NHS
Hambleton, Richmondshire and Whitby
Clinical Commissioning Group

A consultation on proposals for building a sustainable future for the Friarage Hospital in Northallerton –

a summary case

North Yorkshire Clinical Commissioning Groups

1. Introduction

The Friarage Hospital has been at the centre of healthcare in Hambleton and Richmondshire since the inception of the NHS in 1948. It is a much loved and highly valued local asset and we want it to remain so for many years to come. To enable that, we have developed a vision for the future of the Friarage Hospital that will ensure the sustainability of services for the next ten to fifteen years.

We would like to know the public's views on our vision. We would also like your views on options for urgent and emergency care which will ensure services to be safely and sustainably provided in the future.

We have identified two preferred options for these services and would like your views on these alongside any alternatives. All suggested models will be considered using the same criteria and your views will help to inform our decision making.

This document sets out our vision for the Friarage Hospital and contains the proposals for sustainable and deliverable service reconfiguration which the CCG believes would secure valuable local hospital services for the population of Hambleton and Richmondshire.

Hambleton, Richmondshire and Whitby Clinical Commissioning Group (HRW CCG) is responsible for buying (commissioning) the majority of healthcare services received by its population, including those delivered from the Friarage Hospital in Northallerton. Ensuring people receive the best possible care within the resources available is a complex task and HRW CCG is committed to undertaking this in partnership with patients, carers, other local stakeholders and partner organisations. Specifically we are working with colleagues across North Yorkshire and the Tees Valley to ensure our services are complementary and to build the capacity and wider resilience of services of our system as a whole.

The CCG is statutorily responsible for public consultation on proposed service change. We have a specific role in planning service change and any proposals for significant change must be carried out in line with the requirements for major service change set out in s.13Q NHS Act 2006 (as amended by the Health and Social Care Act 2012) for NHS England and s.14Z2 NHS Act 2006 for CCGs.

We are undertaking this process because it is our job to commission services that are "Fit 4 the Future" clinically and financially, reflect the views of patients, public and clinicians wherever possible and deliver the needs of our population within the resources that are available.

Our structure means that we are accountable to NHS England and our Council of Members which is made up of GP representatives from our 22 local GP practices. The Council of Members sets the strategy for the CCG; and the Governing Body, which includes clinical and lay representation, makes decisions based on recommendations.

2. Strategic context

The Friarage Hospital is managed by South Tees Hospitals NHS Foundation Trust (the Trust). The Trust has two main hospital sites: The James Cook University Hospital in Middlesbrough provides a major trauma centre and specialist services, whilst the Friarage Hospital in Northallerton offers local 'district general hospital' services. The Trust has three other community hospitals and provides a range of acute and community services in local settings including patients' own homes. The Trust provides health care to a population of 435,000, which extends to a 1.5 million population catchment area for its more specialist services.

The Friarage Hospital is one of the smallest district general hospitals in the country, serving a rural population of around 144,000 across Hambleton and Richmondshire. Services provided from the Friarage Hospital include ambulatory emergency care, inpatient, day treatment and outpatient services in a wide range of specialisms including infectious diseases, diabetes, respiratory medicine, oncology, rheumatology, pain, orthopaedics, urology, general surgery, breast surgery, gastroenterology, a midwifery-led birth unit and short-stay paediatric assessment unit, and a wide range of diagnostics and support functions.

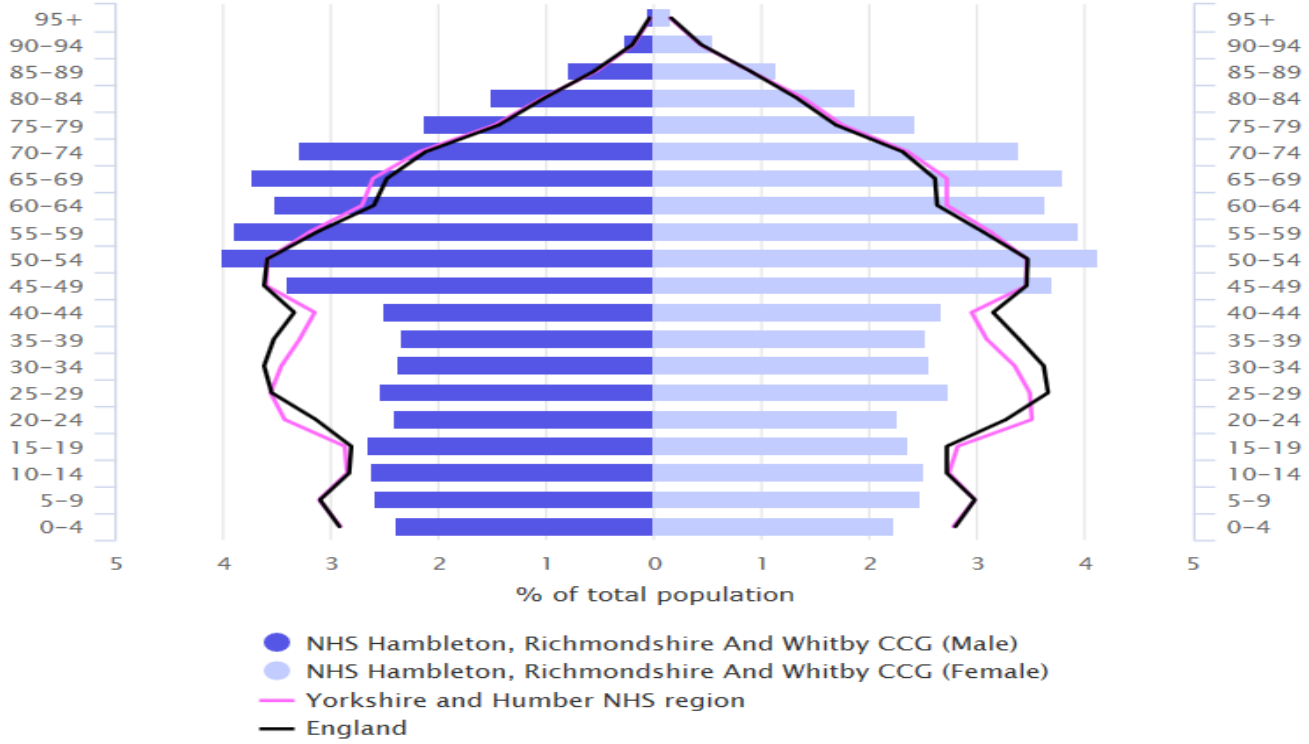
Until recently, the Friarage Hospital also provided an accident and emergency department (A&E) for adults and a minor injury unit for children, and a small critical care unit (3-6 beds). As a result of temporary changes in place since March 2019, the A&E is currently running as an urgent treatment centre (UTC) for adults and children, and there is no critical care unit on site. Some surgical procedures and clinical conditions require co-location with critical care provision and therefore, since March 2019, these have no longer been provided at the Friarage Hospital. This includes colorectal surgery, all emergency surgery, higher risk patients and medically unwell patients who would benefit from intensive care.

The Friarage Hospital has seen a number of service developments and investment over the last 15 years, with money from HRW CCG and the Friends of the Friarage charity supplementing hospital Trust investment at the site. Recent developments include the expansion of radiology services following the opening of the new MRI scanner and a multi-million pound cancer redevelopment in partnership with Macmillan Cancer Support and Sir Robert Ogden which opened in December 2018.

The catchment area for the Friarage Hospital covers 1,000 square miles. Outside of urban areas and market towns, Hambleton, Richmondshire and Whitby is sparsely populated with 70.6 per cent of the population living in rural areas and 15.3 per cent of the population living in areas which are defined as super sparse (less than 50 persons/km). Hambleton is a large, mainly rural district, running from York in the south to Darlington in the north. Approximately 10 per cent falls within the North York Moors National Park. There are five market towns – Bedale, Easingwold, Northallerton, Stokesley and Thirsk – and 130 villages. Just over half of the population live outside of the market towns and population density is one of the lowest in the country. Richmondshire is one of the largest districts in England, covering an area of just over 500 square miles (1,319 square kilometres), two thirds of which is in the Yorkshire Dales. The main population centres include Richmond, Catterick Garrison, Leyburn, Hawes and Reeth.

Hambleton and Richmondshire districts are both seeing significant housing and population expansion – current and planned – with approximately 10,000 new residences expected to be built across the area in the next five years. Catterick Garrison, in line with the Ministry of Defence's Army 2020 rebasing plan, is expected to become the third largest town in North Yorkshire by 2024. Therefore, a significant part of our future planning for the Friarage Hospital is to ensure that care can also be provided to our newly expanded populations. The total number of patients registered to practices within the HRW CCG area is approximately 144,000. The resident population is forecast to be 152,900 by 2025 (0.1 per cent change since 2018) and 151,500 by 2040 (1.1 per cent change since 2018). Much of the population is healthy and well. However, the effect of isolation is a major challenge across a rural and sparsely populated area and is an issue frequently raised by service users and carers.

Life expectancy at birth is 80.9 years for men and 84.2 years for women, both above the national average. Life expectancy varies for men and women considerably across North Yorkshire (between the most affluent and the most deprived).



Age Profile – GP registered population by sex and five-year age band 2017

The population profile in the HRW CCG area is markedly different to England. In essence, there are higher numbers of people aged in their 50s and over, compared to the England average. The higher proportion of older people in the HRW CCG area means there is higher demand for services and a requirement for the CCG to ensure it is appropriately commissioning services that are fit for an ageing population.

HRW CCG is also expecting:

- The number of people in Richmondshire District aged 65 and over to increase from 9,200 to around 12,300 by 2021
- The number of people in Hambleton District aged 65 and over to increase from 19,400 to around 25,400 by 2021

3. Population health needs

The Joint Strategic Needs Assessment (JSNA) for North Yorkshire brings together local authorities, community and voluntary sector service users and NHS partners in research to show a comprehensive picture of local health and wellbeing needs. While our population benefits from health outcomes that are better than the national average in many areas, it is recognised that age is directly linked to the prevalence of long-term conditions, such as heart disease, diabetes, chronic obstructive pulmonary disease and dementia. As people get older, they are increasingly likely to have at least one long-term condition, with many having to manage several conditions at the same time. In addition, frailty is increasingly recognised as an important health and social care issue. Particularly in those patients who are over 85 years old, frailty makes people more vulnerable to falls, more at-risk of an admission to hospital and less able to recover after a crisis or episode of ill-health.

The rate of emergency admissions for acute conditions that should not usually require hospital admission is higher for HRW CCG when compared to the national rate (1,446 per 100,000 locally compared to 1,273 per 100,000 population nationally). The gap between the CCG rate and the national rate is widening, from 62 per 100,000 in 2011/12 to 174 per 100,000 in 2014/15 (JSNA Annual Report 2016).

Our CCG's 'care closer to home' vision builds on the findings from the JSNA which recognises the need to develop "versatile and flexible local responses and services" and plan for increasing numbers of older people with more intensive needs. In order to achieve this vision it is acknowledged that there is a need to strengthen services for prevention and provision of care close to home as an alternative to continually investing in acute (hospital) services. HRW CCG, together with partners, has worked over the last three years to realise the vision of "care closer to home" through transformed community services. Community beds and local services are embedded within communities and health and social care teams are now more aligned to GP practices to better support the local population in a more integrated way. The introduction of new pathways for end-of-life care and discharge from hospital means people have more choice to be cared for in their own homes or local communities.

4. Case for change

The case for change has the following elements:

- The medical workforce challenge - to provide safe sustainable services

- The population challenge - the need to shape services to support a growing elderly population with complex health needs
- The hospital configuration challenge – meeting the needs of specialist hospital medicine to improve health outcomes

The workforce challenge

Workforce recruitment challenges and changes in medical education are making it increasingly difficult to safely staff emergency services at the Friarage Hospital. There are national shortages of doctors in many specialties including anaesthesia and emergency medicine and also changes in the European and global recruitment market. Medical education reforms have led to increasing specialisation, fewer doctors in non-training "staff" posts, and stipulate that doctors in training need to experience the full range of clinical scenarios. The case for change highlights particular workforce and clinical challenges faced by the Friarage Hospital.

- The Friarage Accident and Emergency department (A&E) is not accredited for training doctors and does not accept specifically identified more serious clinical emergencies. Achieving the required standards identified by the Royal Colleges to allow training doctors to achieve this appears very difficult if not impossible.
- In 2016 the Friarage Hospital lost its accreditation for training doctors in anaesthesia.
- The critical care unit at the Friarage Hospital has previously been run by consultants in anaesthesia with skills in critical care. Intensive Care Medicine has developed into a speciality in its own right, requiring clinicians with specialist training. Such individuals are not available in sufficient numbers to maintain an effective rota at the Friarage Hospital.
- The increasing need to support effective medical care for the growing older population requires a workforce skilled in managing the frail elderly and those with multiple health conditions. Such a workforce is being developed at the Friarage Hospital, but achieving sustainability requires a clear vision for the future Friarage model.

South Tees Hospitals NHS Foundation Trust has carried out extensive recruitment drives to fill staffing gaps in the most challenged specialities. Despite these efforts, achieving staffing numbers to meet the required standards of safe and sustainable rotas in the areas above has proven difficult. Such difficulties reached crisis point in the early part of 2019 when the medical rota covering the Friarage Critical Care Unit could no longer be maintained. Consequently, the Critical Care Unit at the Friarage

Hospital could not safely remain open. This led to changes to the A&E department, emergency admissions and some planned surgery in order to ensure patient safety without a critical care unit on site (due to essential clinical co-dependencies).

The workforce challenge is not unique to the Friarage Hospital or the Trust. In the North East of England 26 per cent of Emergency Medicine Consultant posts remain unfilled. Only half of the training posts in Anaesthesia are filled in Yorkshire and the Humber, with the North East only slightly better at 67 per cent (RCoA, 2017). Wider socio-economic factors have driven changes to the medical workforce, such as the reported reduction in the number of doctors operating in the NHS who were trained in the Indian subcontinent (NHS 2018). Furthermore, the way the medical workforce is managed has changed significantly over the last 15 years. In particular the NHS has had to absorb, firstly, the impact of the European Working Time Directive (2003), with doctors working a maximum of 48 hours per week, leading to a requirement for more doctors, and secondly, the shift in medical workforce from generalists to specialists, as has been seen in Critical Care and Anaesthetics.

Although the Trust has attempted to manage gaps in rotas with locum and agency staff, this is recognised to be only a temporary solution. In the event that staffing gaps become too large, the Trust would be required to close the Friarage Hospital to admissions, an eventuality which all parties would see as undesirable and something that should occur only in extreme situations.

This has meant the Trust had to find alternative ways of providing the services with safe staffing levels, for example in the emergency department, the critical care unit and developing a model of emergency medicine consistent with delivering good health outcomes. Continuing with the previously existing healthcare models in the unit, without the required workforce is considered impossible. There is evidence that when a coherent model is developed and clearly articulated to the medical community a sustainable workforce and service model is achievable.

The population challenge

Though many people in Hambleton and Richmondshire enjoy good health, many will be living longer with more long-term conditions and experiencing and often living with frailty. Care should be as close to home as possible to help these people stay well and independent as long as possible. This means investing in services out of hospital, known as care closer to home or “Home First”. This ensures that when patients are admitted to hospital the services can meet the needs of those who are very frail or have dementia and ensure their length of stay is no longer than clinically necessary.

There is a growing body of evidence to validate the home first approach for people living with frailty (for example Kortebein 2008). An NHS England study, outlined in its document, Safe, Compassionate care for frail older people using an integrated care pathway (NHSE 2014) summarised the evidence and made key recommendations for the delivery of care in a safe and compassionate way for the future.

HRW CCG has been working with colleagues to develop a more robust assessment and care planning process, particularly for elderly and frail patients so that patients and their families are well supported and local GPs and community staff caring for them have a better understanding of their care preferences later in life. This means that a person's care needs are being assessed in the most suitable environment so their long-term needs can be met, and they can be supported to live independently. The development of integrated multi-professional teams will ensure a more flexible approach to delivery of community care, 24 hours a day and seven days a week. These teams look at the care of patients at risk of hospital admission who require extra support and discuss frequently admitted patients who are at risk of further admission to hospital. The integrated locality teams also support the patients admitted into step-up/step-down beds. Severely frail patients receive a comprehensive assessment and a care plan is put in place to ensure the patient receives the correct health care and support.

The hospital configuration challenge

Whilst strong community teams wrapped around patients in their usual residence is seen as the foundation of high quality care for the population, it is recognised that access to specialist medical opinion, supported by rapid access to modern diagnostic tests are an essential component of seamless care. This suggests that hospital services will need to be configured to support effective care and embrace the 'Home First' approach. A responsive and integrated urgent and emergency care service at the front door of the hospital system, embraces the concept of 'Teams without Walls' (Royal College of Physicians 2008). Thus, patients with complex health conditions, including the frail elderly, are more likely to stay independent if they have:

- early access to specialist opinion
- prompt access to a range of diagnostic tests
- initiation of rehabilitation and re-ablement when required
- support of a multi-disciplinary team

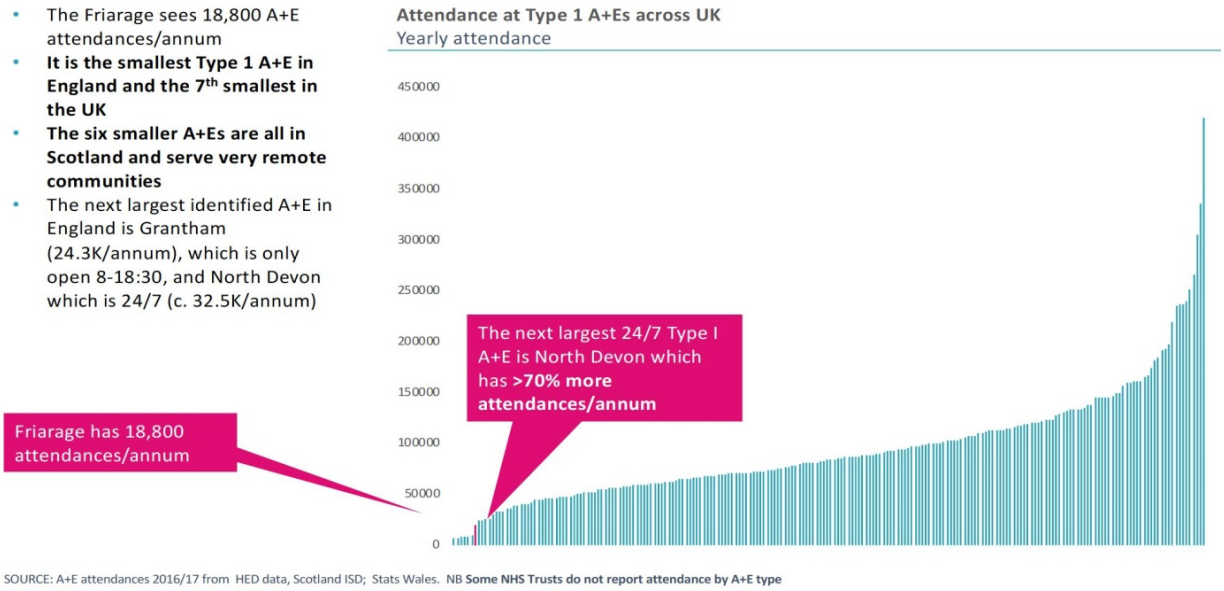
Like most small district general hospitals, the range of medical emergencies treated at the Friarage has changed over the last 13 years with provision becoming more

specialist and centralised. For example, some heart attacks (ST elevation Myocardial Infarction) have not been treated at the Friarage since 2006; acute stroke care and orthopaedic trauma since 2011; and consultant obstetrician led maternity and inpatient paediatric services since 2014. However, this period also saw the emergence of new models of care, such as ambulatory emergency care, day treatment antibiotic therapies, and a greater focus on care delivered in people's own residence.

Prior to March 2019, the Friarage Hospital had the A&E department with the lowest number of attendances in England, fewer than 19,000 per year. Only very remote areas, such as those in very rural Scotland, maintain units with lower activity volumes; these are much further from larger specialist centres than is the North Yorkshire population.

The Friarage has the smallest A+E department in England, seeing fewer than 19,000 attendances per year

- The Friarage sees 18,800 A+E attendances/annum
- **It is the smallest Type 1 A+E in England and the 7th smallest in the UK**
- **The six smaller A+Es are all in Scotland and serve very remote communities**
- The next largest identified A+E in England is Grantham (24.3K/annum), which is only open 8-18:30, and North Devon which is 24/7 (c. 32.5K/annum)



SOURCE: A+E attendances 2016/17 from HED data, Scotland ISD; Stats Wales. NB **Some NHS Trusts do not report attendance by A+E type**

A number of smaller hospitals in England have reconfigured their emergency departments to cope with the lower activity numbers and the need to centralise specialist services, such as cardiac and stroke care. The challenge of managing hospital care in smaller District General Hospitals (DGHs) has been widely recognised in recent literature (see for example, Mascie-Taylor et al 2015, Nuffield Trust 2018, ACRA 2015). ACRA (2015) concludes that a catchment population of more than 200,000 is considered the minimum to allow economies of scale for acute hospital

care and a travel time of 60 minutes as the maximum travel time for most emergency care. Although HRW CCG has a population of 144,000, at the edges of the CCG geography patients will access hospital care at units other than the Friarage Hospital. The Advisory Committee on Resource Allocation (ACRA) calculates the regular DGH population served by the Friarage Hospital as 81,910. Even when taking into account seasonal variations in the population of North Yorkshire, the catchment of the Friarage Hospital is only estimated to be around 100,000, well below the 200,000 figure for maintaining a traditional DGH model.

As with stroke and cardiac care, there is also increasing evidence of the volume quality relationship for complex medical care: for example in the provision of Critical Care medicine (Abbenbroek et al 2014, Nguyen et al 2015) and colorectal cancer surgery (Huo 2017). This suggests that certain medical interventions may be better provided in larger specialist centres, where a volume-quality relationship may be demonstrated, or where the at-scale provision is necessary to support sustainable service delivery.

In terms of the NHS desire to meet the needs of its population, hospital care at the Friarage should primarily focus on dealing with the large majority of patients accessing care, and on supporting effective care for those, such as the frail elderly, who may not need complex specialist intervention.

In summary the case for change is to provide a clinical service model that is:

- deliverable and sustainable with the available workforce
- addresses the needs of the local populations
- is consistent with the requirements of modern specialist medicine
- delivering the best possible health outcomes.

5. Scenario appraisal and options development

5.1. Journey from clinical service review to services being changed

Local consultants, GPs, nurses and therapists with management support looked at each area of service and gave recommendations as to how they think services could be better organised in the future. It was also very important at this stage that local people had an opportunity to say what is important to them about these services.

In 2017, the Trust and HRW CCG undertook a series of 12 public engagement events held across Hambleton and Richmondshire, questionnaires and meetings with interest

groups to explain the challenges of sustaining the traditional service model at the Friarage Hospital and to seek feedback on what was most important to the public and stakeholders to inform the development of the future model.

Clinical working groups then developed these scenarios (clinical modelling) and appraised these against best practice, workforce, activity, and financial parameter criteria, and those which were important to patients and staff. This process was overseen by a Clinical Steering Group which included representation from senior leaders and clinicians in primary care and the ambulance service as well as the Trust and CCG.

Throughout this process each option and scenario was assessed against the same criteria of:

- Safety and quality;
- accessibility;
- feasibility;
- affordability;
- clarity for the public (where to go and when); and
- opportunity for integration

Both the clinical reviews and public engagement formed the basis for a business case for change which was then reviewed and considered by the CCG as it is their statutory duty to ensure the right NHS services are in place for local people. Further scrutiny was also carried out by NHS England and an independent Yorkshire and Humber Clinical Senate review of services took place in May 2019, made up of experienced clinicians from other parts of the county, who critiqued and assessed the business case and provided a formal review.

The conclusions of clinical assessment and the evidence outlined above is that the most sustainable future for the Friarage involves a single option for inpatient care:

- A consultant-delivered acute medical service, daily, with anaesthetic support on site, meeting the needs of 75% of patients (compared to previous activity volumes)
- Medical patients repatriated for care closer to home after initial assessment and treatment at The James Cook University Hospital
- Short-stay elective surgery: Surgical day case, short stay inpatients in specialties such as orthopaedics, urology and gynaecology, supported with

extended recovery in theatres to enable safer surgery for more complex patients

The clinical steering group concluded that potential sustainable options for urgent and emergency care were:

1. Replace the emergency department with a 24/7 Urgent Treatment Centre model, dealing with approximately 90 per cent of urgent and emergency presentations
2. Replace the emergency department with a UTC as above but closed overnight opening 8am to midnight.

5.2. Why we did not take forward the A&E model as an option

The original business case model was developed in 2018 before the need to close the A&E and institute the temporary urgent care model in March 2019. The clinical modelling included assessment of the previously existing service. This included review reports provided by national health bodies, such as Royal Colleges. In their report, the Royal College of Emergency Medicine (RCEM) highlighted concerns that the Friarage A&E is badged to the public as a Type 1 A&E Department but actually offers a more limited A&E service. The workforce challenges were recognised by the RCEM, particularly as this means there is no current prospect of achieving the 24/7 A&E consultant cover.

The RCEM concluded that the A&E model reviewed at the time of their report was not considered sustainable due to medical and nursing workforce recruitment difficulties, essential co-dependencies (critical care) and reducing volume of demand.

The assessment of all partners, including all clinical groups was that:

- Providing any form of an emergency department model requires on-site provision of critical care, including 24/7 on site senior anaesthetic and airway management support
- Recruitment to support a sustainable rota for the Friarage critical care unit had been repeatedly unsuccessful over a significant period of time
- Continued support to the Friarage Critical Care Unit from James Cook Hospital could not be guaranteed without significantly undermining the Critical Care service at James Cook, with a wider patient impact than that of the Friarage

Taking this into account, maintaining an A&E department is not considered to be realistic or deliverable for the Friarage Hospital. This has been confirmed by the CCG

Governing Body and in discussion with NHS England at the strategic review of service change. As a result, HRW CCG will not consult on the provision of a Type 1 A&E department, as this model cannot be achieved, and it would be dishonest of the CCG to suggest that a 24/7 emergency department model is viable for the Friarage Hospital.

Other more radical options, like moving the Friarage Hospital site to an elective ('cold') only site, or a model without inpatient beds, were considered to be against the commissioning principles of the CCG and would lead to an unacceptable demand on other local units, which were unlikely to have the capacity to manage the significant change in patient flows.

5.3. What we are consulting on

Following the process above we are now consulting on:

- our vision for building a sustainable future for inpatient care at the Friarage Hospital, and
- how urgent care could be delivered in the future.

Inpatient care

The conclusion of clinical assessment is that the most sustainable future for the Friarage involves the following model for inpatient care:

- A consultant-delivered acute medical service, daily, with anaesthetic support on site, meeting the needs of 75% of patients (compared to previous activity volumes)
- Medical patients repatriated for care closer to home after initial assessment and treatment at James Cook
- Short-stay elective surgery: Surgical day case, short stay inpatients in specialties such as orthopaedics, urology and gynaecology, supported with extended recovery in theatres

Urgent and emergency care

Based on our clinical review and what people told us during engagement, the clinical steering group appraised scenarios and developed two possible and sustainable options for urgent and emergency care which were:

Option 1 - Replace the emergency department with a 24/7 Urgent Treatment Centre model, dealing with approximately 90 per cent of urgent and emergency presentations.

Option 2 - Replace the emergency department with a UTC as above, but closed overnight open 8am to midnight.

The urgent treatment centre options were assessed by the HRW CCG Governing Body. That assessment concluded that the 24-hour UTC option would be preferable in terms of local access. However, it is evident that more limited opening would be more sustainable for the available clinical workforce and is more cost effective. This secures the longer-term future of the service.

The Yorkshire and Humber Clinical Senate review of services in May 2019 concluded:

> The Senate is supportive of the proposed clinical model which we agree is a step in the right direction towards providing a sustainable future for the Friarage Hospital. We very much commend the innovation in this model which looks to sustain an acute hospital model that does not rely on 24/7 resident anaesthetic cover.

This support was confirmed by NHS England at the strategy review of service changes in July 2019. The conclusions of the clinical steering group were supported by the HRW CCG Governing Body and Trust Board of Directors and thus the two options were agreed as those which would be considered in consultation.

6. Options going forward for consultation

6.1. Inpatient care model

The preferred inpatient model and rationale is described below:

Overview of the medical model

Patient admissions to the Friarage Hospital would be selected, using a senior triage phone pathway and maintaining national standards in patient quality and safety. This gives the opportunity for a senior clinical decision maker (acute physician) to decide if the patient can be safely managed at the Friarage Hospital or would need to follow a clear patient pathway to James Cook or other providers.

Acutely unwell patients would not be admitted when there is not a senior doctor onsite to triage, assess and treat. However, patients who need to be admitted to James Cook would then be repatriated to the Friarage Hospital if they meet that site's clinical criteria but are not well enough to be discharged from hospital. Robust repatriation protocols

will ensure patients are identified and transport commissioned to convey them safely to the Friarage Hospital to continue their care.

Clinical process

This 'selected medical take' service model is designed to provide senior decision-making early in the patient pathway. For elective patients, this is achieved through the pre-assessment process. For acute admissions, this is consultant-led decision-making.

This acute admission process begins with GP or paramedic contact to a consultant physician for telephone triage, then assessment on arrival at site. If any patient attends the UTC and needs admitting they can be seen and accepted in person.

Acute admissions within the clinical scope of the new Friarage model would be accepted during the hours 8:30am to 6:30pm on weekdays and 8:30am to 4:30pm at weekends and bank holidays. This includes:

- Ambulatory care patients
- Acutely unwell patients not expected to deteriorate, to the point of requiring Level 2/3 care
- Patients requiring surgical assessment but not expected to require a theatre visit
- Patients with a documented ceiling of care, whose needs can be met within the scope of the Friarage

Criteria for consideration include early warning score assessment, initial differential diagnoses and likely prognosis. The triage will be done by a consultant with consideration of the holistic needs of the patient and the services and expertise available at the Friarage Hospital.

No emergency surgery will take place on site. A daily acute surgical ward round will support the identification of patients who require transfer to James Cook for surgical treatment. Patients for specialties outside of the Friarage clinical scope will be diverted or transferred to James Cook. For many specialities there will be no significant change (for example, acute stroke, spinal, neurology, gynaecology, and orthopaedics pathways).

Elective surgical patients at the Friarage Hospital will be risk stratified on the basis of the procedure and any potential co-morbidities and deemed low-risk. Should patients deteriorate or require medical care, this will be overseen by the acute medical team.

Maintaining patient safety

- Admissions will be entirely consultant selected and as such each patient will be accepted according to the situation on the ground, local knowledge and the patient's clinical characteristics.
- It is highly likely that only patients who have been deemed not for escalation to critical care would be admitted to the medical wards after assessment on the clinical decisions unit. Patients who would benefit from escalation of care and/or deemed at risk of deterioration will be transferred to James Cook.
- There will be daily consultant review (early evening) of all patients on site in order to ensure that all are safe and appropriate to continue to receive their care and treatment at the Friarage Hospital.
- The model proposes that many admissions (over half the previous volume of attenders, given the reduced opening hours) can be safely cared for at the Friarage Hospital, as above. This balances patient safety, access to higher care and specialist services, with care closer to home.
- The Friarage Hospital will continue to provide the highest standards of care for patients within its defined clinical scope with consultant-delivered acute ambulatory and inpatient service, supported by specialist advice, and transfer to James Cook in an emergency.
- A Standard Operating Procedure (SOP) will detail the procedure for emergency transfer for patients requiring critical care.
- A SOP will detail the procedure for urgent and routine transfer for patients requiring the facilities/expertise at James Cook (as now).
- The site will maintain a Cardiac Arrest Response Team compliant with Resuscitation Council Standards for an acute hospital, including Advanced Life Support skills and the ability to deploy an airway.
- This will be followed up with a Category 1 response by the ambulance service to transfer the patient.
- The safety of all patients is the highest priority and plans, SOPs, staffing and training will be put in place to manage these circumstances, regardless of expected low frequency of occurrence.

Repatriation

- For patients diverted to James Cook, who are expected to have a short length of stay (less than 48 hours), the focus will be on getting them safely home whenever that is clinically appropriate.

- The model proposes that patients are repatriated to the Friarage Hospital, if their total length of stay is expected to be more than 48 hours
- This enables care closer to home.
- It enables the patient to be pulled into locality care pathways for discharge and frailty.
- As long as the patient has been reviewed by a consultant and deemed suitable for ward level care then they can be safely repatriated to the Friarage Hospital from James Cook emergency department or acute assessment units, where senior decision makers are present 24/7.

In the consultation process it is important the CCG is able to effectively engage with its population and stakeholders in evaluating the inpatient model, identifying opportunities to improve it, where possible, and seeking to mitigate any risks that are described.

Anaesthetic model

There will be senior anaesthetic presence on-site each day, seven days a week to support the safe care of all patients in case of an urgent need for airway support. This provides an additional degree of safety on site and enables the acute medical service to safely accept patients without having to await the arrival of an on-call anaesthetist. . It is proposed that there would be no critical care unit at the Friarage Hospital, but that extended recovery would be provided in the theatres suite to enable a longer recovery period which will be overseen by an anaesthetist, for patients post-operatively.

Emergency transfer protocols will be put in place to facilitate rapid transfer to the James Cook site for any patient requiring immediate critical care.

Urgent Treatment Centre protocols, senior decision-making for admission of acute medical patients and pre-assessment of elective surgical patients should be effective in ensuring that patients admitted to the Friarage Hospital can be safely managed on site. Any patients where there is a question over their suitability would be transferred to James Cook. All patients remaining at the Friarage Hospital will be reviewed each evening by the medical team (including anaesthetist). In the very occasional circumstance patients may deteriorate unexpectedly, the site anaesthetist would support their immediate care providing airway management before transfer to James Cook. If this situation was to occur after 9pm, when an anaesthetist is not resident, an immediate priority ambulance transfer would be arranged. The hospital would maintain

a resuscitation response team to acute hospital standards (Resuscitation Council) 24/7 to provide an immediate response.

Plans to manage intensive care demand are as follows:

- With the exception of the impact declared to Darlington Memorial Hospital of 0.75 critical care beds, the critical care activity is expected to be absorbed at James Cook.
- The High Dependency Unit (HDU) at James Cook will have an increase in one bed, making a total of 17 beds
- The HDU currently provides level 2 care; from the start of the new model the HDU will become a flexible High Dependency Unit /Intensive Care Unit.An increase in the number of staff will allow the unit to flexibly manage level 2 and level 3 patients.
- Five Post-Anaesthesia Care Unit (PACU) beds will be available in the theatre complex for elective patients currently admitted to the High Dependency Unit.
- The added benefit of the new model is that it provides a dedicated post anaesthetic care unit for elective patients (including cancer patients).
- These plans are being worked up for delivery by estates and facilities, workforce and finance, and have been implemented in part as an urgent temporary measure from 27 March 2019.

Surgical model

The surgical services model provides elective short-stay surgery for patients generally of lower acuity, ASA[1] Level 1 and 2, (selected as per pre-assessment). All cases being either short stay on a pre-defined inpatient pathway (as at present for orthopaedics and spinal surgery) or managed through the surgical admissions unit (SAU) and post-operative surgical day unit (POSDU) on day case or short-stay pathways.

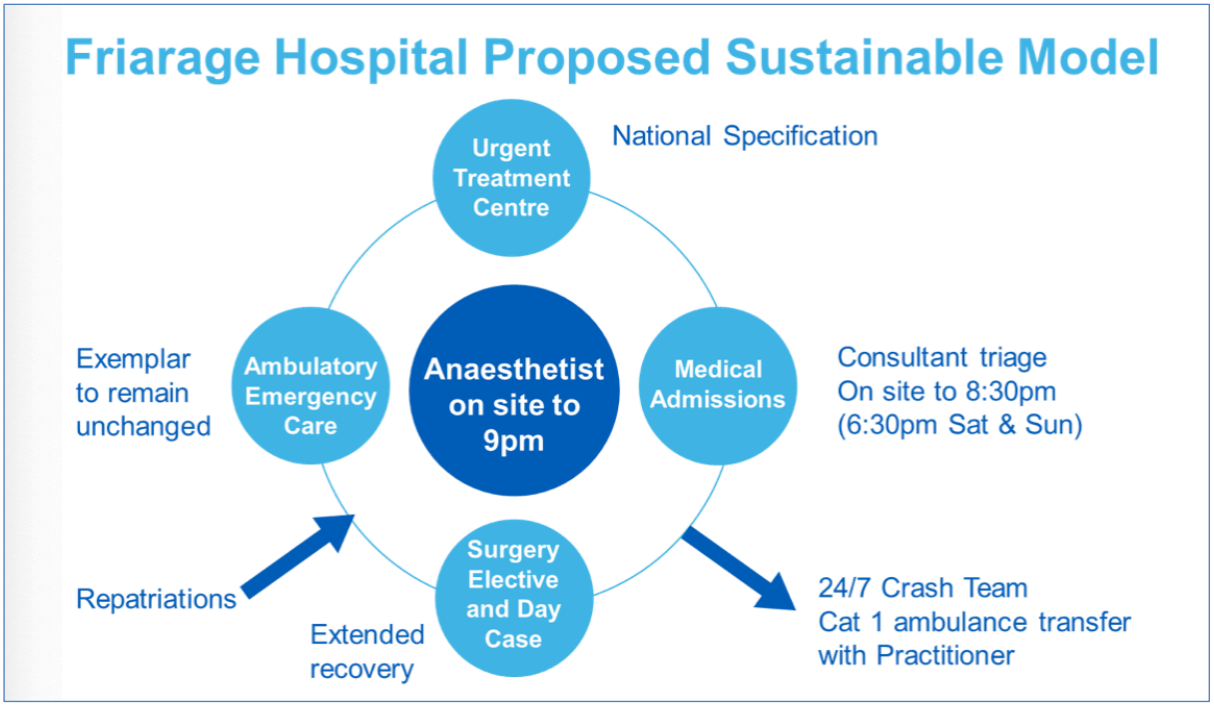
Patients triggering ASA grade 3 at pre-assessment may be appropriate for Friarage Hospital day case surgery subject to anaesthetic pre-assessment. Patients triggering ASA grade 3 would not generally be accepted for surgery requiring an overnight stay. Patients with an expectation or likelihood of requiring critical care post-operatively will have their operation at James Cook.

[1] ASA – The ASA physical status classification system is a system for assessing the fitness of patients before surgery developed by the American Society of Anaesthesiologists

Therefore, major colorectal surgery, and some other procedures such as some thoracic surgery, will not be undertaken at the Friarage Hospital (regardless of ASA status of the patient) due to the nature and risks of the surgery.

The theatre capacity released would be utilised by bringing theatre lists from James Cook, so there is no net loss of theatre capacity. Analysis has shown that there are many patients from the Friarage Hospital catchment who access their surgery at James Cook and which could be provided at the Friarage Hospital within the clinical scope of the new model. Patients from the Tees Valley also access surgery at the Friarage Hospital and this would continue.

The new model is summarised, below:



6.2. Urgent Care models – 08.00 to midnight UTC, versus 24 hour UTC options

The two 'front of house' models to discuss during the 12-week consultation are the 24 hour and the 08.00 to midnight Urgent Treatment Centre (UTC) options. Considering the risks and benefits of the two UTC options includes assessment that:

- Footfall through UTC overnight would be low. However, currently the late evening has a high level of activity
- Some of the previous activity will not profile to attend the UTC; other patients may attend earlier in the day when they are aware that the service is available
- There is a requirement for additional resources if the service is delivered longer than the 16 hours (staffing whole time equivalents and shift patterns)
- Greater risk to deliverability of a 24-hour UTC as significant increased staffing required (13.7 whole time equivalent Nurse Practitioners compared to 8.7) to maintain minimum staffing levels, recruiting and sustaining 24/7 rosters
- In the overnight period there will be limited back-up infrastructure on site – no admission route on site, no medical back-up – UTC staff will call 999 for patients clinically out of scope who self-present
- Safety and governance of the UTC will be more resilient when other clinicians and services are available on site to call upon for support or advice.

Integration of the UTC with GP Out of Hours

The CCG currently commissions a service to provide access to GP care during evenings and weekends for the local population. Although this service provides care that overlaps with that of a UTC, at the moment the services are separate. There exists a significant opportunity for the CCG, in collaboration with STHFT and the GP Out of Hours provider, Harrogate and District NHS Foundation Trust, to integrate the GP Out of hours service with the UTC. This may allow efficiencies to be achieved from both services which will allow a more sustainable workforce model whilst still allowing 24/7 access to urgent care.

Activity comparison by hours

To assess the potential impact between the two UTC models it is helpful to assess the differing levels of patient demand seen across the 24 hour period. Analysis suggests that the large majority of activity is within the hours of 08.00 and 20.00, with very low average demand after midnight.

The summary table of activity as compared between 08.00 to 19.59 (described as 'in hours') and 20.00 to 07.59 confirms the large majority of patient activity happens between 08.00 and 19.59.

In Hours /Out of Hours Comparison	Attendances April to June 2019	%
In Hours (08.00-19.59)	3,546	83%
Out of Hours (20.00-07.59)	705	17%
Total	4,251	100%

Further analysis looking at 8-hour time bands demonstrates the very low number of attendances after midnight.

Time-band	Attendances April to June 2019	%
08.00 to 15.59	2,399	56%
16.00 to 23.59	1,594	37%
00.00 to 07.59	258	6%
Total	4,251	100%

The activity profile of the hours of demand for urgent care is shown in the detailed table below using the 2019 quarter 1 (April to June) activity figures forecast averaged by hour of day and day of the week.

Figure 1 - Friarage Urgent Treatment Centre Attendances by hour and day of the week 2019

	Attendances							
Time of day	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Total
00	0	0	1	0	0	1	1	3
01	0	0	0	0	0	0	0	0
02	0	0	0	0	0	0	0	0
03	0	0	0	0	0	1	0	1
04	0	0	0	0	0	0	0	0
05	0	0	0	0	0	0	1	1
06	0	0	0	0	0	0	1	1
07	1	1	1	1	1	1	1	7
08	1	2	1	2	2	2	2	12
09	3	3	4	4	4	4	4	26
10	3	4	3	3	5	5	6	29
11	3	3	3	2	4	4	3	22
12	3	3	3	3	4	3	4	23
13	2	4	3	4	3	3	6	25
14	4	2	3	4	3	3	3	22
15	3	4	2	3	4	5	4	25
16	3	4	3	3	3	4	3	23
17	4	3	4	3	3	3	4	24
18	4	3	3	3	2	3	4	22
19	4	2	3	2	2	4	3	20
20	2	2	1	2	2	1	3	13
21	1	2	2	2	1	1	1	10
22	1	1	1	1	1	1	1	7
23	1	1	1	0	1	0	0	4
Total	**43**	**44**	**42**	**42**	**45**	**49**	**55**	**320**

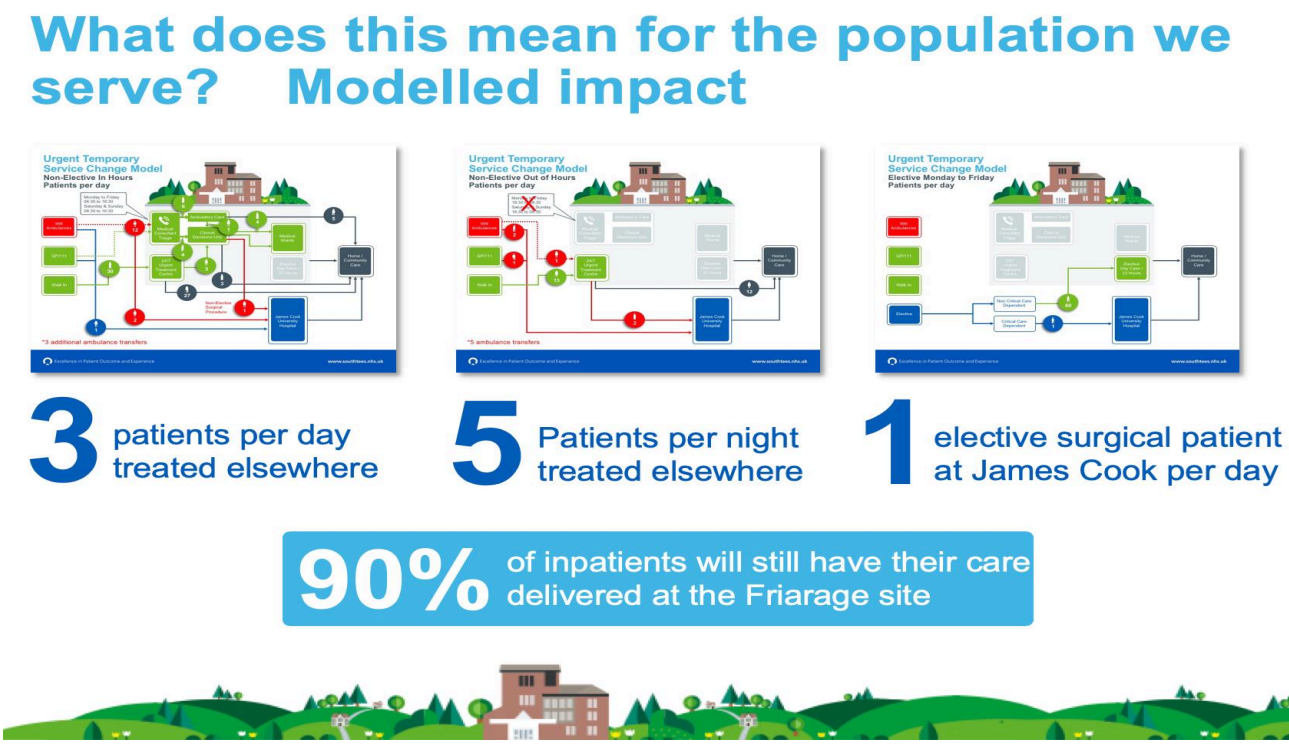
7. Assessment of the implementation of the temporary model

The service changes instituted in March 2019 were temporary changes before the opportunity for consultation with the CCG's population. The model that's been operational since March 2019 is broadly the same as the Option 1 model put forward in the consultation. The activity figures from the experience of the model in practice are summarised below:

	Modelled Activity	Actuals 27-Mar to 13-Jul	2018 equivalent period	Change 2019 vs 2018	Change Vs Model
UTC attends	5388	5822	6191	-369	434
UTC attendances under 18s	763	1498	1067	431	735
FHN admits non-elective	1417	1727	2285	-558	310
Repatriations to FHN	234	168	41	127	-66
Total: FHN NEL & Repats	1651	1895	2326	-431	244
FHN admits elective	5170	5246	5041	205	76
NY occupied bed days JCUH	12675	9639	8551	1088 (10 beds)	-3036

The conclusion from the early experience of the model in practice has been positive and supportive of the assumptions from the models developed by the clinical teams. In summary:

- More than nine in ten patients who would have previously attended A&E have continued to be treated at the Friarage Hospital.
- There has been a 39 per cent increase in the number of children attending the (temporary) UTC.
- More than 95 per cent of total prior demand continue to receive their treatment at the Friarage Hospital, either in the Urgent Treatment Centre, as an outpatient, as a day-case or as a hospital admission.
- There has been no compromise of clinical safety or quality in any way and there have been no serious incidents or never events as a result of the changes made.



The activity comparison of the new model with planning forecasts is largely as predicted. The additional capacity commissioned from Yorkshire Ambulance Service (YAS) has been sufficient to support additional patient transfers. The Friarage Hospital will manage its inpatient bed base to 85 per cent midnight bed occupancy, in line with nationally recognised best practice, to ensure that patients are not transferred off site due to lack of bed capacity. Thus far, there have been no patient safety issues linked to the service changes.

The impact on County Durham and Darlington NHS Foundation Trust (CCDFT) has been, largely as predicted, relatively small. The increase in patients from the Northallerton catchment has been 4-5 patients per day, although that increase will include some level of growth in demand as well as the service changes.

7.1. Independent review of the urgent temporary changes

An independent report into emergency services at the Friarage Hospital concluded that South Tees Hospitals NHS Foundation Trust had a sound case to make changes earlier this year. Commissioned by Richmond MP, Rishi Sunak, the report by healthcare management consultancy, Carnall Farrar, surveyed A&E services across the UK and showed that it was extremely rare for a hospital of the Friarage's

size to be able to maintain full A&E provision, and much larger hospitals had already had to make similar changes due to similar staffing issues.

Mr Sunak asked Carnall Farrar to address three critical questions concerning the changes to emergency care at the Friarage Hospital, including ***Is this temporary model appropriate for the specific needs of our rural community and is it sustainable for the future?***

The healthcare consultancy found:

- The enhanced Urgent Treatment Centre model with a Clinical Decisions Unit maximises access to care for local people compared to a typical UTC
- The Trust's forecast that only 10 per cent of the old A&E's patients will need to be treated elsewhere has proved to be correct in the early weeks of the temporary closure.
- Changes at the Friarage Hospital should have minimal impact on the neighbouring James Cook and Darlington hospitals.
- Travel time analysis and clinical studies evidence suggests there should be no impact on patient mortality as a result of the changes and change in travel patterns
- There is an opportunity to significantly increase the number of sick children seen at the Friarage Hospital (implementation of the urgent temporary change model shows greater than anticipated increase in the number of sick children seen at the Friarage).
- Implementing the new model of care is dependent on having an adequate workforce to deliver it. The Trust needs to have an increased focus on developing existing nurses as emergency nurse practitioners and recruiting new staff as required.
- Without this, there is a risk that opening hours of the Urgent Treatment Centre may need to be reduced leading to the Friarage Hospital only being able to care for c.70 - 80% of its current A&E patients as opposed to the 90%. However, a reduction in UTC opening hours would not impact on hospital admissions which are dependent on the opening hours of the clinical decision unit (open 12 hours/day)

The full report is available upon request.

8. Impact assessments

The CCG has undertaken full impact assessments:

- Equality impact assessment
- Quality impact assessment
- Privacy impact assessment; and
- Sustainability impact assessment

All assessments have been shared and evaluated by NHS England and the Yorkshire and Humber Clinical Senate. Copies of each can be provided by the CCG upon request.

Financial assessment

The initial financial assessment suggests a recurrent additional cost to the NHS of approximately £245,000 per year for the provision of the 24 hour UTC model as compared to the 16hour option. This would suggest the NHS and its partners would need to be clear that this premium was justified in terms of the improvements in health outcomes and access and that there would be an opportunity to reduce investment elsewhere.

9. Consultation process

It is important we describe the overarching strategy for building a sustainable future for the Friarage Hospital. This will provide the context for the case for change and enable a broader description of how the options outlined interface with other services within the localities and builds upon the significant transformation and investment in out of hospital care over the last five years.

Managing the process and outcome of consultation

These options will be taken forward for formal public consultation across Hambleton and Richmondshire. This is anticipated to run for at least 12 weeks from September 2019 with a recommendation being taken to a CCG Extraordinary Governing Body after evaluation of the feedback from the consultation process.

- What happens to the responses? During the consultation, all the feedback and responses will be collated, in the same way as we have done with information received during the pre-consultation engagement events. At the end of the consultation a report will be produced identifying the themes and issues raised.

- Decision-making process. The outcomes report will be discussed with the CCG Council of Members (which is made up of representatives from each of our member GP Practices). The final decision will be made by the HRW CCG Governing Body once they have had time to consider the consultation feedback and responses.
- The role of the Scrutiny for Health Committee. The way we have developed our proposals and the way we will reach a decision, is being overseen by North Yorkshire Scrutiny for Health Committee, made up of local councillors. The Committee has the power to refer both the outcome of the consultation and the decision-making process to the Secretary of State for independent review.
- Public involvement. The views of the public are extremely important to the CCG and we would like the public to get involved by telling us what they think of the options listed within this document. The CCG website will include a dedicated page for the consultation, and an online and printed survey will be available to complete.
- Consistent with rules for cooperation and competition. Where there are any procurement requirements with this service change we will follow the legal procurement frameworks.

10. Conclusion

We want to stabilise and maintain services at the Friarage Hospital to secure a strong and stable future for the hospital. Its existence remains at the heart of HRW CCG's ambition to improve the health and wellbeing of its population by ensuring there is quality-driven care available close to home.

Through engagement already carried out concerning the future of the hospital, the public has given us their views and suggestions, as well as their issues and concerns. Principally, these were:

- Ongoing fears for the future of the Friarage overall
- Concerns relating to the possibility of increased travel distances and the availability of public transport to access inpatient care, should services at the Friarage Hospital not be available
- Queries relating to the detail and practicalities of the community-based treatment model and the move away from secondary care

We have developed a clinical model which would ensure sustainability of services over the longer term, rather than continue to attempt to address workforce issues as they

occur. This single option solution which has been developed following an analysis of the clinical evidence, the needs of the population and taking account of public opinion, would be to establish the following services on the Friarage Hospital site:

- Urgent Treatment Centre, for minor injury and illness in adults and children
- A consultant-delivered acute medical service, daily, with anaesthetic support on-site, meeting the needs of 75% of patients admitted as an emergency. Repatriation of patients to the Friarage Hospital for care closer to home when they no longer need assessment and treatment at James Cook
- Elective (planned) surgery for day case short stay inpatients

HRW CCG wishes to consult on the best model for the UTC which supports the objectives of the health economy.

The proposed changes would allow the CCG to:

- Commission safe and more appropriate care in the right clinical environments
- Enable the continued development of an integrated health and care system across Hambleton, Richmondshire and Whitby

Hambleton, Richmondshire and Whitby CCG, together with our partners at South Tees Hospitals NHS Foundation Trust will be consulting on our vision for building a sustainable future for inpatient care at the Friarage Hospital, and two options for an Urgent Treatment Centre model. In the coming weeks, patients and stakeholders will hear more about the process of consultation and the many opportunities to get involved.

The CCG believes this is the right thing to do.

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