetings, letters, newsletter articles and social media have been used to ensure all clinical staff and GPs are actively involved and we have had views and engagement from all practices across the locality including the military practices. Both GPs and hospital clinicians are supportive of the clinical proposals developed by the CCG. 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. We have detailed in the Chapter 4 the engagement methods used. GP attendance at CCG Council of Member meetings has been good and all of the Council of Members practices have been contacted to provide an appraisal of each of the options developed. This includes the military practices within our CCG boundary. We have also ensured a Clinical Review Meeting took place, so that we could ensure strong clinical engagement in all of the new options developed through public consultation. This involved both primary and secondary care and CCG Commissioners. All options have also been reviewed independently by NCAT, who have provided advice on the clinical viability of each of the options which emerged from the public consultation. GP practices and the GP Council of Members participated in the option appraisal and final CCG recommendation to Governing Body and a summary of this can be found in Chapter 10.</td>
</tr>
<tr>
<td>Strengthened public and patient engagement &amp; role of LAs</td>
<td>Following the engagement phase, a robust public consultation was undertaken from September to November 2013. This included: - A detailed consultation document and developed an on line public survey - Public meetings all of which were independently chaired for which we developed a DVD which went online so those unable to attend the meeting could access and developed Q&amp;A and factsheets which provided supplementary information - An array of different meeting with interested groups - Community meetings with LA groups, HealthWatch, the Facebook campaign group etc. - Extensive media briefings and radio and TV interviews - Regular briefings with the Overview and Scrutiny Committee of</td>
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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
- Clinical Review Meetings which local authors and local Councillors have attended

All consultation exercises had their consultation and communication plans signed off by the North Yorkshire County Council Overview and Scrutiny Committee and the outcomes of these are reported back. In addition to formal consultations, patient views were sought during the design of each new service for the open access families. We have also briefed Health and Well-Being Boards and attended all Health Overview and Scrutiny Committee meetings.

All outcomes from the referral to the Secretary of State and associated Independent Reconfiguration Panel Review have been fully implemented in order to find a unique solution and to explain to the public during the consultation period why Option 1 from the public engagement phase was not viable.

Finally, we have engaged with the Corporate Director for Adult Social Services and the Assistant Directors of Children’s Services. This has comprised of regular briefings and one to one meetings.

We have detailed all of the public consultation and the key themes within Chapter 4. The outcomes of the feedback have been fed into this report to develop mitigating actions to address concerns raised and these are summarised below:

Maternity
- Choice is important in relation to maternity care; there are different perceptions about the concept of choice relating to location and type of birthing service. Location of services can impact on the choices people make and some feel that moving services further away from where they live is, in effect, restricting their choice.
- Women need to be supported to make informed choices and this will require access to better information about services that are available.
- There is a strongly held perception among many of the women spoken to, that having to travel further to access birthing services increases risk. This perception is often based on personal experiences where the belief is that the outcome of a previous pregnancy would have been different (generally worse) if they had had to be transferred or travel further to access services.
- There are real fears about having to travel longer distances; whether this was known and planned for in advance, or as a result of having to be transferred from one unit to another during labour.
- Women were also concerned about the capacity available at The James Cook University Hospital site
- Generally this time women have been more positive about the concept of a midwifery led unit and we have strongly articulated that centralising services can improve outcomes for mothers-to-be.

Paediatrics
- Accessibility and proximity are important and while people are prepared to travel for expert paediatric help, there is concern that services may not be available locally and this causes particular anxiety for parents of children with complex needs.
- People suggested that we should review paediatric community nursing available to provide expert clinical advice / home visits when a child was ill it could reduce hospital and A & E attendance. Provision of a 7 day
working for PSSAU will support this.

We have developed our preferred option in light of the public feedback in order to find a unique solution to the resolving the issues maternity and paediatrics services face in line with the Independent Reconfiguration Panel feedback.

<table>
<thead>
<tr>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>All decisions around service redesign are related to national evidence and best practice. The CCG has also ensured that a local evidence base has also been established.</td>
</tr>
</tbody>
</table>

In December 2011 NCAT were 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 Trust start a process of public engagement as soon as possible.
- The Commissioners and the Trust consider the consequences for the maternity services at The Friarage Hospital and look to develop a sustainable vision for maternity services on The Friarage Hospital site in keeping with the above conclusions.
- The Commissioners and the Trust, in consultation with the public describe a vision of children’s and maternity services which will be centred at The Friarage Hospital.
- The Commissioners and the 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 The Friarage Hospital and The James Cook University Hospital.
- The Commissioners and the 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 Trust should consider the requirements for parental accommodation at The James Cook University Hospital.
- STHFT 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.

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

STHFT 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.

In addition, following the public consultation we have asked NCAT to complete a desktop review of the new options which have come forward and determine the clinical viability of each. This is summarised in detail in Chapter 5.

<table>
<thead>
<tr>
<th>Consistency with current and prospective choice</th>
</tr>
</thead>
<tbody>
<tr>
<td>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</td>
</tr>
</tbody>
</table>
maintain and enhance their skills. Recruitment and retention will be maximised. This proposal increases choice for patients. Currently patients and families in Hambleton and Richmondshire have a range of local hospitals they can use should they need or wish to opt for a consultant led unit:

- County Durham and Darlington NHS Foundation Trust, Darlington
- York Hospitals NHS Foundation Trust, York
- Harrogate and District NHS Foundation Trust, Harrogate
- South Tees Hospital NHS Foundation Trust, Middlesbrough

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 from the above 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 (although some will also have shorter travel times to their closest provider).

The range of specialist paediatric outpatients at The Friarage Hospital 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.

Conclusion
The CCG are therefore assured that we have been able to fully meet the reconfiguration tests and can provide suitable assurance for NHS England Area Team and for key stakeholders that a robust process has been followed and adhered to.
8. Assessment of the Options to go forward to the GP Council of Members

The CCG has reviewed all of the information contained within the previous chapters to formally assess the viability of each of the options – the two options the CCG has presented and the three options that were received following the public consultation.

Each option has been reviewed against the scoring criteria previously used and outlined in Chapter 3. Summarised below is the assessment of all five of the options against the criteria and this includes an assessment of the risks of each option and associated cost implications.

Option 1 - Provision of a Midwifery Led Unit, Paediatric Short Stay Assessment Unit, Full Paediatric Outpatients and Enhanced Paediatric Community Nursing

This option:

- meets both the clinical safety and sustainability criteria
- was the option overwhelmingly favoured by the public (59 out of the 62 who responded to the specific question)
- will ensure appropriate care can be delivered as close to home as clinically possible.
- ensures compliance with national guidance both now and in the future
- is supported by NCAT
- ensures we are able to continue to utilise The Friarage Hospital in order to deliver services locally.
- ensures STHFT will have the capacity and capability within their workforce to deliver this model of service without the threat of unplanned closures and this will address the issues caused by the recent retirement of a number of local consultants.

The consultation addressed the following:

1. Opening hours of the PSSAU

STHFT have provided a breakdown of the costs for the PSSAU for both 5 days and 7 days. Taking into account the low numbers of children that present as emergencies at weekends, the overall viability of the model is based on consultant working in outpatient clinics whilst also overseeing the PSSAU, and the present Monday to Friday pattern of outpatient services delivered at The Friarage Hospital (and most other hospitals) it is agreed that the present tariff would not cover the cost of operating the unit at weekends. The extra resource required to fund consultants providing a service without the concurrent outpatient clinics will be significant at a cost of circa £266k.

The CCG executive therefore assessed that it is more beneficial to open the unit for 5 days per week but, in line with public opinion, extending the hours from 10am to 10 pm. The CCG will then review future requirements in more paediatric community nursing to cover the weekend period to ensure that local families, especially those with children who have complex needs continue to get access to local services. As more NHS services are delivered on a 7 day footprint including outpatient and diagnostic services in may become possible to extend the opening hours of the unit.
2. **Support for the MLU**
This was well supported as the preferred model of care, and the majority of respondents confirmed that they would use the local MLU.

3. **Ambulance transfer in an emergency**
The CCG felt that in order to commission a safe model of care guaranteed ambulance availability should be provided. A dedicated ambulance will therefore be commissioned and its effectiveness evaluated during the first year.

4. **Sustainability of the MLU**
Positive promotion of the benefits, as well as the limitations of the MLU with GPs, community midwives and the general public will be key to its ongoing success. The CCG is clear however that if the number of births at the unit is low this may threaten the safety and sustainability of the service it delivers and thus its long term viability if numbers fall below 300 per annum. This will be reviewed after 6 months.

5. **Sustainability of PSSAU**
Again positive promotion of the service with local GPs, community nurses and the public will be crucial. If the service is poorly used it is unlikely to be sustainable into the long term. Weekend cover will be reviewed after 6 months.

6. **Developing community children’s services**
Enhancement to the paediatric community nursing service and the PSSAU will support children to be appropriately cared for in their own home and/or assessed and monitored avoiding an overnight admission to hospital in a number of cases. This service will become a seven day a week service allowing interventions such as IV antibiotics, enemas and wound management to be done in the patient’s home. This supports the national direction of travel for more care for children to be delivered in a home setting.

7. **Provision of local outpatient services**
The CCG and STHFT are committed to providing more outpatient services locally and ensuring better use of technologies in line with option 3 received from Andrew Newton. These developments are now included in Option 1 and 2. This is in line with the recommendations of the Independent Reconfiguration Panel which require the CCG to explore a unique solution.

8. **Parking at The James Cook University Hospital**
This was also an issue raised during the Fit 4 the Future CCG engagement on older people’s services undertaken recently. A free shuttle service for all patients, staff, visitors etc. between The Friarage Hospital and The James Cook University Hospital sites will therefore be piloted over the next year. This will help address the issues raised by mothers who may have new born babies in SCBU and may experience difficulty accessing the hospital in Middlesbrough for a prolonged period of time.

9. **Signage to The James Cook University Hospital**
STHF and the CCG accept the suggestion from a member of the public that road signs to the hospital from the south are inadequate and will work with the relevant local authorities to rectify this urgently.

...
In summary, to implement Option 1, there are a number of additional investment areas which will require consideration by the Council of Member. These are summarised in the table below:

**Maternity Services Investment**

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency ambulance services to support maternity, and improve general ambulance availability in the locality</td>
<td>£272,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>£272,000</strong></td>
</tr>
</tbody>
</table>

**Paediatric Services Investment**

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Paediatric Nursing</td>
<td>£60,000</td>
</tr>
<tr>
<td>PSSAU Provision 7 days per week (tariff plus cost due to low levels of activity at the weekends)</td>
<td>£266,000</td>
</tr>
<tr>
<td>Telemedicine for open access families and other paediatric children</td>
<td>£50,000</td>
</tr>
<tr>
<td>Taxi Utilisation for families</td>
<td>£20,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>£396,000</strong></td>
</tr>
</tbody>
</table>

**Additional investment into the HRW CCG area**

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Shuttle Bus (to be utilised for the whole population of HRW CCG and staff)</td>
<td>£67,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>£67,000</strong></td>
</tr>
</tbody>
</table>

The total cost for these services is £735k.

The CCG agrees Option 1 offers the most efficient use of resources in line with national guidance and ensures improved utilisation of staff and a sustainable model for the future, mitigating any associated risks.

If this model is agreed by both the Council of Members and the Governing Body, STHFT has confirmed that they could implement this model within a 6 month timeframe. Further work would need to be completed to finalise local specifications and the acceptance criteria.

**Option 2 - Provision of a Midwifery Led Unit, Paediatric Outpatient Services and Enhanced Paediatric Community Nursing**

This was the alternative option put forward by the CCG and again the option meets both the clinical safety and sustainability criteria but with lower level of appropriate care being delivered close to home.

As with Option 1, this model ensures compliance with national guidance both now and in the future. This model is supported by NCAT and ensures some services
continue to be delivered locally at The Friarage Hospital. It would be simpler to achieve both the current and future standards in relation to paediatric services as these would be able to centralise at JCUH with all paediatric consultants onto one rota both in and out of hours.

Option 2 allows for the development of the Midwifery Led Unit, which as previously noted from the public consultation, the majority of the responding public said they would support.

This model does not allow for local children to be assessed at The Friarage Hospital as there will not be the provision of a PSSAU, rather an urgent outpatient facility without observation beds, where less unwell children can be assessed as outpatients only. This would mean that paediatric consultant cover would remain at The Friarage Hospital for outpatient services only. Whilst this option does support better compliance with the national model, there is some concern from both consultants and the general public that local care will be lost. The CCG is passionate about keeping as many services locally as is safe to do so and therefore; this was not the local GPs preferred model.

It was recognised however, that this model was sustainable for the long-term future but would limit access, and therefore reduce patient acceptability and overall patient experience. This was confirmed in the responses received from the consultation, where the minority of respondents, only 3 out of 62 who answered this question (5% of respondents), confirmed this was their preferred option.

It would also mean that there was redundant space at The Friarage Hospital through removal of the paediatric ward and would not support as well the desire for a sustainable future for The Friarage Hospital.

The CCG has assessed the investment required for this model. The costs are the similar to those outlined in Option 1.

**Maternity Services Investment**

<table>
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<th>Cost</th>
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<tbody>
<tr>
<td>Emergency ambulance services to support maternity, and improve general</td>
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<td><strong>Total</strong></td>
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<td>Community Paediatric Nursing</td>
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<td><strong>Total</strong></td>
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Additional investment into the HRW CCG area

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<td>£67,000</td>
</tr>
<tr>
<td>Total</td>
<td>£67,000</td>
</tr>
</tbody>
</table>

The total cost for these services is £469k.

STHFT has confirmed that they could implement this model within a 6 month timeframe.

Option 3 – Submitted by Andrew Newton

This option was presented by Andrew Newton, who is a father of a child with open access and this option was reviewed independently by NCAT - Appendix 6 and through the Clinical Review Meetings Appendix 10 with representatives from both the CCG and STHFT. NCAT concluded that Andrew Newton’s proposal does not run counter to the two options proposed by the CCG, but would be new service developments and would need to be considered, as part of the annual and strategic business planning. As a result of this option, the new services the CCG will develop include:

- Review of paediatric community nursing
- Improve access to primary care
- Utilisation of telemedicine (video-conferencing between clinician and patient)
- A move towards 7 day a week outpatient services in line with national guidance

All of the options, other than the in-patient paediatric overnight service remaining at The Friarage Hospital, have now been incorporated into Options 1 and 2. The Friarage Hospital cannot, for reasons explained in Chapter 3, have an overnight paediatric in-patient service. NCAT confirmed that they would not support the proposal of an in-patients’ overnight service as a viable option.

Option 4 – Submitted by David Williamson

This option was presented by David Williamson who is a nurse and “Save our Friarage” Facebook Campaigner. As above, this option was also reviewed independently by NCAT and through the Clinical Review Meeting with representatives from both the CCG and STHFT.

NCAT concluded that David Williamson’s proposals cannot be supported on the grounds of clinical safety, due to the clinical risk this introduces through nurses and/or junior level trainees assessing acutely unwell children who could potentially deteriorate.

NCAT also state that they do not believe this option is sustainable and believe that SHOs working unsupervised would be unlikely to have their training approved by the General Medical Council. The present situation (with consultants on call) is
considered to be unsafe thus the proposed change would make matters worse by having consultants at greater distance, albeit over the phone, and could potentially cause more patient safety issues if a child was to suddenly deteriorate. For this reason that the CCG do not feel this is a clinically viable or sustainable option for the future.

Option 5 – submitted by Richmondshire District Council

This option was presented by Richmondshire District Council. As with Options 3 and 4, this option was also reviewed independently by NCAT and through the Clinical Review Meeting with representatives from both the CCG and STHFT. An additional meeting was also held on 27 January 2014 to further review the proposal. NCAT concluded that Richmondshire District Council’s proposal was in essence a consultant led service for both maternity and paediatrics and was not materially different to proposals previously discounted by the CCG during the engagement phase of this service reconfiguration.

Whilst the Council’s paper extensively explored the costs and the different staffing models from around the UK, none of these were deemed to be viable solutions to the staffing and recruitment issues faced by STHFT in order to become compliant to national standards both now and in the future.

Both NCAT and the CCG strongly support the case made by the Council for the more widespread use of Advanced Care Practitioners. These nurses take 3-7 years to train depending on the level at which they work. Had STHFT opted some years ago to develop extended scope nurses to work at a level that would replace junior and middle tier doctors it may have been possible to sustain the service at The Friarage Hospital in the short term. As these nurses are not available within the trust and a fully trained workforce is not available to recruit locally this is not deemed to be a suitable alternative.

Nationally, the drive to improve quality and safety of services for patients will require the wide scale implementation of national guidance which is structured around medical training and availability. Therefore any such model at The Friarage Hospital (and elsewhere) would be short term at best. Most of the units visited are facing the same issues outlined here. However, the CCG will work closely with STHFT to develop the use of extended scope nurses to sustain services at The Friarage Hospital and The James Cook University Hospital as part of their workforce planning.

NHS Health Education North East confirmed there is no real prospect of middle grade training doctors being made available to work at The Friarage Hospital because there is not considered to be adequate exposure to clinical work for training purposes. There are also significant difficulties employing research fellows, non-training grade doctors and locums. In a situation where they would be working alone out of hours with a consultant only on call from home and therefore mostly unsupervised real issues of safety and quality arise – Appendix 4.

NCAT reiterated their support for the CCGs clinical case for change and highlighted that the main concern with maintaining a consultant led model for paediatrics and maternity services was the sustainability, safety and quality of these services. NCAT
therefore do not feel that they can presently support this model which does not meet safety and quality standards.

Richmondshire District Council has suggested this service can be delivered for £200,000 but have provided no detailed evidence to support this. The CCG has requested supplementary information to understand the costs further. We have however received a full breakdown of the costs of a safe and compliant service by STHFT. These have been verified by the CCG financial accountants and contracting teams. The breakdown of these has been provided in the Business Case, produced following the engagement phase, and is available – Appendix 5

The CCG do not feel this is a clinically viable or sustainable option for the future on the grounds of safety, affordability and in terms of meeting national standards.

NCAT have since the meeting confirmed that whilst they strongly supported the employment of ANNP where appropriate they acknowledge the workforce is not available and that it is often a more expensive option than middle grades if employed out of hours, and this would therefore increase the cost beyond the £2.7 million highlighted if the consultant led service was to continue at The Friarage Hospital.

**Risk Assessment of Viable Options**
The CCG executive appraised all of the options, the two original proposals developed after the engagement process and the additional three options from the public consultation, and following advice from NCAT, the CCG believes that the only two viable options to be assessed by the GPs in their practices and then by the Council of Members are Option 1 and Option 2 and we have therefore risk assessed the two options.

The CCG used the risk matrix to identify the risks with each of the options which is included within Appendix 14. It identifies the risks associated with this model. These were reviewed with the Council of Members to ensure all risks had been appropriately assessed. These are summarised in the tables below:

**Identified Risks for Option 1**

<table>
<thead>
<tr>
<th>Risk No.</th>
<th>Key Risks for Option 1</th>
<th>Risk Rating</th>
<th>Mitigation</th>
<th>Risk Rating following mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Risk mothers do not choose to give birth in the MLU</td>
<td>4 x 4 = 16</td>
<td>The provider and the CCG need to actively promote the new service and the benefits to both the public and staff in order for them to make informed decisions.</td>
<td>4 x 3 = 12</td>
</tr>
<tr>
<td>2</td>
<td>Risks related to delay in accessing consultant care for a mother-to-be with changing risk factors or acutely unwell child during their episode of care</td>
<td>5 x 5 = 25</td>
<td>This will be mitigated through clear policies and procedures and effective escorts of midwife with mothers to be on the ambulance, which will</td>
<td>1 x 3 = 3</td>
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<td></td>
<td></td>
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<tr>
<td>---</td>
<td>----------------------------------------------------------------</td>
<td>---</td>
<td>----------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Available bed capacity at James Cook for both maternity, paediatrics and SCBU</td>
<td><em>5 x 5 = 25</em></td>
<td>Assurance provided to the CCG on the bed capacity modelling completed by the provider and that they have worked with other local providers to ensure appropriate levels of resilience are in place.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Risk of referral back to the Secretary of State for Health. The impact of delaying the implementation of the new service models given the impending retirement of local consultants could lead to a temporary closure of the services at The Friarage Hospital.</td>
<td><em>3 x 5 = 15</em></td>
<td>The CCG has completed a robust engagement and public consultation and there is no further work the CCG can now do on this. We will continue to work closely with OSC and North Yorkshire County Council and hope to avoid this risk. The risk of judicial review remains.</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>PSSAU recruitment and retention of staff</td>
<td><em>3 x 3 = 9</em></td>
<td>Clear recruitment plans and detailed future workforce plan to be developed by STHFT. Develop the future role of nursing teams to be able to support tier 1 and tier 2 rota.</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Compliance to new national standards post 2014</td>
<td><em>3 x 4 = 12</em></td>
<td>The centralisation of paediatric and maternity services strengthens the move towards compliance with national standards.</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Public understanding to make informed decisions and choices</td>
<td><em>4 x 3 = 12</em></td>
<td>Strong communication around the new services, pathways of care and support available to signpost patients from GPs and NHS 111.</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Primary care understanding of new pathways and their role as gatekeeper to secondary care</td>
<td><em>4 x 3 = 12</em></td>
<td>Strong communication around the new services, pathways of care and utilisation of practice development</td>
<td></td>
</tr>
</tbody>
</table>
## Identified Risks for Option 2

<table>
<thead>
<tr>
<th>Risk No.</th>
<th>Key Risks</th>
<th>Risk Rating</th>
<th>Mitigation</th>
<th>Risk Rating following mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Risk mothers do not choose to give birth in the MLU</td>
<td>4 x 4 = 16</td>
<td>The provider and the CCG need to actively promote the new service and the benefits to both the public and staff in order for them to make informed decisions.</td>
<td>4 x 3 = 12</td>
</tr>
<tr>
<td>2</td>
<td>Risks related to delay in accessing consultant care for a mother-to-be with changing risk factors</td>
<td>5 x 5 = 25</td>
<td>This will be mitigated through clear policies and procedures and effective escorts of midwife with mothers to be on the ambulance, which will be on standby and dedicated to The Friarage Hospital on a 24/7 basis.</td>
<td>1 x 3 = 3</td>
</tr>
<tr>
<td>3</td>
<td>Available bed capacity at James Cook for both maternity, paediatrics and</td>
<td>5 x 5 = 25</td>
<td>Assurance provided to the CCG on the bed capacity</td>
<td>2 x 3 = 6</td>
</tr>
<tr>
<td>#</td>
<td>Description</td>
<td>Points</td>
<td>Details</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>------------------------------------------------------------------------------</td>
<td>--------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Risk of referral back to the Secretary of State for Health. The impact of delaying the implementation of the new service models given the impending retirement of local consultants could lead to a temporary closure of the services at The Friarage Hospital.</td>
<td>3 x 5 = 15</td>
<td>The CCG has completed a robust engagement and public consultation and there is no further work the CCG can now do on this. We will continue to work closely with OSC and North Yorkshire County Council and hope to avoid this risk. The risk of judicial review remains.</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Paediatric access for the local population including those living in deprivation</td>
<td>5 x 5 = 25</td>
<td>Ensure improved access to primary care, NHS 111, community services and enhanced paediatric outpatients.</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Compliance to new national standards post 2014</td>
<td>3 x 4 = 12</td>
<td>The centralisation of paediatric and maternity services strengthens the move towards compliance with national standards.</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Public understanding to make informed decisions and choices</td>
<td>4 x 3 = 12</td>
<td>Strong communication around the new services, pathways of care and support available to signpost patients from GPs and NHS 111.</td>
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<td>8</td>
<td>Primary care understanding of new pathways and their role as gatekeeper to secondary care</td>
<td>4 x 3 = 12</td>
<td>Strong communication around the new services, pathways of care and utilisation of practice development events to focus on referral process and new service models. CCG monitor and audit appropriateness of referrals and provide further education as appropriate.</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>PSSAU acceptance criteria</td>
<td></td>
<td>Ensure clear</td>
<td></td>
</tr>
<tr>
<td>Score</td>
<td>Problem Description</td>
<td>Action 1</td>
<td>Action 2</td>
<td>Score</td>
</tr>
<tr>
<td>-------</td>
<td>------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>7</td>
<td>4 x 3 = 12</td>
<td>Ensure robust contract management and audit of activity and costs.</td>
<td>Ensure patient and GP feedback on the new service models.</td>
<td>4 x 2 = 8</td>
</tr>
<tr>
<td>10</td>
<td>Public perception is there is no long term strategy for The Friarage Hospital and therefore it becomes harder to recruit and support.</td>
<td>Develop further public engagement around the future of The Friarage Hospital</td>
<td></td>
<td>2 x 2 = 4</td>
</tr>
</tbody>
</table>
9. Extra-ordinary Council of Members (CoM) Meeting

The CCG is made up of 22 constituent GP practices. The decision making process is described within the Constitution and has been agreed by all practices. The GPs decided it was appropriate that the decision about Paediatric and Maternity at The Friarage Hospital should be made by all practices through the Council of Members and ratified by the Governing Body rather than delegating the responsibility to the Governing Body alone.

Each practice has one CoM representative and one vote irrespective of the practice size. Physical attendance at a meeting is not required to vote. Practices are required to respond when a vote is required. This may consist of a positive or negative response or if necessary e.g. where there is a conflict of interests, the practice may report that it abstains from voting. For a vote to be positive there must be a majority amongst the practices who voted i.e. 51%.

GP Council members unable to attend were contacted in order to check their acceptability of the outcome and any feedback they wished to share. The CoM used the appraisal criteria detailed below to evaluate each option. It should be noted this is the same criteria the CCG used to evaluate the options at the conclusion of the engagement phase.

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Criteria 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>

The criteria were weighted using a ‘weighted pair’s model’ where each criteria is given a relative score of importance compared to the criteria above scores 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.

The CCG also develop three filter questions, using the criteria already agreed, to explicitly articulate the minimum criteria required for inclusion.

Safety of any service is the most important issue, meeting nationally prescribed standards is key to an assessment of the fundamental safety of any model proposed. 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 as close to
home as possible should be dismissed. The following filter questions were developed and agreed at the meeting.

**Filter Questions and Scoring System**

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

---

The option meets minimum safety requirements?  
- Yes  
- No  
  - Record why not  
  - Reject

The option is sustainable?  
- Yes

The option provides care close to home where clinically appropriate?  
- Yes  
  - Full option appraisal
On January 23 2014, prior to the extra-ordinary CoM meeting the CCG sent to each of the practices a suite of documents explaining all the options, outlining the additional options and information relating to the investment requirements and the decision making criteria. All additional options received were provided in full to the practices.

They also received a template to return to the CCG or to bring to the CoM meeting on February 7 2014 which they were required to complete in their practices in discussion with their practice teams for their scores for each option.

The meeting was chaired by Henry Cronin, HRW CCG Chair and both the military practices and HealthWatch attended the meeting, along with the other CCG practices. In order to ensure transparency in the process the 7 February 2014 Council of Members meeting was recorded/videoed and a full transcript of the meeting has been made available in Appendix 10 and the video can be watched via the CCG website.

Prior to scoring the options, the practices were asked:

*Was the practice in agreement with the decision making process?*

*and*

*Did the option meet the requirements of the filter questions and therefore was eligible for scoring?*

Thirteen of the twenty-two member practices attended the meeting, no practices delegated authority to another practice. Nine practices provided written submission only. Seventeen practices formally scored the options.

GP Council Members agreed with the prioritisation process and agreed to score the two options the CCG had previously shortlisted. As this was a unanimous decision by the Council of Members, they did not score options 3-5.

59% of GP Council Members were present at the meeting. The scores from the practices present were then combined with the postal returns from each practice who did not attend the meeting. The total weighted scores are summarised in the table below. The preferred option voted for by the Council of Members was option one which 21 practices agreed was their preferred option. There was a strong differential in the weighted criteria score between option one and option two. For option two scored lowest for patient safety and experience, access and cost effectiveness.

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Weighted Score for Each Option</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Option 1</td>
</tr>
<tr>
<td>Patient Safety</td>
<td>17.6</td>
</tr>
<tr>
<td>Affordability</td>
<td>14.56</td>
</tr>
<tr>
<td>Clinical Effectiveness</td>
<td>17.1</td>
</tr>
<tr>
<td>Patient Experience</td>
<td>13.26</td>
</tr>
<tr>
<td>Sustainability</td>
<td>16.35</td>
</tr>
</tbody>
</table>
Below is a summary of the key points raised relating to each of the options discussed and the votes taken for investment areas:

<table>
<thead>
<tr>
<th>Key themes</th>
<th>Commentary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decision making criteria</td>
<td>The CoM Representatives felt it was important to retain the same criteria that had been used for the previous decisions for the options appraisal.</td>
</tr>
<tr>
<td>Filter questions</td>
<td>The CoM Representatives felt that the filter questions need to be applied to options 3, 4 and 5 and therefore these options should not be scored. There was a further discussion about whether option 2 met the care close to home criteria. However, the overall view was it did and should be scored, as it did retain care close to home for midwifery services.</td>
</tr>
<tr>
<td>Care close to home</td>
<td>The CoM Representatives felt care close to home was important and they felt strongly they wanted to ensure safe local services were maintained wherever they could be.</td>
</tr>
<tr>
<td>Richmondshire District Council (RDC) Proposal</td>
<td>The CoM representatives raised concerns about the viability of the Richmondshire District Council proposal which was not thought to be financially viable and realistic in terms of taking away patient choice, in a time when the NHS Constitution is looking to enhance choice for patients. It was also thought choice would be further extended as for many patients in Richmondshire, County Durham and Darlington NHS Foundation Trust is closer. Local CCGs wanted choice to continue to be offered and all local providers have confirmed they will be able to cope with increased demand. Supporting letters are included in Appendix 4. CoM Representatives supported the CCG is their approach to adhered to the Royal Colleges guidance.</td>
</tr>
<tr>
<td>PSSAU consistency in model and investment PSSAU for 7 day working</td>
<td>The CCG Executive made a working assumption that the preferred option from the public consultation and based on weekend activity volumes would be for a five day service 9am to 9pm. The GPs discussed this at length at the meeting and felt that greater benefit would be had if the opening hours moved to 10am to 10pm and that it would be better to offer a service to local patients seven days per week. The CoM Representatives felt that it would be inappropriate to commission a different model of service during the week than at weekends as this could</td>
</tr>
</tbody>
</table>
lead to confusion for local families. They also did not feel this was in line with the national drive towards 7 days working and that as commissioners the CCG needed to ensure the long term approach fitted with national context. They were therefore not in favour of the model presented which were centred on a five days service. South Tees Hospitals NHS Foundation Trust had proposed the activity was so low there was no justification for 7 day working. The CoM Representatives also did not feel the CCG could base the service decision on historical activity alone but that it was better to commence with the 7 day opening and then review use after 6-12 months.

Due to the decision to make the PSSAU 7 days the CoM Representatives did not feel a community paediatric nursing service was required for weekends.

Further discussion was had about why South Tees Hospitals NHS Foundation Trust had not previously enhanced their tier 1 and 2 provision to ensure a sustainable local model.

There was a discussion that the CCG needed to monitor the investment made over and above tariff, to ensure if activity increased they were not paying twice. It was suggested the CCG Contracting Team needed to carefully monitor this in an open book way with South Tees Hospitals NHS Foundation Trust, based on an agreed activity level.

The consensus of discussion therefore was for a 7 day service, open 10am to 10pm.

CoM Vote – 21/22 practices voted for this investment (met the 51% majority)

Emergency Ambulance Investment

The CoM Representatives thought it was a lot of money for the CCG to invest when there was no evidence of need and that YAS should be able to respond within the national targets for ambulance response times and within current resources.

The Chair and Clinical Chief Officer confirmed the public had expressed their concerns strongly during the public consultation and that as such we needed to listen to their views. The ambulance would be able to respond rapidly if a mum-to-be required urgent transfer to The James Cook University Hospital. They also confirmed that YAS did not feel able to guarantee the responses times given their current performance and as such this had caused the temporary closure of Bishop Auckland MLU. The CCG felt the only way to provide a safe MLU locally was if we could guarantee the response times and the only way to guarantee the response times was to provide further investment.

The CoM Representatives discussed how this staffing resource could be used to ensure better local health services. The CCG executive explained the ambulance paramedics would be used in local practices during working hours and out of hours to support clinical staff in A&E and Out of Hours GP based in The Friarage Hospital. The ambulance will also be available for local calls within agreed postcodes. This investment would therefore strengthen urgent care responsiveness in the locality as well as providing a service to the MLU.

The general consensus was this should therefore be approved and also monitored after 6 months to review performance and benefits in order to review at 12 months. Therefore the MLU/YAS will need to track transfers and staff utilisation. The CoM Representatives therefore agreed to fund.
<table>
<thead>
<tr>
<th>CoM Vote – 17/22 practices voted for this investment (met the 51% majority)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Shuttle Bus providing transfer between The James Cook University Hospital and The Friarage Hospital</strong></td>
</tr>
<tr>
<td>The CoM Representatives initially felt the CCG should not invest in the shuttle bus service. They felt the provider trust should be responsible for funding this service and that they could explore cost savings and internal efficiencies as a result.</td>
</tr>
<tr>
<td>The Chair outlined the financial pressure the trust are facing and confirmed the CCG were prepared to share the cost (50/50) with the trust.</td>
</tr>
<tr>
<td>The CCG confirmed this would be beneficial to all patients, carers and the local workforce. Transport to The James Cook University Hospital was expressed as a concern by the public through the Fit 4 the Future programme (CCG consultation on elderly care across the three localities). The CoM Representatives felt that this cost should not be attributed solely against this project as it would benefit all specialities not just paediatrics and maternity.</td>
</tr>
<tr>
<td>One of the CoM Representatives suggested the bus should not be free of charge but given car parking charges at The Friarage hospital it was felt this would mean patients are charged twice and the meeting felt this was unfair.</td>
</tr>
<tr>
<td>The CoM Representatives therefore agreed a 50/50 cost share of the shuttle bus between the CCG and South Tees Hospitals NHS Foundation Trust and that this should be reviewed along with the emergency ambulance trust 6 months after the service has been operational.</td>
</tr>
<tr>
<td><strong>CoM Vote 18/22 practices voted for this investment (met the 51% majority)</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Taxi Utilisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>There was some discussion as to whether it was fair and equitable to only apply this to paediatrics and whether it should be rolled out to all specialities. CoM representatives asked if the CCG had done costs for all specialities. The CCG confirmed this was only for out of hours and for those with exceptional circumstances. The CCG said it would be too difficult to estimate costs for all specialities and that they did not have these. The CCG had done this specifically as a result of health inequalities faced by this cohort of patients (paediatrics). It was agreed if this was successful and utilised; the CCG would review whether it was appropriate to expand to other specialities.</td>
</tr>
<tr>
<td><strong>CoM Vote - 21/22 practices voted for this investment (met the 51% majority)</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Telem medicine</th>
</tr>
</thead>
<tbody>
<tr>
<td>CoM representatives stated that the money for telemedicine investment was equivalent to a whole time additional nurse and it was felt this would be more useful. They therefore voted against the investment in telemedicine.</td>
</tr>
<tr>
<td><strong>CoM Vote – 3/22 practices voted for this investment (not met the 51% majority)</strong></td>
</tr>
<tr>
<td>Whilst the CoM representatives did not vote in favour of the telemedicine investment, the CCG has a separate workstream relating to ‘Improving quality through the use of technologies’ and this work will be taken forward under this workstream and the investment will come from the Better Care Fund but it will not be a specific investment for paediatrics alone.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Safety of the Midwifery Led Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>One CoM representatives also queried the overall safety record of MLU and raised a question of whether it was safe to commission an MLU and what...</td>
</tr>
</tbody>
</table>
evidence was there to substantiate this.

The Clinical Chief Officer highlighted a recent report, Birthplace Study which looked at 65,000 births in both consultant led and midwifery units and found no difference in safety standards. The CCG shared this report with practices after the meeting.

| Additional options | CoM representatives were asked if they had further comments to make in relation to the other options submitted and no further comments were made. |

A table summarising the scores and votes by practice can be found in Appendix 15.

**Conclusion**

The recommendation to the CCG Governing Body is to approve Option 1 (the CCG Preferred Option), which provides a service model based on a PSSAU and midwifery led unit at The Friarage Hospital, Northallerton, underpinned by additional transport investment. This option has been further developed as a result of the public consultation, CoM feedback and the additional options received. The amended investment based on Council of Members feedback to support the delivery of Option 1 is therefore:

**Paediatric Services Investment**

<table>
<thead>
<tr>
<th>Service</th>
<th>FYE Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSSAU Provision 7 days per week – 10am to 10pm</td>
<td>£266,000</td>
</tr>
<tr>
<td>Taxi Utilisation for families</td>
<td>£20,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>£286,000</strong></td>
</tr>
</tbody>
</table>

**Additional investment into the HRW CCG area**

<table>
<thead>
<tr>
<th>Service</th>
<th>FYE Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency ambulance services to support maternity, and improve general ambulance availability in the locality which provides enhanced local services in primary care and in A&amp;E out of hours to support Out of Hours GPs. This will ensure a Band 6 paramedic and Band 3 on a 24/7 basis. Additional funding to support this initiative is also coming from the Better Care Fund (£78,000).</td>
<td>£272,000</td>
</tr>
<tr>
<td>Community Shuttle Bus (to be utilised for the whole population of HRW CCG and staff and is based on part share with South Tees Hospitals NHS Foundation Trust)</td>
<td>£67,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>£339,000</strong></td>
</tr>
</tbody>
</table>

The Governing Body are therefore asked to approve an additional investment of £625,000 overall, broken down by £286,000 investment in paediatrics and £339,000 to support the local population for Hambleton and Richmondshire.

**Next steps and Implementation**

The following next steps have been identified by the project team:
• Feedback of the findings and distribution of this report to key stakeholder Boards and Committees including; NHS South Tees CCG, NHS England Area Team, Overview and Scrutiny Committees, Council of Members, Health & Wellbeing Board, Children, Young People & Maternity Programme Board, Children’s Trust Executive Group (March 2014 – April 2014).

• Feedback to all other stakeholders including the public in a range of appropriate formats (March 2014 – April 2014).

• Feedback to all maternity services providers on decisions relating to existing service provision with a view to the development of service improvement plan (March 2014).

• Finalisation of Paediatric and Maternity Services Specification including acceptance criteria etc. (March – April 2014).

• Implementation planning in order to deliver the service changes with main providers and the Ambulance Trust (April – October 2014)

• Development of the specification and tender for the community shuttle bus service (April – September 2014)

**Potential future risk and legal challenge**

The CCG recognise that there remains a significant risk of referral to The Independent Reconfiguration Panel or to Judicial Review. Any referral will need to be made within a three month timeframe from the date that the CCG Governing Body makes the decision (i.e. 27 February 2014). The most significant risk the CCG faces from any referral is that we could be restricted from implementing the future proposals. The CCG therefore have to acknowledge this heightens the risk of a temporary closure of The Friarage Hospital’s maternity and/or paediatric service, due to the availability of consultant and other medical staffing.

Whilst the CCG and STHFT will do everything to avoid this situation occurring, it remains a real risk. The CCG has therefore scored this risk on our risk register as a risk level of 25 (5 x 5) using the CCG’s scoring mechanism. There are no further mitigating actions the CCG can take at this stage.
10. Key Learnings to Date

HRW CCG has had significant learning from the reconfiguration of maternity and paediatric services process and these are summarised below:

Strengths

1. Engaging with the public raises the profile of the local NHS and allows the dissemination of wider positive messages.
2. Joint work with local providers strengthens relationships between doctors, nurses and managers working in the hospital and the community fostering cooperation on other pieces of work to improve the patient experience of care.
3. Rigorous attention to the detail of the process requirements and reports.
4. Development of strong relationship with OSCs and local and national politicians.
5. The consultation events:
   • Presentations and the use of DVD at the public consultation events
   • Consultation document – clear and readable and in plain English
   • Format of the meeting was well structured and independently chaired.
   • Everyone had the opportunity to ask lots of questions and engage with the local clinicians from primary care and secondary care who were on the panel
   • Group discussion with vulnerable groups such as the open access families

The CCG would improve the process by:

1. Require a detailed business case which included costs, activity, workforce plans to be presented to the Governing Body and key questions answered at an initial stage.
2. Ensuring a consistent, resourced and robust project management team throughout the whole process.
3. Developing more realistic timescales acknowledging that working across organisations slows progress but is essential.
4. The CCG needs to review its Constitution to ensure key decisions are made available to the public as is the case with Governing Body Meetings.
5. Improving the consultation:
   • Involve a broader range of GPs in the public meetings.
   • Ensure clear and consistent branding of all materials, names of services, and locations.
   • Consider further options to improve public and patient attendance and response rates:
     o more intensive engagement of clinical teams locally to promote the event
     o door-drops
     o engagement events at individual GP practices
     o banner signage at key sites
     o phone questionnaires
   • Consider (when appropriate) involving more Governing Body lay members in public meetings – members of the public appreciate their attendance and being given the opportunity to ask them questions.
• Ensure sufficient time is allowed for not only the production of all documentation but also for appropriate cross-organisational review and time for changes to timelines from referrals to IRP etc.
• Encourage more senior involvement and attendance from other NHS providers where applicable, and encourage them to participate in debate when appropriate.
• Ensure all the senior team have undergone media training.
## Appendices

<table>
<thead>
<tr>
<th>Appendix</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix 1</td>
<td>Additional Options following Public Consultation</td>
</tr>
<tr>
<td>Appendix 2</td>
<td>Health Needs Assessment and Activity Modelling for Maternity and Paediatrics</td>
</tr>
<tr>
<td>Appendix 3</td>
<td>Public Consultation Document and Fact Sheets</td>
</tr>
</tbody>
</table>
| Appendix 4 | Correspondence from other NHS Bodies during the consultation period  
  - NHS Deanery for Paediatrics for Health Education North East letter  
  - NHS Regional Analytics Team at NHS England letter  
  - NHS Grampian letter  
  - South Tees Clinical Commissioning Group letter  
  - County Durham & Darlington NHS Foundation Trust letter  
  - York Hospitals Foundation Trust letter  
  - Harrogate & District Foundation Trust letter |
| Appendix 5 | Proposed Reconfiguration Business Case |
| Appendix 6 | NCAT Reports |
| Appendix 7 | Public Engagement Phase Report |
| Appendix 8 | Communications and Engagement Strategy |
| Appendix 9 | Public Consultation Feedback Report |
| Appendix 10 | Clinical Review Meetings and Council of Members Meeting Transcripts |
| Appendix 11 | Response letters to authors of additional options |
| Appendix 12 | Equality Impact Assessment |
| Appendix 13 | Travel Impact Assessment |
| Appendix 14 | CCG Risk Matrix |
| Appendix 15 | Council of Members Voting Summary |