

Response to Proposals within the Consultation Document on Options for the Future of Children's and Maternity Services at

**THE FRIARAGE HOSPITAL
Northallerton**

and

Our Model for the Future Provision of Children's and Maternity Services

November 2013

Report Compiled by

Cllr John Blackie - Leader of Richmondshire District Council

Cllr John Robinson – Chair of the RDC Scrutiny Committee 2

Mrs Penny Hillary – RDC Scrutiny Support Officer

**Richmondshire District Council
Mercury House
Richmond**

Abbreviations used in this report:-

FHN - Friarage Hospital, Northallerton
NDDH – North Devon District Hospital, Barnstaple
DCH – Dorset County Hospital, Dorchester
YDH – Yeovil District Hospital
DGE - Dr Grays Hospital, Elgin
BGH - Borders General Hospital, Melrose
D&GH - Dumfries & Galloway Hospital,
SCBU – Special Care Baby Unit
PSSAU – Paediatric Short Stay Assessment Unit
PAU - Paediatric Assessment Unit
ANNP – Advanced Neonatal Nurse Practitioners
GPVT – GP Vocational Trainee
SPR – Specialist Registrar
NCAT – National Clinical Advisory Team
CLU – Consultant Led Unit
HRWCCG – Hambleton, Richmondshire & Whitby Clinical Commissioning Group
RCPCH – Royal College of Paediatrics and Child Health
RCM – Royal College of Midwives
RCOG – Royal College of Obstetricians and Gynaecologists
IRP – Independent Reconfiguration Panel
NYCC – North Yorkshire County Council
RDC – Richmondshire District Council
SOHC – Scrutiny of Health Committee (NYCC)
YAS – Yorkshire Ambulance Service
NYYPCT – North Yorkshire & York Primary Care Trust
Local NHS in North Yorkshire – (Collective term) South Tees Hospitals NHS Foundation Trust & HRW CCG
WTE – Whole Time Equivalent

Summary of Events

During the last 2 years the discussions and documents that have been produced by the Hambleton, Richmondshire & Whitby Clinical Commissioning Group (HRWCCG) about the 24/7 Paediatrics and Obstetrics Services at The Friarage Hospital have been significantly less than straightforward to follow, especially for the public:

- In December 2011 the National Clinical Advisory Team (NCAT) visited at the request of the CCG.
- They discussed **7 potential options**.
 1. Keep the in-patient service as it is, i.e. retain the children's in-patient ward, and have more senior doctors present on site.
 2. Run the Friarage as a 'small and remote unit' as the service cannot run to the standards expected in bigger units.
 3. Run a five day working ward.
 4. Run a paediatric day unit (as a five or seven day service).
 5. Provide **enhanced** outpatient services (emergency as well as routine), increase specialist clinics and run a 'see and treat'/assessment facility but with no inpatient overnight facility.
 6. Provide outpatient services.
 7. Do not provide a children's service at the Friarage.
- Doctors and staff said their preferred option for paediatrics was Option 5 (Improving childrens outpatient and assessment facilities during the day and not to care for children overnight at the Friarage).
- Within the NCAT reports the following points are made:
 - ☑ NCAT agreed with those they met on the day of their visit that presently they have a first class service but also agree that it is not sustainable in this way for the future, and they must start planning now, particularly with the coming retirements of senior consultants."
 - ☑ The obstetric unit had only survived and continued to give a great service with the dedication and hard work of a small number of obstetric consultants and the supporting clinical team."
 - ☑ NCAT has already recognised the high calibre of the nurses and midwives supporting the obstetric unit and SCBU".
 - ☑ The Friarage Hospital is loved by its local community. They wish to see a vision for the hospital which sees it being sustainable into the future and we would strongly support this".
 - ☑ The public's main concern was not about paediatrics, but the retention of maternity services which has a good deal of support."

- Views expressed on the day of the NCAT visit were "The big unknown is what will happen at Darlington, as that could put considerable pressure on JCUH.
- From February to June 2012 the Engagement Exercise followed with the public discussing all **7 options**.
- During the Engagement Exercise the public showed a great strength of feeling that both 24/7 paediatric and maternity services should not be downgraded and different solutions found to keeping them both. This was borne out by:
 - ◆ 30+ local Parish Councils, Richmondshire District Council and Hambleton District Council, North Yorkshire County Council all deciding (in variously worded resolutions) to support the continued provision of a 24/7 consultant-led service,
 - ◆ A Facebook campaign group of over 3000 members,
 - ◆ The petition of 10,000 people,
 - ◆ A Family Rally / March by 4000 people, organised by the Leader of RDC and led by him and the local MP William Hague who addressed the Rally
 - ◆ At the various engagement meetings held around the districts attended by 465 people.
- In June 2012 The GP Council of the HRW CCG put those **7 options** through "a *rigorous options appraisal*" which reduced them to **3 options**, one of which was to sustain a consultant led paediatric and maternity service, as follows:

Option 1: Sustaining a consultant led paediatric service and maternity unit, requiring significant investment to achieve safety standards. It was suggested in the description of the option that "this service would still remain fragile in terms of sustainability".

Option 2: (Their Preferred Option) Paediatric Short Stay Assessment Unit (PSSAU) and midwifery led maternity service with full outpatient services and enhanced community service provision. Note no hours or days of operation for the PSSAU were put forward within this option, other than to say there would be no overnight in-patient facilities available. This option would be delivered within tariff, so therefore would require no additional investment by the CCG. Minor additional transport costs would be incurred but it is hoped that ambulance costs would be met by efficiencies elsewhere in the system locally.

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

- On the 16 August 2012, the GP Council of the CCG, which consists of a representative from each practice developed a clinically preferred option using the scoring tool which had been used previously in each practice and then collated the scores. The outcome of this process was the clinically preferred option was option 2. The rationale behind the decision was that it offered the best access to high

quality services within the financial envelope available. Option 1 was declared “unaffordable” and Option 3 provided reduced access.

- On the 25 September 2012 the NHS Yorkshire & York (PCT Cluster) Board met to consider the report with a view to agreeing the 3 options for inclusion in a formal NHS consultation. The report outlined the 3 options above. However it was then announced that the Board had taken legal advice that the consultation should not take place on an option that could not be delivered and agreed that consultation should only take place on **2 Options**, Options 2 and 3.
- A key message that the CCG said they wished to deliver during the Engagement Exercise was that stakeholders **could influence the decision making process** and that it was **not a “done deal”**.
- On the 24 October 2012, the CCG released a press article stating that they were going to put the Consultation on hold because they believed the decision not to include Option 1 would prompt the NYCC Scrutiny of Health Committee to refer the consultation process to the Secretary of State for review.
- On the 20 December 2012, Councillor Jim Clark, Chairman of the NYCC Scrutiny of Health Committee formally referred the proposals to the Secretary of State for Health. **(Appendix 3)**
- On the 23 May 2013, the response was received from the Secretary of State that this matter should proceed to Consultation but that other options must also be considered **(Appendix 3)**
- On the 2 September 2013 the Consultation Period commenced on the 2 options and concludes on the 25 November, the date of this submission.

We suggest the result of all of the above has been to cause the following:

- ◆ Public confusion
- ◆ A lack of public trust and confidence that the public view was ever going to be taken into account in the process
- ◆ Lack of confidence in South Tees Trust, the CCG, and the GP Cluster Board
- ◆ Mixed messages from the CCG about whether the changes were really about staffing issues, sustainability, safety or cost
- ◆ The referral by the NYCC SOHC to the Secretary of State for Health

We reject the HRW CCG proposals in their current form and provide our arguments within this submission in support of this rejection.

Richmondshire District Council at its meeting on 20th November 2013 resolved “that neither of the two options meet the healthcare needs of the local communities in Richmondshire”.

We would welcome the chance to work with the local NHS openly and honestly to finalise a solution that provides a safe service for the people of the Richmondshire and Hambleton Districts that retains a 24/7 consultant-led children’s and maternity service, albeit in a different model of future provision described later in this submission, which keeps services local and sustains the Friarage Hospital into the future.

We also believe that the 2 options proposed in the Consultation document fail to meet the standard NHS tests for reconfiguration of its service have failed to be met for the following reasons:

- 1. The proposals will not improve patient outcomes.** There will be no improvements in the quality of the service received, in fact there will be a reduction in the quality of service received.
- 2. The poll of all GPs in the HRW CCG in supporting an Option that retained a 24/7 consultant-led service voted the Friarage Hospital as their No.1 choice for:**
 - Patient safety
 - Clinical Effectiveness
 - Equity of Access
 - Patient experience
- 3. The views of the people who were consulted were not taken into account** in that the overwhelming majority of people said they wished the 24/7 consultant-led services to be retained, albeit in a bespoke model of future provision
- 4. The proposals are not in the interests of the local community nor in the interest of the local health services and do not meet the needs of the local population.**
- 5. Patient choice has not been taken into account.**

Referral by the North Yorkshire County Council Scrutiny of Health Committee (December 2012)

On the 20 December 2012, Councillor Jim Clark, Chairman of the NYCC Scrutiny of Health Committee formally referred the proposals to the Secretary of State for Health after the Engagement Phase because the former NHS North Yorkshire & York PCT had announced that a Consultant Led model for Childrens and Maternity would not feature in the Consultation Stage. In their letter (**at Appendix 3**) the Committee made many valid points against the proposals and some of these are reiterated within this response. Attached at (**Appendix 4**) is the response from the Secretary of State and the IRP Panel.

Part of the IRP's response to the letter from the Committee was as follows:

"However, the Panel considers that the draft document produced in preparation for formal consultation and shared with the SoHC could usefully be adapted to satisfy all requirements. In such circumstances, a clear explanation of the case for change is required. If it is considered that Option 1 is not viable, it is important to demonstrate why it is not viable – by providing suitably detailed analysis to show what it would mean in terms of sustainability, affordability and quality.

The consultation may also wish to invite new options and not limit respondents to those listed. Any new options put forward can be evaluated post-consultation in line with the agreed criteria".

Arguments to support the rejection of the HRW CCG Proposals in the Consultation

General arguments

- 1 The problem raised with the NCAT in December 2011 was with the paediatrics service and not the maternity service and was raised by the Consultants within paediatrics itself. It was not because safety had been compromised, nor was it because of complaints by the public or regulating bodies. Indeed even the NCAT report recognised that the Friarage provides a first class service that enjoys the full confidence of all the communities it serves.
- 2 It is considered that the situation in paediatrics has been exacerbated by chronic understaffing and underfunding for several years by the South Tees Hospitals NHS Trust. It appears that a carefully thought out Strategy for Consultant succession has not been a feature of their future planning. This omission now is compromising the future of maternity services.
- 3 It is our opinion that the original 7 options should have included an option to invest and sustain the service using the most cost effective solutions, as in other Hospital Trusts we have reviewed on-going investment over the past years has been a feature of their business planning, which has placed them in a much better position to face the future.
- 4 Both current Options 1 and 2 will have a significantly detrimental impact on the services provided to the women, children and the families within Richmondshire and Hambleton in the future.
- 5 The GP's carrying out the Options Appraisal made an error of judgment to exclude Option 1 (to invest and sustain the service) from the Consultation as they themselves had scored 4 of the 7 criteria highest for Option 1 and, therefore, from that point forward the process was flawed.
- 6 During the Engagement Exercise this was the option that was clearly conveyed to the CCG and the Trust as being the public choice. The GP's were misled because they were given the highest possible costs of providing Consultant Delivered Services to Royal College Guidelines, rather than an enhanced and improved Consultant Led Service, when we have seen many examples of other hospitals safely staffing the services in less expensive ways by using less consultants and a variety of ways to cover the middle grade.
- 7 GPs in the HRWCCG were misled into thinking that Option 1 was unaffordable by an overinflated cost of providing consultant delivered services to Royal College Guidelines. These Guidelines have the status of being recommendations and nothing more onerous.

- 8 We have found no evidence of other hospitals meeting them and those we questioned said, as one Consultant neatly put it "an exercise in wishful thinking". Our visits to small hospitals similar in size and footfall to the Friarage uncovered a variety of bespoke staffing structures but all with something in common: a patient safety and satisfaction record the equal of the excellent record at the Friarage.
- 9 Neither option provides an improved service.
- 10 Accessibility to the maternity service for mothers-to-be who are or prove to be high risk has been seriously hampered as the James Cook University Hospital is not located in the catchment area of The Friarage Hospital. It is 23 miles from the Friarage to the James Cook University Hospital.
- 11 Similarly accessibility for the parents and relatives of children who are admitted to hospital has been made more difficult by the transfer of the in-patient beds to the JCUH.
- 12 Relatives and visitors attending hospital to see either mothers with their newly born babies (especially if the baby has been confined to the Special Care Baby Unit) and to children admitted as in-patients will have to incur considerable extra expenditure in both fuel and car parking costs and time to reach and return from the JCUH.
- 13 There are actually 24 practices within the CCG Area but the 2 military GP practices, one which is at Catterick Garrison, do not appear to have been included in any discussions, even though the Trust relies on the military to make up some of the staffing in Obstetrics and Paediatrics at a junior level at The Friarage and the Practice will include mothers and children of military service families. These families make considerable use of the Friarage Hospital services.
- 14 We consider that the wording of the option to retain a 24/7 consultant-led service in the various documents it appeared in was unnecessarily negative with the intention of persuading GP's to overlook it as an option as it focuses heavily on affordability. This is despite the HRW CCG saying that finance was not an issue in the review of the services at the Friarage Hospital. We note that the Options the HRW CCG put forward in the Consultation give a positive focus on finances.
- 15 We are unsure as to why the costs of Option 3 are similar to Option 2 when it does not include the PASSU unit.
- 16 It is important to note that if the 3 options had remained within the Consultation, it is unlikely that the process would have stalled and would have continued through to the Consultation stage.
- 17 We challenge the statement that Option 1 could not be delivered, and further believe it can be delivered at a significantly lower cost than the £2.7 million suggested by the HRW CCG.

A number of the smaller hospitals facing the same challenges, serving very extensive rural catchment areas, and having around the same number of live births as the Friarage have been able to re-arrange their clinical staffing structure to retain a 24/7 consultant led service, and are planning a bright future ahead for between £200,000 and £400,000 annually.

This level of extra investment is well within the financial envelope of the local NHS to provide for a new model of future provision which continues to feature consultants on a 24/7 basis.

It is very important to note that these hospitals have safety records that rival the excellent safety record at the Friarage Hospital.

- 18 We were disappointed to find there were no detailed costs in the Consultation document. It is essential for the public to be confident this is an open and transparent process so just showing a bold figure of £2.7 million without explaining how those additional costs are made up is unsatisfactory.

We appreciate they are stated in one of the many appendices that accompany the Consultation document, but the appendices have not been made available at the public meetings and burying them in amongst a huge welter of pages is akin to hiding them from public view.

- 19 The HRW CCG said they wanted stakeholders to influence the decision making process but the GP Cluster Board paid no attention to this statement when they decided to exclude Option 1(to sustain the services) from the Consultation, a message which was very clearly articulated by the public in the Engagement process as being their preferred choice.
- 20 The HRW CCG say their justification for change has been driven by the clinical concerns of the Consultants that lead the service to provide a safe sustainable service for the future, and not about finance, yet time and time again finance weighs heavily on the arguments it advances on decision which options to propose for the future.
- 21 3 different hospitals were visited by the Trust and CCG along with members of the NYCC Scrutiny of Health Committee in 2012.
1. South Tyneside Hospital was currently consulting to change their children's services and have subsequently done so. They now have a 24/7 paediatric assessment unit, which a child could be admitted overnight and then moved on to a hospital offering in-patient facilities. The hospital still retains a 24/7 consultant-led maternity service.
 2. Wansbeck did not provide paediatric services at the time of the visit, but are still continuing to provide 24/7 consultant obstetric services. They have been operating their system for 10 years very safely so it is sustainable in the long term.

3. Horton General Hospital (HGH) in Banbury was the only hospital they visited that was operating both a full 24/7 obstetric and paediatric service. This service is still in full operation now.

Not all of the facts reported in the business case (Page 69) by the South Tees NHS Trust are correct regarding Horton General Hospital, viz:

South Tees NHS Trust stated that HGH had lost its training accreditation for middle grades. In fact there has never been training accreditation for middle grades.

Also they said the future of the HGH maternity services was under review but that comment is now out of date. The service has been up and running in its new consultant based form from August 2013 and the Oxford University Hospitals Trust, which includes the world famous John Radcliffe Hospital, has repeatedly expressed its total commitment to maintaining and sustaining it.

- 22 Many other hospitals facing similar challenges in similar circumstances to the Friarage and providing the same 24/7 consultant-led services have been put to the Trust as being worthy of examination.

The results of a very well supported RDC Survey of Small Hospitals and the report of the RDC Fact Finding Visit to the South West in October 2012 were immediately made available to the local NHS.

It is a disappointment to record that to our knowledge no detailed discussions have taken place between the local NHS and any other hospitals. If they have, they have not been reported in public and there have been several opportunities to do so.

- 23 It is difficult to escape the conclusion that the local NHS appears to have no interest in alternative solutions other than its own. This has given rise to the public's perception throughout both the engagement process and the NHS statutory consultation of a "done deal".
- 24 In August 2004 there was an Acute Services Review of Hartlepool and Teesside carried out by Professor Sir Ara Darzi. His initial brief was extended at the end of 2004 to include The Friarage Hospital as well as the impact of centralisation of specialist services at the James Cook.

It was his view that shifting services to JCUH over a period of years had caused a destabilising effect to other hospitals.

An extract from Professor Darzi's recommendations in 2005 is as follows:
*"The JCUH should retain its full range of district general hospital-type services and its range of tertiary and supra-regional services. The proposed move of upper-gastrointestinal cancer services to UHNT should free up a modest amount of capacity. **Work should also be intensified to improve integration with and make full use of capacity at the Friarage Hospital, for example in orthopaedics and ophthalmology, to reduce capacity pressures at the JCUH.**"*

Detailed work to come up with a robust and sustainable future services strategy for the Friarage Hospital is underway. I have not anticipated the outcome of those deliberations but believe that changes will be necessary. **Work should focus on securing the future of A&E services, maternity and acute medicine.** It will be hard to justify major trauma and emergency surgery out of hours remaining at the Friarage for the longer term. **However, greater use of the Friarage to relieve capacity pressures at the JCUH should help to secure key services at the latter, for example, anaesthetics”**

The Friarage faces similar pressures to those faced by most acute hospitals serving populations of less than a third to a half a million people. Its ability to withstand those pressures until now has in large been part down to the commitment of its clinical and wider staff team and **the strong support it receives from the local community.**

Integration of services with those at the JCUH – which could provide a route to future sustainability – has until now been limited. Discussions are under way about developing a sustainable future service strategy for the hospital. **Any moves of services out of the Friarage would have repercussions for the capacity at the JCUH, as well as Darlington and a number of other hospitals as far afield as York, Harrogate and Leeds”**

The Leader of Richmondshire District Council, Cllr. John Blackie, in his role as Chairman of the North Yorkshire County Council’s Scrutiny of Health Committee (2002-2009) was present when Professor Darzi (as he was then, Lord Darzi now) published his Report in 2005 that contained the above recommendations. It took place in a Civic Centre in Hartlepool.

Cllr.Blackie specifically asked Professor Darzi about what sort of maternity service at the Friarage did he envisage in his recommendations. He replied without hesitation “a 24/7 consultant-led service”.

Professor Darzi offered to return to the Friarage at a later date to support work on its future. It is unclear whether he did return and if so whether any report of what transpired has been published.

- 25 Fast forward to the present day and now the JCUH has severe capacity problems with obstetrics and Professor Darzi’s recommendations are still as relevant today as they were then. Unequivocally this leads to the conclusion that there should be no downgrading of The Friarage. The two hospitals can work together and strengthen each other.
- 26 The Friarage has the scope and capacity to become a much more effectively used hospital. It is loved by those who already use it and know how valuable it is. It should be seen as an asset to the JCUH and not a burden.
- 27 An alternative model for the future provision of the children’s and maternity services lies within the examples and suggestions within this report. We ask that all options advanced during the Consultation must be clearly, accurately and fairly costed in detail and considered together by all before any final decision is taken.

28 The Friarage has an important role to play in the future for providing local hospital based 24/7 care and a clear vision must be developed for its long term sustainable future without delay.

29 The South Tees NHS Trust strap-line on its website is "Together we do the amazing".

It is imperative that this resolve must be put to the test to arrive at a solution to the satisfaction of the public and the patients that the Trust serves.

We are certain that our Model of future provision contained within this submission provides the solution the local NHS should have been seeking from the outset. So far, some 23 months on from the very start of this long process there appears to be a total unwillingness to make any change whatsoever to the position it set out initially.

The hope that, as William Hague MP said in his speech to the Family Rally/March in May 2013, the NHS would realise it is there to serve its communities rather than the communities being there to serve the NHS, appears a false dawn, at least insofar as the local NHS in the Richmondshire and Hambleton Districts of North Yorkshire are concerned.

Arguments to support the rejection of Options 1 and 2 in the Consultation

OPTION 1 (the Trusts and CCG's preferred option) would leave the residents of Richmondshire and Hambleton with a **free standing Midwife Led Unit (FMLU)** and a **Short Stay Paediatric Assessment Unit**.

OPTION 2 would leave the residents of Richmondshire and Hambleton with an **Outpatient Only Paediatrics Service** and a **free standing Midwife Led Unit**.

Option 1 (worded quite similarly to the previous Option 2 (on Page 4) but **without the word "enhanced"** in relation to community service provision) includes:

- Develop a Paediatric Short Stay Assessment Unit (PSSAU) at The Friarage Hospital. Note that again no hours or days of operation for the PSSAU were put forward within this option, other than to say there would be no overnight in-patient facilities available.

Questioning by the public at Consultation meetings appears to indicate that whilst the HRW CCG would prefer a 7 days a week service, the South Tees NHS Trust wish only to provide a Monday – Friday service.

- Continue to deliver community paediatric nursing and consultant paediatric outpatient service at the Friarage.
- Invest in an MLU for women with low risk births at the Friarage and continue to provide community midwifery and outpatient services locally.

Option 2 (very similar wording to the previous Option 3 (on Page 4) again **without the word "enhanced"** relating to community service provision) includes:

- Continue to deliver community paediatric nursing and consultant paediatric outpatient service at the Friarage.
- Invest in an MLU for women with low risk births at the Friarage and continue to provide community midwifery and outpatient services locally.

Option 2 has been stated as not preferred by the HRW CCG because of its reduction in access (Page 9 of Engagement Document)

Arguments to support the rejection of the proposal for a Freestanding Midwifery Led Unit

On the grounds of Patient Safety

Safety is of paramount concern to all the women who want to use The Friarage now and into the future and there are grave concerns that safety at a Freestanding Midwife Led Unit (FMLU) will be compromised.

We would say from the outset that we have the utmost confidence in the skills, expertise and caring approach of the excellent team of midwives that have served the Friarage Hospital and its patients so very well and so very safely over the years.

However there are other factors to take into account beyond their control which mean that despite their first class care, safety is being seriously compromised in the proposal to establish a FMLU at the Friarage Hospital.

Patient safety was weighted the highest by GP's in the Options Appraisal.

At present with a Consultant Led Service, it is clear to see from the data below that The Friarage has an excellent safety record.

Current patient safety record

Paediatric Deaths in Hospital (over a 3 year total)

The Friarage	3
James Cook	24
Darlington MH Trust	11

Maternal Deaths in Hospital (over a 3 year total)

The Friarage	0
James Cook	1
Darlington MH Trust	1

Stillbirths in Hospital (over a 3 year total)

The Friarage	1
James Cook	47
Darlington MH Trust	48

Neonatal Deaths in Hospital (over a 3 year total)

The Friarage	0
James Cook	37
Darlington MH Trust	16

The Figures above, taken from Page 17/18 of the CCG Business Document clearly show that The Friarage has the best safety record and this cannot be improved by downgrading the service to a FMLU.

There would be no improvement in patient outcomes as patient outcomes are already excellent.

We heard at a recent meeting that there are times when the Labour Ward and the SCBU at JCUH are full, although they say this is rare. When that happens we were told that they divert to the Friarage or North Tees Hospital or further afield.

If the proposals go ahead the Friarage will not be available to divert to causing greater stress, uncertainty and travel for patients.

Ambulances and Transfers compromising safety

There has been concern for some time regarding the capabilities of the Yorkshire Ambulance Service to reach Richmondshire residents quick enough in time of need.

Figures for 2013 up to August 2013 show the Yorkshire Ambulance Service is only reaching 57% of call-outs within 8 minutes in Hambleton, Richmondshire and Whitby instead of the national target to reach 75% within that time. This significant under-performance against the National Orcon standards has been a feature of the YAS service (and its predecessor TENYAS service) for many years.

YAS serves the whole of the Yorkshire Region but they say they are only failing to meet targets in our part of rural North Yorkshire.

Ambulances could be further stretched by extra requests for calls from women going into labour who fear that they do not feel safe going the extra distance to James Cook under their own transport arrangements. That is an unknown factor.

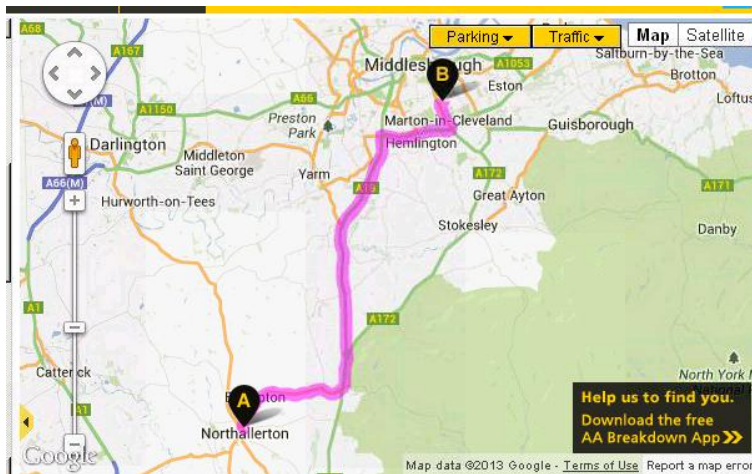
Page 83 of the Trust's Business Document states that the Yorkshire Ambulance Service would only need one additional ambulance funded for an initial period of 12 months whilst the actual implications of the changes are assessed. We believe this temporary provision builds in uncertainty for the long term future of the FMLU, and the parlous state of the finances of the NHS in North Yorkshire will see the provision not made permanent, despite the need on patient safety grounds.

Furthermore, the HRW CCG stated during a recent public consultation meeting that they actually believe that no extra ambulances would be needed because the YAS have recently, over a 3 month period, improved their response times (after its many years of under-performance referred to above). It appears our fears on [patient safety grounds expressed in the preceding paragraph may be confirmed as the HRW CCG Are now saying the extra ambulance will only be provided for 6 months and reviewed after that period has passed.

The transfer Journey by Ambulance compromising safety

If the Friarage became a Midwife Led Unit and women in labour need to travel to a consultant this is the journey they will have to undertake:

This journey is 22.5 miles in distance and from the AA Route Planner would take 37 minutes, although it is accepted that this would be quicker by blue light ambulance.



The journey would take the ambulance from Northallerton onto the A684 which would take approximately 6 minutes and then onto the A19 Northbound into Middlesbrough for the rest of the journey (some 31 minutes).

The A19 is a major trunk road in England running approximately parallel to and east of the A1 road.

From data received from the Highways Agency, the A19 Northbound has been closed during the last 3 years, the following times:

Between November 2010 and November 2013 there were **18 road closures** on the A19 Northbound of varying lengths between Northallerton and Middlesbrough, 5 of those were planned road closures and 13 were unplanned road closures due to road traffic accidents. Some of these road closures extended over several hours.

This means that on at least 18 occasions over the last 3 years lives would have been put at risk by having to transfer a mother during labour to JCUH, because the alternative route to the A19 would take an ambulance much longer to complete the journey.

It is understood that the recommended safe transfer time from one hospital to another when a mother-to-be is experiencing difficulties giving birth is 30 minutes, and this includes 8 minutes for the ambulance to arrive at the Friarage before setting off with the patient. It can be seen that even the standard transfer time between the Friarage and the JCUH when the A19 is open takes the patient beyond this safety limit, and clearly well beyond in the event of a road closure.

In the event of an adverse event affecting the health of the mother or her baby because emergency transfers are acknowledged to be one of the risks involved in the HRW CCG Trust's options, it is hard to overstate the devastation that would be caused to families in this process, not to mention the cost claims for negligence that would have ensued on the NHS.

It appears the local NHS are prepared to take these risks to patient safety on board in the options to downgrade the service at the Friarage they claim to have been devised on grounds of patient safety.

The picture below is from a recent incident and road closure in August 2013.



The A19 northbound was closed between the A67 at Crathorne and A174 at Redcar after emergency services were called to the smash involving the HGV and a Vauxhall Corsa. Cleveland Police said it was likely that this stretch of the A19 would be closed for some time while investigations continue.

Road accident on the northbound A19 on August 6, 2013

On the grounds of the scrutiny of the HRW CCG GPs own Options Appraisal

In the HRW CCG GPs Options Appraisal, and on Page 108 of the Business Case the criteria by which they made their decisions on the options were decided are as below:

- ◆ Safety had been highlighted as a key issue
- ◆ There were some national standards to meet
- ◆ Any option had to be sustainable for at least five years
- ◆ Any option not keeping clinically effective care closer to home to be dismissed

The GP's carrying out the Options Appraisal chose Option 1 (to invest and sustain the service at The Friarage for 4 out of 7 criteria below)

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

The criteria was then weighted using the 'weighted pair's model' where each criteria is given a relative score of importance compared to the criteria, out of 100. Patient safety was weighted the highest as you will see below:

Criteria	COMPARISON						Relative Score	Weight (%)
	A-B	B-C	C-D	D-E	E-F	F-G		
Patient Safety	100						100	16%
Affordability	88.8	100					89	14%
Clinical Effectiveness		107.3	100				95	15%
Patient Experience			85	100			81	13%
Sustainability				117.7	100		95	15%
Equity of Access					87.7	100	84	13%
Cost Effectiveness						100	84	13%
TOTAL							628	100%

The weighted results were as follows:

	WEIGHTED RESULT		
Criteria	Option 1 – Invest in existing service at the Friarage	Option 2 – SSPAU & MLU	Option 3 – Paediatric Outpatients & MLU
Patient Safety	19.11	15.61	10.35
Affordability	4.39	15.28	15.42
Clinical Effectiveness	16.10	15.03	12.45
Patient Experience	14.91	12.52	7.23
Sustainability	5.62	14.73	15.80
Equity of Access	15.85	13.59	7.79
Cost Effectiveness	5.20	13.92	12.92
TOTAL WEIGHTED SCORE	81.17	100.68	81.97

On 4 out of the 7 criteria, the GP’s in the Options Appraisal voted to **retain the services at the Friarage**. The key concern around **Patient Safety**, the option to retain a 24/7 consultant-led service at the Friarage Hospital outscored the other options by a significant margin, as did Patient experience.

Out of the top 4 criteria selected by the GP’s in the Options Appraisal, The Friarage scored the highest in 3 of them.

The CCG say the case for change for this reconfiguration is about safety and sustainability but the GPs chose Investing in the Friarage for Patient Safety, Clinical Effectiveness and Patient Experience.

They have been led to believe that recruitment is a barrier to sustainability but our report shows many examples of other hospitals that are successfully recruiting in a variety of ways and as a result have been able to keep themselves sustainable.

On the grounds of future sustainability

There is a growing body of evidence that Freestanding Midwifery Led Units (FMLU’s) are unsustainable in the long term.

Indeed, Page 114 of the CCG’s Business Case states “The recommendation to the Board is that a service model based on an SSPAU and midwifery led service should be explored as an option through public consultation **but the risks of a requirement for future change if up-take is low must be made clear during consultation** to encourage continued public debate about which models best address issues of safety, sustainability and patient preference.

Page 79 of the CCG Business Document states that an option which offered no deliveries at The Friarage would reduce the choice of place of delivery for more women than any other option.

We would say that to put in place a FMLU is very likely to prove the first step on a short pathway to having no deliveries of babies at the Friarage at all, as it is (by the local NHS's own admittance) an unsustainable long term model.

When questioned at one of the consultation events, residents were told "to be viable you need about a **minimum** of 300 women who would have to book but unless they choose to do that we could not run the unit safely. 300 babies a year means one a day -if it is less than that how do you maintain the skills of the midwives?"

The RCOG Statement on NICE Clinical Guideline 55 Intrapartum Care – Care of Healthy Women and their Babies during Childbirth states:

RCOG supports normal birth but recognises that complications during childbirth are unpredictable and can occur even in low risk births. Although rare in the low risk population, delay in attending to an emergency can result in life threatening consequences for the mother and her baby.

When emergencies do occur when delivering at home or in a stand alone midwifery unit the transfer time to the hospital is crucial to minimise the risks and enhance safety. Studies from Scotland and elsewhere have indicated that 30% of first time mothers assessed as low risk require transfer to an obstetric unit at some stage of labour.

The RCOG favours co-located MLU's (i.e. very closely the arrangement that is the current mode of service at the Friarage now) which guarantee access to a multi-disciplinary team of specialists should the need arise.

Co-located units do not tax the ambulance service and provide access to delivery in a midwifery set up. It also provides women with the option to request an epidural for pain relief. It avoids long waiting times and a possible "rough ride" in an ambulance when mothers are already in pain or in the second stage of labour. Team care throughout pregnancy is likely to give more reassurance, higher quality of care, safety and continuity. This should result in better outcomes and increased satisfaction.

Many FMLU's have already either closed or are in danger of closing. The following is not a complete list:

1. The Jubilee Birth Centre, Cottingham – **CLOSED** 2011
2. Maidstone Hospital, Kent - **CLOSED**
- 3.** Grantham MLU – **CLOSED**
4. Bournemouth Midwife Led Unit – Under Threat
5. Bishop Auckland MLU (290 births) – Temporarily Closed (due to concerns about ambulance transfers)
6. Wycome Hospital MLU – Closed For 3 Months (Due to staff shortages)
7. Berwick MLU – CLOSED from August 2012 – due to low numbers (30 births) (REOPENED AGAIN on partial hours)
- 8.** Lymington Birth Centre – **CLOSED**
9. Crowborough Birth Centre – Under threat
10. New Hope Cross, Wolverhampton – Temporarily closed (due to staffing)
11. Dover Birth Centre – **PLANNED TO CLOSE** 2012/2013
- 12.** Wakefield – **CLOSED**
13. Southport – **CLOSED** 2005
14. Hemel Hempstead – **CLOSED** 2005
15. Brent – **CLOSED** 2008
16. Canterbury – **CLOSED** 2012
17. Llandough Birth Centre – **CLOSED** 2011
18. Tair Afon Birth Centre – **CLOSED** 2012

The Royal College of Midwives has said midwife-led units with fewer than 300 births a year are unlikely to be financially viable if they are fully staffed around the clock.

Evidence also shows costs in midwife-led units can be significantly higher than consultant-led units. "At East Kent University Hospitals Foundation Trust's standalone midwife-led centre, births cost around twice as much as in the main hospital, said assistant head of midwifery Bine Browne".

HSJ's figures show existing midwife-led units are often underused and some appear to be unsustainable.

17 out of 32 stand alone centres - those not on the same site as a consultant-led unit - have seen falls in the number of women giving birth over the last 3 years, according to figures obtained by the HSJ.

Relating to the 2004 Review of Hartlepool and Teeside Hospitals and following an IRP Report in 2005/06, Hartlepool Hospital became an FMLU and North Tees remained as consultant-led. At that time there were 2018 births at North Tees Hospital and 1,680 at Hartlepool. There are now 3200 births at North Tees and only 300 at the FMLU in Hartlepool.

The experience at Hartlepool casts a shadow over the long term future of any FMLU established at the Friarage, as it had a higher number of births when consultants were present (1680) than the Friarage has now, and the retention rate for a MLU birth is only 300.

The South Tees Clinical Futures report in 2005, which examined the future of services at the Friarage Hospital, said the following:

"The success of a Midwifery Led Unit is wholly dependent on the ability of a low dependency service to meet the expectations of local people. There is no certainty that such a service would be well used – and there is local experience at Guisborough of the difficulty of achieving target numbers of deliveries.

"The lead in time required to establish an MLU; consequences for surrounding maternity units; the economics of running this service model and the reduction in choice for patients make this option inherently unattractive".

Author – The current Director of Planning at the South Tees NHS Trust: Mrs Jill Moulton

Update: [The Guisborough Unit permanently closed in 2006](#)

These extracts are very telling - it appears there has been a complete change of mind at the South Tees NHS Trust about the various operating aspects of a FMLU at the Friarage Hospital.

In order to achieve sustainability there is no dispute that the situation does have to change because people are retiring or have retired and they need to be replaced. In addition the service should have had investment in it before now but the Trust has relied on the goodwill of the present consultants to carry the service up to this point. This should not rule out the possibility of investment in the service in the future.

The key issues around recruiting middle grades and appointing consultants is being managed successfully by other hospitals in a variety of bespoke ways so we consider it should not be portrayed by the local NHS as being difficult or impossible to do.

There is overwhelming public support for the Friarage Hospital to continue thriving, going from strength to strength and continuing to deliver the safe, excellent services that it currently delivers.

The JCUH is excellent at delivering specialist services, and it has become a centre of excellence for Stroke, Trauma, Neurosciences, Renal Medicine, Cardiothoracic, Vascular Surgery and Cancer services. There is very strong support for the services it offers amongst all those in the catchment area of the Friarage.

However it is acknowledged that the Friarage is a centre of excellence for maternity and children's services and both the Engagement process and the statutory consultation has robustly demonstrated that it is the wish of the public it serves that it remains that way.

In the GP Options Appraisal, it was agreed that any option had to be sustainable for at least 5 years. We believe our model for future provision is very capable of being safe and sustainable for a period exceeding that length of time.

The Merger of The Friarage with South Tees NHS Hospital Trust

In 2003, just 10 years ago, the Friarage Hospital merged with South Tees NHS Hospitals Trust. The key reason for the merger was to **secure the future of The Friarage Hospital.**

An Extract from a South Tees Trust Report in 2003 to NYCC SOHC

*"The PCT's Vision and Values statement contains a commitment to **safeguarding local hospitals** whilst ensuring access to the most appropriate specialist services where this is needed. **This has been supported by the commitment to meet the relevant revenue costs of the redevelopment of the Friarage hospital site.***

In addition, the merger of the Friarage Hospital into South Tees Hospitals NHS Trust in April 2003 was intended to secure the future of the hospital.

*The report went on to state: "The fact that the Friarage is now part of a larger Trust helps in the management of some of these problems (referring to the problems that small hospitals face), but, **further innovation is needed if services are to be provided to the right standard.** The Trust and PCT are working together and with local communities to develop options to respond to these challenges."*

On the grounds of patient experience

In the Options Appraisal, the GP's chose Investing in the Friarage when considering patient experience.

We feel that women are entitled to receive continuity of care from conception to birth. The midwives a mother-to-be sees from Day 1 of their care through to the midwife or consultant who helps deliver her baby should be from the same Trust, the same familiar environment. Women should not have to consider a traumatic transfer by ambulance from a midwifery unit to a consultant unit if they or their baby gets into difficulty.

Women in labour (written by a mother)

The day a new life begins is the most special day of a women's life. Women have the right to the best experience that can be achieved taking their own, and their baby's safety into account. Babies have the right to the best beginning.

Most women would probably wish to give birth in a "low tech" way but the reality is that quite a high percentage require to be close to the consultants or require pain relief that only being in a consultant unit can give. Even those women identified as being eligible for an MLU would prefer to have the safety net of a consultant at hand should the need arise, hence why co-located units are successful and many freestanding units are not.

More women are being classed as higher risk because of age, lifestyle etc. This trend is unlikely to decrease in the future and means that they will have to give birth where the consultant is.

Loss of Gynaecology Services

An FMLU will mean the loss of Gynaecology Services which will have a great impact on women of **all ages**. Elective and Non-Elective admissions of a lower dependency nature totals around **700 annually**. There would be no inpatient services which would put a greater strain on people from rural areas in terms of travelling, visiting, loss of choice of where to go and potential capacity issues for other hospitals.

On the grounds of patient choice

An FMLU appears to be an unsustainable option for any length of time and its costs do not provide good value for money.

Home Births

According to the RCM and the RCOG, the rate of home births have remained low at approximately 2% but it is believed that if women had true choice the rate would be around 8-10%.

Richmondshire and Hambleton women who choose a home birth need to know that the consultant is not so far away otherwise it will deter them from choosing a home birth, or the criteria for a home birth will become so tight that it will not be an available choice for them.

An FMLU at The Friarage would deter women from choosing a home birth, especially those mothers-to-be in the Dales, as the distance to the JCUH would be too far. For example the distance from the town of Hawes (population 1500) to the JCUH is 60 miles.

Women historically have not chosen to deliver their babies at Darlington Memorial Hospital in Darlington, County Durham, because very few babies from the HRW CCG

Area have been born there. Page 13 of the CCG Business Document shows that annually only 4% (46) of women registered with a Hambleton & Richmondshire GP Practice have given birth there.

The same data shows only 8% of women have given birth at JCUH.

87% of Hambleton and Richmondshire women do, however, choose The Friarage to give birth. Nearly 1300 women choose The Friarage where they can currently have the option of a high tech or low tech birth. They do not have to make a choice about safety because the safety record is excellent and they know a consultant is on hand if needed.

Only 19 women from Hambleton & Richmondshire chose a home birth in 2011/2012 according to Page 36 of the business plan. This would reduce further if consultant services were to be withdrawn from the Friarage. The distance into James Cook would be too far.

Geography and travel

Many patients, women, families and children already have a considerable travel time to get to hospital from many parts of Richmondshire. From the Upper Dales for example they need to travel between 55 – 65 miles.

The weather the Upper Dales experience in the winter is characteristically hostile, with frost, ice, and particularly snow a regular feature between late October and Spring. In late March 2013 the high moorland routes were closed by snow drifts of 10 -15 feet in depth, and even the lower level main routes out of the Upper Dales in the valley bottoms were impassable on a number of days for several hours at a time.



The distance from Hawes to the Friarage Hospital in Northallerton at 38 miles is already a long enough journey for a woman in labour. There have been a number of occasions when expectant mothers have given birth to their babies in lay-bys on route to the Friarage. The idea of them having to travel another 22 miles to James Cook is totally unacceptable to them.

Unlike the journey to the Friarage, the quickest route for the journey from Upper Wensleydale to the JCUH involves using the high level tank road on wild moors near Catterick Garrison, a lonely and intimidating road in winter in daylight, let alone the dead of night when swirling fog and low cloud is an additional hazard.

No wonder the attendance at both the Engagement process meeting and the Consultation meeting in Hawes were each attended by well over 100 people, many more than in meetings held in much larger towns.

During the winter months even getting about to do the daily routine is particularly worrying for residents in the Upper Dales, without making extra long-distance unplanned or planned journeys to hospitals, clinics, doctors and so on.



In addition to our residents, the Hambleton and Richmondshire areas have a very significant number of families visiting for holidays and days out throughout the year.

Arguments to support the Friarage to retain its 24/7 consultant-led services

- The CCG's Needs Assessment Pack identifies Richmondshire as having the highest rate of low birth weight babies in North Yorkshire, low birth weight being a marker of poor maternal health
- The CCG's Needs Assessment Pack states there are teenage pregnancy hotspots in Northallerton, Catterick and Thirsk.
- The CCG's Needs Assessment Pack states C sections are on the increase at The Friarage
- The CCG's Needs Assessment Pack identifies Richmondshire and Hambleton as having high rates of hospital admissions in children as a result of injury and the statistics are significantly worse than the rates for England.
- There are 1889 admissions annually to the paediatric ward, and 482 paediatric admissions were between 8pm – 8am. 21% of A&E activity for children is from 8pm to 8am, and 77% of this is up to midnight.
- Page 26 of the reconfiguration documents states that deprivation (which is associated with poorer health) is higher than average in parts of Richmond, Colburn and Northallerton.

Catterick Garrison (England's largest military base)

- The military practices which has been noted have not been included within the CCG do not seem to have been consulted either. One of these practices is in Catterick Garrison and will have a patient list which includes military wives and children who very extensively make use of services at the Friarage.
- Also the MOD provide doctors to work in obstetrics and paediatrics which bolster the services at the Friarage.
- Research shows that the structure of the population amongst the MOD families in Catterick Garrison, the largest Army Garrison in Western Europe is heavily weighted towards young families, mostly those of the soldiers who serve our nation so very bravely.

Army units are sent on overseas assignments from time to time, for example to Afganistan, and this very often leaves young mothers alone in the Garrison, expecting babies and / or with young families. Often it is the case that they do not have transport of their own to rely upon. Whilst public transport to Northallerton is not over generous, it is possible to get to the Friarage for a hospital appointment, and return within a reasonable time frame. It is almost impossible, and only with a large number of bus changes to get to the JCUH and back within a day from the Garrison.

- The peace of mind of the soldiers who serve our Nation overseas, and come from Catterick Garrison has been completely overlooked in the Consultation.

Those with young families, or partners who are expecting a baby or both, need to feel that their loved ones left behind in the Garrison will have the hospital facilities they require close at hand and reasonably accessible, otherwise it can become a source of great worry to them whilst with their unit and posted abroad.

Whilst Darlington Memorial Hospital is closer to Catterick Garrison than the Friarage, traditionally over many years the families of those serving the Nation have attended by choice the Friarage Hospital for their maternity and children's services.

The Duchess of Kent Hospital in Catterick Garrison had a maternity wing which served the Army families for many years. When it was closed down, in the 1980's, it was on the basis of the re-assurance "Do not worry – there will always be the Friarage for maternity".

On the grounds of Capacity Issues at JCUH

This is a very important concern which we believe has not had the attention paid to it that it should have during this process.

JCUH serves a population of around 500,000 for its core local hospital services, and 1.5 million for its tertiary specialist services, for example the first class heart and cancer services it provides.

The Friarage Hospital serves a rural population of 122,000 over an area of 1000 square miles.

The Darlington Memorial Hospital serves a current population of 600,000 and a core population of around 125,000

Activity Assumptions

South Tees NHS Trust clearly state that it is at capacity for obstetrics and the birth rate is continuing to grow. The patient experience of mothers-to-be whilst in confinement was described as just "adequate" at the Consultation meeting in Hawes in October by the Head of Maternity Services at the South Tees Trust, Mrs. Fran Toller.

Just to cope with growth in its own area it needs to expand physically. In the JCUH catchment area of Middlesbrough and Redcar and Cleveland, local councils have stated there is expected to be 11,500 new homes built over the next 15 years, which inevitably will include many young families to the area and an increase in births.

However, when the new hospital at Wynyard is built as it is planned to be in 2017, North Tees Hospital and Hartlepool Hospital will close and North Tees (at Stockton) presently has 3200 births per year. It is certain that a significant proportion of this patient flow will go to JCUH, which will be nearer to Stockton than Wynyard.

Page 63 of the CCG's Business Case states that the plans for additional capacity have been based on providing an additional 1000 births at a cost of £6 million.

Mysteriously, at the Consultation meeting in Richmond held on 20th November 2013 the audience were informed that this figure has now been reduced to £1 million.

It seems that these 1000 births would soon come from its own area without the additional uptake from Hambleton and Richmondshire, where it should be noted, growth over the next 13-15 years will see some 7335 new homes built.

It is contended that the JCUH will be unable to cope with this steeply increasing extra patient load.

For paediatrics JCUH says it has capacity to take children from The Friarage but unless a child is very sick and needs the specialised care of JCUH, we consider the Friarage offers parents from Hambleton & Richmondshire everything they need.

Parents of those children with complex healthcare needs that require Open Access to the paediatric services will often have other children to consider, together with the distances and costs involved with the extended travel. For them the Friarage is a treasured asset to assist in the hugely demanding task of caring for a child with these complex healthcare needs.

Page 36 of the Trust Business Document shows that annually on average 58 babies from outside of North Yorkshire use the Special Care Baby Unit (SCBU) facilities at the Friarage.

A solution to address the capacity problems experienced by JCUH would be to promote giving birth at the Friarage. The slightly smaller facility with an excellent safety record and an ethos of a family circle approach to care would be the ideal place to have a memorable and unpressured birth experience

If JCUH actively encouraged some of their mothers to consider giving birth at the Friarage and promoting it as a smaller, more intimate experience, yet just as safe with consultants at hand, then it would immediately help with the capacity problems currently at the JCUH and those additional pressures it will face in the future. This will increase the number of live births at the Friarage, maintain / improve the skills of the clinical staff, and will balance sustainability at both hospitals.

There are several larger communities between Northallerton and Middlesbrough where it is equidistant or thereabouts to either hospital yet the JCUH is the usual choice. It is these communities that could be the target for this initiative.

Whenever this suggestion has been made, it appears to have been branded by the local NHS as a non-starter without any reason given for why it should be. It will feature in our model of future provision later in this submission.

Future Housing Growth – Hambleton & Richmondshire

Hambleton and Richmondshire are served by only one district hospital, the Friarage within the boundary of the CCG. Although the CCG covers Whitby as well, the population of Whitby has a choice of Scarborough Hospital or the JCUH.

The boundaries are complex, with the Friarage being part of South Tees NHS Trust which lies in Middlesbrough, beyond the CCG Area. However it is all the more important that the HRW CCG maintains full general hospital services at the one hospital that it has in its area. The area has been marked out for population growth.

Housing growth in Richmondshire (including the Yorkshire Dales National Park) over the next 15 years expects to see an additional 3060 new homes. 1900 of these are expected to be built in Catterick Garrison, where a new town centre and the opportunities for growth provided by the A1 upgrade will strengthen the district

centre. Housing delivery is expected to progress at the rate of 180 homes each year on average.

Housing growth in Hambleton over the next 13 years (to the end of the Plan Period) is expected to be in the region of an additional 4,335 new homes. 808 will be in the Bedale Sub Area, 1,363 are expected in the Northallerton Sub Area and 1,313 are expected in the Thirsk Sub Area. There will be a further 420 in the Stokesley Sub Area. All these localities look to the Friarage Hospital for their maternity and children's services.

Future Housing Growth – Middlesbrough

Housing growth in Middlesbrough to 2029 (the end of the plan period) is expected to be in the region of an additional 7,000 dwellings, with approximately 400 dwellings delivered per annum on average.

Future Housing Growth – Redcar & Cleveland

The Draft Redcar & Cleveland Local Plan, currently out for consultation, proposes the development of up to approximately 4,500 dwellings at an average of 300 units per annum over the period 2014/15 to 2028/29.

Excluding commitments on small sites which are distributed throughout the borough (estimated at 300 dwellings), the indicative geographical sub-area breakdown is:

Greater Eston area: 1100 units
Redcar / Marske: 1500
Guisborough: 700
East Cleveland: 900

Future Housing Growth – Stockton

Although the majority of residents of Stockton will probably at present choose to use the maternity and paediatric services that are currently at North Tees Hospital, there may well be some who will choose the JCUH because they can exercise their choice and it is relatively close by so this should also be taken into account.

However, if the new hospital at Wynyard is created as planned in 2017 it would mean the closure of North Tees Hospital and Hartlepool Hospital and this will entail a large increase in women and children choosing James Cook who are already at capacity for obstetrics.

From the above it is clear to see that capacity will remain an on-going issue for JCUH with the continuing growth in the populations it already serves, without taking the extra births generated from the housing growth in Hambleton and Richmondshire.

Overall Housing Growth

Middlesbrough	-	7000
Redcar & Cleveland	-	4500
Sub Total	-	11,500

plus (unquantified) the patient flow when North Tees Hospital in Stockton closes when the new hospital at Wynyard opens in 2017 - North Tees currently has 3200 births per year).

plus growth in:

Richmondshire	-	3060
Hambleton	-	4335

TOTAL - **18,895**

(plus those expectant mothers and families with children who are unwell displaced if the Friarage services are downgraded – the local NHS estimate between 500 – 750 expectant mothers will annually have their babies at the JCUH)

Arguments in support of the rejection of a Paediatric Short Stay Assessment Unit (PSSAU)

On the grounds of Patient Safety

Under the current proposals, Page 56 of the Business Case says that the PSSAU would be provided in place of inpatient paediatric facilities would be available 5 days a week, 10.00am -10.00pm, with the last child to be seen no later than 8pm. They say further discussions would need to be had about trialling a Saturday. They suggest that they could not resource a 7 day assessment unit.

Although the possible opening hours have been mentioned in the Business Case, they were not included in the Consultation for consideration and debate.

Our visits to various small hospitals indicate that the busiest time for patients to arrive at their paediatric unit is between 6.00 pm and 11.00 pm at night. To set the time at 8.00 pm for the last child to be examined cuts the service off from the greatest number of its potential users. Our visits also indicate that the numbers of

patients arriving at the paediatric units throughout the day and evening at weekends is very little different to those on Monday – Friday.

This demonstrates clearly that the Trust and the CCG are not taking note of the concerns that have been overwhelmingly voiced over the accessibility and safety of a unit based on this proposed operational plan. It may also explain why they state that this Option would incur no extra costs.

Patient Admission Criteria

Page 56 of the CCG's Business Case states that there will be strict criteria for children being allowed to use or not use the Paediatric Assessment Unit. However the exact criteria are not made clear in the documentation, so it is hard to arrive at a judgement.

Children coming into A&E

Page 57 of the Business Case states that there will be no change for major or minor injuries but for minor illnesses where a child needs to see a paediatrician if the Assessment Unit is not open, children will be directed elsewhere.

There is great potential for confusion and waste of valuable time and expense in what is proposed. Parents are not usually in a position to judge whether their child is suffering from a minor illness, and so decide themselves on which is the best location to head for.

This uncertainty is a factor that threatens the health and safety of the children at risk.

Loss of Maternity and Special Care Baby Unit (SCBU)

The CCG state that under both options it would mean that high risk obstetric services, as well as the Special Care Baby Unit would be lost. We have examples within this report of hospitals where 24/7 consultant delivered obstetric services have been retained despite there being significant changes to the Paediatric Services.

South Tyneside for example has a 24 / 7 Children's Assessment Unit, but only allow unwell children to stay overnight for the first night before transferring them to a hospital with in-patient facilities.

We heard that sometimes JCUH is full (labour ward & SCBU) and they use the FHN at these times or Durham or elsewhere but that will not be possible under the options that they are proposing.

On the grounds of Future Sustainability

Impact on families, patients and visitors

When families have other children it makes it extremely difficult, time and cost wise, to have to travel significant distances beyond their homes. The Friarage is highly regarded as a local community asset of huge value being in the centre of a large town, the administrative town of the County. Being there 24/7 for the communities that it serves is the best value option from the point of view of those the Friarage is there to serve.

On the grounds of Patient Experience and Choice

Paediatric Open Access

For the children and babies with complex health conditions who are discharged from hospital and provided with Open Access the knowledge that this is available locally is hugely re-assuring to their parents.

For example, a child or baby from Thirsk will have a 40+ minute journey to the nearest hospital offering Open Access instead of a 15 minute journey. This would result in a very difficult journey and, in some cases, may result in an ambulance being called where currently personal transport is used.

The loss of the Open Access facility, although it is only for a small number of patients, does heap stress on top of the often very stressful and demanding role of caring for a child with complex healthcare conditions. Parents very often care for their children for many years.

- The CCG's Needs Assessment Pack identifies Richmondshire and Hambleton as having high rates of hospital admissions in children as a result of injury and the statistics are significantly worse than the rates for England.
- There are 1889 admissions annually to the paediatric ward, and 482 paediatric admissions were between 8pm – 8am. 21% of A&E activity for children is from 8pm to 8am, and 77% of this is up to midnight.

As referred to above these statistics do challenge on their own account the proposed mode of operation of the PSSAU as offered with the Consultation document. The proposals of the local NHS do not meet the healthcare needs of the local communities it is there to serve. The key criterion of any healthcare service provision change is improvement in the outcomes for the patients, and we strenuously argue that what is being proposed is significantly detrimental to these outcomes, disastrously so for patients who are accorded Open Access status because of their complex healthcare conditions and needs.

On the grounds of Cost

The figure of £2.7 million to provide a consultant-delivered service has been challenged at every public meeting where the downgrading of the Friarage has been discussed. The local NHS has failed to convince the public of the authenticity and credibility of the figure. Trying to pursue explanations within the documentation provided to underpin the Consultation has been equally unconvincing.

Following them up at a public meeting by questioning the local NHS merely adds to the dense fog that clouds the exact nature of the actual costs themselves. **More of this later in this section.**

The main report states that the additional cost of maintaining a consultant-led service would be £2.7million. Actually what is being provided is a consultant-delivered service and reference to this unnecessary and extravagant upgrade can be found in the section that follows on Our Model for the Future Provision of the Service.

On p105 (electronic) of the report, the £2.7 million is divided into an additional cost of £1.6 million for the paediatric service (for 10 additional WTE) and £1.123million additional cost for the obstetric service (for additional staff).

However, as stated on p9 of appendix 6 it states that “taking into account both changes in cost and likely loss of income the Trust’s financial position will be adversely affected by all of the options considered.”

The table at the bottom of this page shows that the difference between the Trust’s preferred option (paediatric assessment unit and midwifery led unit) and the consultant delivered model is £1,440,000 (-£1,312,000 compared with -£2,752,000).

Indeed the difference between the cheapest option (outpatient only paediatrics service and no deliveries at FHN) and the most expensive (consultant delivered model) is £1,796,000.

By now the determined investigator of the actual costs may well be confused.

There are only limited costings for the different options. The table at the bottom of p9 (and repeated on p81) takes its figures from the table at the top of p9 (repeated on p 80). In turn these figures are taken from the tables on pages 51, 54, 58, 59, 63 and 66.

The first line of the cost element of these tables gives Medical Staffing costs, including WTE. However, there is no proper breakdown into consultant/middle/junior grade or ANNPs.

The comments above the tables for Option 1 (paediatrics on p51 and obstetrics on p59) give some indication of the numbers of proposed staff at which grades, the other options do not.

Capital costs

Pages 67-70 of Appendix 6 refer to the capital costs which would be incurred and which have not been highlighted by the Trust. The options referred to on p67 are 'options 2a and 2c and 3a and 3c' so do not match options 2, 2a, 3 or 3a used on p9 nor the options 2a and 2b or 3 on pages 40-42.

Confused still ??

It is not clear on the capital costs implications for each of the options costed on p9.

However, the capital costs estimates to improve facilities at the JCUH range from £6 million to £10 million.

As stated on p70 of this appendix, 'this investment would significantly reduce availability to commit to any further capital expenditure beyond that already built into our plans' and could therefore affect other potential improvements to James Cook.

Essentially, the costings are not sufficiently detailed to allow proper scrutiny of them.

Instead we rely upon information gained by questions at the meeting with Richmondshire District Council on 20th November 2013, which were answered by Jill Moulton, Director of Planning at the JCUH, and Dr. Vicki Pleydell, Accountable Clinical Officer for the HRW CCG.

- The extra cost of a consultant-delivered service at the Friarage is £2.7 million.
- However to the South Tees NHS Trust there will be a loss of income as patients who formerly used the Friarage Hospital will instead seek their healthcare services from other hospitals, and in particular from the Darlington Memorial Hospital. The figure in the costings above are a loss of £1.3 million of patient income, but at the meeting it was suggested the figure would be nearer £2 million.
- Whilst this sum is lost to the South Tees Trust it will still have to be paid out by the HRW CCG but it will be very nearly all lost to the health economy of North Yorkshire.
- The capital cost of upgrading the facilities for maternity described currently as only 'adequate' at the JCUH are shown as between £6 million and £10 million in the documentation, as indicated above.
- However this amount was suddenly reduced to £1 million for a new theatre alone at the meeting on 20th November. It appears there will be a number of measures taken to improve capacity at the JCUH, including converting 3 bedded bays to 4 bedded bays, and conversion of redundant spare space into new bedded bays.

- The cost of the proposed free bus service between the Friarage Hospital and the James Cook University Hospital will be £250,000 per year. This is new line of expenditure as a free inter-hospital bus service has never been available in the past.
- The cost of the proposed additional ambulance to bolster the response times for emergency inter-hospital transfers for mothers-to-be who develop complications giving birth at the Midwife-led unit at the Friarage and need to be transferred to the JCUH, plus calls to the more remote communities where the distances to the JCUH for an expectant mother in difficulties is too risky to undertake in their own transport is £250,000 per year.

The wildly inaccurate capital costings, ranging from £1 million to £10 million, the cost of £2.7 million to provide the service being offset by £2 million of lost patient income and £500,000 of extra service costs, give credence to the statement from the South Tees NHS Hospital Trust that "taking into account both changes in cost and likely loss of income the Trust's financial position will be adversely affected by all of the options considered."

The HRW CCG will maintain they have to pay for the birth wherever the mother-to-be chooses, and clearly they do, but it is funding lost to the healthcare economy of North Yorkshire if it is spent beyond the borders of the County.

However it can be said that merely quoting a figure of an additional cost of £2.7 million, as shown on Page 7 of the Consultation document and describing this as additional investment is highly misleading when the other expenditure and loss of income mentioned here is taken into account.

What is certain is that the Friarage Hospital needs no capital investment as it was subject to a multi million investment 6 or so years ago which upgraded the facilities for children's and maternity services to 1st class status.

And judged by the experience of other small hospitals on which our Model for the Future Provision of the services is based, you could continue a very safe and sustainable 24/7 consultant-led service for £200,000 annually.

It is better that we let the figures do the talking.

Alternative options for the Model of Future Provision at the Friarage Hospital

General points to be taken into account

1. The Independent Reconfiguration Panel (IRP) advised that “The consultation may also wish to invite new options and not limit respondents to those listed. Any new options put forward can be evaluated post-consultation in line with the agreed criteria”.
2. The Secretary of State for Health, in announcing his decision not to refer the proposals to the IRP at this stage directed the local NHS to review any new options submitted during the Consultation to the same exhaustive process to those they had put forward themselves.
3. Richmondshire District Council has led the way in researching and visiting other small hospitals around the country in 2012 and 2013.
4. As a result of carrying out this work it has been able to produce evidence based real examples of a range of precedents and solutions that are being worked up and down the country which can be drawn upon to sustain services at The Friarage into the future. A package of these options will be assembled to form our model of future provision for the Friarage.
5. The CCG stated on Page 8 of their 112 page engagement document that at the request of William Hague and other local politicians they have left no stone unturned to look at small paediatric and maternity units and had received the research that this Council had undertaken in 2012.
6. Visits were made by the CCG to South Tyneside, Horton General Hospital in Banbury, and Ashington Hospital, Wansbeck in the early stages of the engagement exercise at the suggestion of this Council and the NYCC SoHC.
7. There is limited commentary of the visits, and very brief reasons why such models would not work for The Friarage.
8. In October 2012 Richmondshire District council visited 3 hospitals in the West Country and produced a report (**Appendix 2**) which was given to the South Tees Trust and the CCG. It appears the local NHS did not follow up any of the alternative solutions offered in the Report, although the hospitals visited were successfully providing a safe and sustainable consultant-led service and overcoming the very challenges we are advised the Friarage faces as well.
9. It appears, according to the local NHS, that whatever solution any other hospital has found to sustain services they were not workable for the Friarage.

10. We believe that this negative attitude to finding solutions stems from the fact that to find a solution is a direction the South Tees NHS Trust / HRW CCG does not wish to travel along, which poses the question William Hague MP asked at the Family Rally / March in May 2012 in front of 4000 people - is the service for the NHS managers and the clinicians or the public and patients?
11. In October 2013, this Council visited 3 further hospitals in Scotland:
Borders Hospital, Melrose
Dumfries and Galloway, Dumfries
Dr Grays, Elgin
12. Information about all those visits features in the pages to follow.
13. It is clear that solutions are there to be worked out if there is a willingness by the South Tees NHS Trust and the HRW CCG to travel in that direction. This is what the public, the patients and the politicians (on behalf of those they represent) dearly want to be the outcome of the engagement process and the consultation

Staffing

The South Tees NHS Trust suggest that the main problems at the Friarage stems from recruiting staff who want to work at small hospitals, and also the clinicians not overseeing enough work to maintain their skills, particularly in paediatrics.

However our evidence confirms that other small hospitals find ways to recruit staff, plan compliant rotas, maintain skills and carry out forward planning well in advance of staff retirements.

Changes needed to staffing at The Friarage were highlighted in the Clinical Futures Report in 2005 and it is obvious that little has been undertaken by the South Tees NHS Trust to address this point since then.

The business case (Page 6) contained details of the Trust's opinion about future staffing numbers if both paediatrics and obstetrics services at The Friarage were to be sustained, as follows. Note we have also included the present staffing numbers at JCUH for comparison.

Paediatric present & future staffing information at the Friarage compared with present staffing at the James Cook University Hospital

	PRESENT PAED STAFFING FHN	FUTURE PAEDIATRIC STAFFING TO SUSTAIN SERVICE FHN		PRESENT PAEDIATRIC STAFFING JCUH
F H N	Consultant Paediatricians 5.4 WTE	Consultant Paediatricians (resident in hospital) 12 WTE	J C U H	Consultant Paediatricians 9.8 WTE
	Middle Grade 0	Second Tier Support (either Middle Grades or ANNP'S) No figures quoted		Middle Grade 9
	Junior Staff 6 (4 GPVT, 2 Military)	Junior Tier 1 staff No figures quoted		Junior Staff 8

GPVT = GP Vocational Trainee

Past, Present & Future Staffing Information – Obstetrics (Maternity) – Friarage (1300 births) compared to James Cook (4200 births with a co-located MLU as well as Consultant Unit)

	PAST OBS STAFFING FHN <i>(2005 clinical futures)</i>	PRESENT OBS STAFFING FHN	FUTURE OBS STAFFING TO SUSTAIN SERVICE FHN		PAST OBS STAFFING JCUH <i>(2005 clinical futures)</i>	PRESENT OBS STAFFING JCUH
F H N	Consultant Obstetricians 4	Consultant Obstetricians 4 WTE + (1 Associate Spec not on call)	10 WTE or (12 WTE, as Middle Grade expansion is not achievable)	J C U H	Consultant Obstetricians 12	Consultant Obstetricians 11
	Middle Grade 7	Middle Grade 6 (5 SPR, 1 Trust Dr)	Not believed to be achievable to expand		Middle Grade 9	9
	Junior Staff 3	Junior Staff 4 (2 GPVT, 2 Military)	with support from Junior Staff		Junior Staff 7	7

SPR = Specialist Registrar, GPVT = GP Vocational Trainee

See Matrix (Appendix 1) to see an easy view comparison on consultant numbers at the various hospitals:

Maintaining skills

Page 37 of the business case states there is limited rotation in Paediatrics to help maintain skills. Consultants at The Friarage do only 2 weeks a year at James Cook and Consultants at James Cook only do 1 week at The Friarage except when extra cover is required.

We have examples within this report of how other hospitals address this by the rotations that they have put in place. This should be able to be replicated by our 2 hospitals.

- Encouraging more births at The Friarage would also address many of the problems regarding throughput, maintaining skills, attracting staff to smaller hospitals and so on.
- It is important to note here that midwives need to maintain their skills too and too little activity at a Midwife Led Unit would soon lead to a deterioration of skill base, a problem with staff retention and more importantly the safety risk to mothers and babies.

Visits to small hospitals facing the same challenges and circumstances as the Friarage

Richmondshire District Council, represented by its Leader, Cllr. John Blackie, visited 6 small hospitals facing similar challenges and circumstances as the Friarage in 2 series of visits – in October 2012 to the West Country and October / November 2013 to Scotland.

On occasions Cllr. Blackie was accompanied by Cllr. John Robinson, Chairman of the RDC Scrutiny Committee which has health within its remit, and the RDC Scrutiny Officer, Mrs. Penny Hillary.

A Report on the visits to the West Country was compiled in October 2012, and subsequently presented to Richmondshire DC and the NYCC SoH Committee. It was included in the documents forwarded to the Secretary of State for Health when the SoHC referred the matter to him in December 2012.

It is included within this submission at Appendix 3.

Other information assembled on the other hospitals in the following pages has been from telephone conversations Penny Hillary has had with the hospitals themselves.

North Devon Hospital, Barnstaple – 1626 births (visited by RDC in October 2012)

Operating Consultant Led Services



Serving a population of 165,000 over 950 square miles
Part of North Devon Healthcare NHS Trust offering acute services centred on North Devon District Hospital (NDDH). The hospital has 341 beds.

24/7 Consultant led Obstetric Unit
Level 1 Special Care Baby Unit
24/7 Consultant led Paediatric Unit
Open Access + Acute Access Facilities

Staffing

All Consultants live within 20 minutes of the Hospital

Paediatrics:

7 Middle Grades comprising General paediatric middle grades:
3x ST3, 1x ST4 (Currently one vacancy filled with locums)
2x Specialty doctors (currently one vacancy filled with locums)

Community paediatric middle grades:
Specialty doctor 0.9 WTE
Specialty doctor 0.6 WTE

6 Juniors comprising 1xF1, 2xGPVTS either at ST1 or 2, 2xFTSTA1 or 2 (intermittently filled by Deanery or by ourselves with stand alone posts)
Currently we also have one additional but temporary part time F1 doctor.

Obstetrics:

6 Consultants,
7 Middle Grades (non training posts)
6 Juniors

Rotas

Paediatrics rota:

General paediatricians work with 5 people doing "resident weeks" Monday to Thursday 4 pm to 10 pm and 9 am to 5 pm on Friday. 2 (not on resident rota) work 1:5.45 nights per week, "resident consultants" work 1:9.3 nights per week. Part time consultant works 1:10.9 nights. This rota will be changed with changes in staffing planned for future.

"We wish to water the frequency down of Consultants on call and put everyone on an equal share of nights. Some resistance but we are getting there with plan for reconfigured service in the New Year assuming it is all signed off."

This will include taking the vacant community staff grade post and turning it into a general post, putting elements to varying degrees of the community work into all posts so removing "stigma" of community work.

Therefore all posts will be general with elements of community posts.

Obstetrics Rota:

6 Consultants do a week on call each which is a full 24/7 on call and during that time they provide 40 hour labour ward cover. The 6 work in 3 teams, the first team is the obstetric team, the 2nd team is oncology and the 3rd team is uro-gynae, and they are a mix of obstetricians and gynaecologists and there is only 1 who does not do obstetrics on a part time basis but he does do the rota.

They recruit for them to cover both Obs and Gynae so they only cover one week in 6 on call. When not on call they are doing their normal duties Monday to Friday. One of the doctors on the obstetrics team works slightly less programmed activity and he provides locum cover for the emergency weeks when the others want to take annual leave & etc. so we always cover the emergency weeks. When they are on call they don't have any theatre time or clinics so they are purely on call available for the labour wards.

Specialist Obstetric Grades maintain skills because they do full sets, section lists, on call and where there is a more difficult case the consultants come in.

Maintaining Skills

Because our obstetric specialist grades do full sets, section lists, on call there is opportunity once every 6 weeks to practice clinical skills and keep them up. They can do suturing, sections etc. and its up to the individual person to keep their skills up. Where there is a more difficult case the consultants come in

We see enough paediatric general work and for neonates we could be seconded regularly to a larger centre or use our 10 day study leave to go to a larger hospital. You could arrange it formally or arrange it yourself.

Recruitment

For the Middle Grade in Obstetrics we have had a very good field of candidates. "Last time we recruited for general paediatric consultants at the beginning of 2012, we had a field of 18 of which 11 were exceptionally good"

We had some problems covering the paediatric middle grade rotas so to help we put in a bid to the SHA about 3 years ago and it is now funded by the PCT for 3 additional consultants so they work until 10 o'clock at night and we have just had a meeting together to move to a cohesive rota so that the traditional rota will work the same as the younger ones.

Future Sustainability

In 2012 a purpose built new Children's unit was opened bringing together services for women, babies and children which includes a purpose-built Children's assessment unit and high-dependency unit, a cardiac monitoring system, school, play and overnight family rooms, improved facilities for parents and a new resource room for Doctor training.

The Children's Assessment Unit is co-located with the SCBU so there is bolstering of skills from the children's nurses. Specialist Clinics are also held there.

This demonstrates a commitment to the future of Womens and Childrens services.

Extra cost of sustaining the Service

The 3 extra consultants appointed 3 years ago costs were approximately £300,000

Patient Safety Record

There is an excellent safety record at North Devon.

Yeovil District Hospital - 1500 births (visited by RDC in October 2012)

Operating Consultant Led Services



Run by Yeovil Hospital NHS Foundation Trust

The Hospital has 345 beds and provides a full-range of clinical services, including general medicine, cardiology, general surgery, orthopaedic surgery, trauma and paediatrics, with an emphasis on enhanced recovery.

24/7 Consultant led Obstetric Unit
Level 1 Special Care Baby Unit

24/7 Consultant led Paediatric Inpatient Unit for children and young adults from birth to 20 years of age
Paediatric Assessment Unit based in A&E

Open Access + Acute Access Facilities

Staffing

All Consultants live within 20 minutes of the Hospital

Paediatrics:

6 Consultants

7 Middle Grade, comprising 2 Speciality Doctors, 3 ST4 & 5,

2 Locum Appointment for Training Doctors (likely to become Speciality Doctors)

7 Juniors

Specialist children's nurses support children attending A&E through the PAU

Obstetrics:

5 Consultants

7 Middle Grade, comprising

7 Juniors

Rotas

Paediatrics Rota:

There is a paediatric 3 tier system, 24 hours a day so at any one time there is a Junior grade doctor and a Senior doctor available. In terms of who is actually physically here ordinary working hours it is well staffed, lots of doctors around.

Out of hours there is a resident junior Doctor who just does paediatrics, a middle grade Doctor who just does paediatrics and an on-call consultant who is not resident in the hospital but within 20 minutes and that is how it has been for about 7 years. .

Obstetrics Rota:

There are 5 consultants, and there is a Consultant on call for the labour ward every day, they do not all provide the obstetric cover but we are considering providing this. We are looking at providing 60 hour cover @ CSNT level 3.

We did implement prospective cover for Obstetrics which means a dedicated Consultant on call for a week for the Labour Ward and changed the rotas to accommodate this.

Maintenance of Skills

“For Paediatrics we see sufficient numbers to maintain skills. We are at Level 1 SCBU which we are happy with and because we will never get sufficient numbers of patients that need a higher level of intensive care”.

Recruitment

Paediatric consultant recruitment has never been a problem, there are no vacancies. Obstetric posts have never failed to be filled.

Future Sustainability

Yeovil’s Clinical Services Strategy 2012-2015 – Developing a new model for a rural District General Hospital states that its inner core of services will be made up of:

- The Emergency Department (A&E)
- Acute Medicine
- Acute Surgery
- Trauma
- **Acute Paediatrics**
- **Acute Obstetrics and Gynaecology**

This demonstrates a commitment to the future of Womens and Childrens services.

The Strategy states that maternity services are not services for the acutely unwell. However, a consultant led obstetric service helps to sustain paediatrics by providing a volume of work associated with the peri-natal and neonatal care. Obstetric services also help to sustain anaesthetics, theatre and critical care services.

The review has concluded that obstetrics should remain as a core service at the Trust with options for the expansion of the obstetric and midwifery service being explored and supported by the physical redevelopment of the Women's Hospital. As part of this, the service will explore the expansion of midwife led services.

Yeovil have been innovative in developing inpatient and transitional facilities for adolescents and young adults.

There is an increasing body of evidence that young people (between 13 - 25 years of age) need and deserve their own facilities. This is an area Yeovil have been in the vanguard of providers.

In late 2011 Yeovil opened on the Paediatric Ward a Young People's Unit (YPU) for those aged from 17 until their 24th birthday. Young people in this age range who need admission are offered the choice of admission to the YPU or the Adult Wards. In each case medical care is provided by the adult teams, but nursing is by the Paediatric staff in the YPU.

It has proved a great success and entailed no significant extra cost.

They are in the process of awaiting acceptance for publication of the paper which details the process and have spoken about the service at a number of regional and international venues.

In broad terms those who need admission to hospital are either very young (less than one year) or very old (over 85). For Yeovil Hospital the figures were roughly 400 aged less than 1 year and roughly 300 for each year of age between 80 and 90. For those aged 17-25 only roughly 100 in each year of age need admission.

Thus there are a number of young adults who need admission, are likely to have needs akin to paediatric patients but will find themselves in adult wards surrounded by predominantly very elderly patients with whom they share relatively little in common, in terms of medical and nursing input.

There are many aspects by which adolescence is in practical terms a more lengthy process now than in the past, and an ever increasing number of paediatric patients with long-term complex conditions are now surviving until adulthood and are in need of inpatient and transitional facilities.

The DoH document *Quality criteria for young people friendly health services* gives more detail about the aspirations for providing such a service, and encourages secondary care providers to take them on.

In our model of the future provision for the Friarage we will be suggesting the South Tees NHS Trust investigates whether this would be a suitable initiative to establish at the hospital.

Extra cost of sustaining the service

Historically to deal with the European Working Time Directive Yeovil District Hospital went from 2 middle grade posts to 7 overnight, but the cost was built into the base budget some years ago.

There has been no additional cost recently to maintain the rotas provided above.

The Young Persons Unit project has not incurred any significant additional costs, and it has helped utilise more efficiently the nursing services available in the paediatric ward whilst allowing a greater availability of beds in the Adult wards.

Patient Safety Record

Yeovil has an excellent safety record.

Borders Hospital, Melrose – 1214 Births (visited by RDC in October 2013)

Operating Consultant Led Services



Borders General Hospital is part of NHS Borders, and is a modern and well-equipped District General Hospital serving the Borders area in South East Scotland. The hospital has 293 acute beds.

24/7 Consultant led Obstetric Unit
Level 2 Special Care Baby Unit
Pregnancy Assessment Unit (Monday to Friday)

24/7 Consultant led Paediatric Unit comprising Ward 15 Noah's Ark which has 11 inpatient beds for children aged 10 days to 14 years.

The Trust has a paediatrician on site 24 / 7, and there are always at least two registered children's nurses on duty 24 / 7 on the children's ward.

Open Access + Acute Access Facilities

They admit children from all specialities including medical, surgical, ENT and Orthopaedics. These 11 beds include the recently opened 2 bedded High Dependency Unit for babies and children who require a higher level of care and a Short Stay Assessment Unit for those who only need to stay for a few hours.

Ward 15 provides a friendly and welcoming environment for the babies, children and families.

Staffing

Paediatrics:

7 Consultants
6 Middle Grade comprising 2 Advanced Paediatric Nurse Practitioners, 2 Advanced Neonatal Nurse Practitioners and 2 Doctors who just cover on call
4 Juniors comprising 1 GPVT, 3 Specialist Registrars (ST4, 5 & 7)

Obstetrics:

5.6 Consultants

6 Middle Grade comprising 3 Registrars, 1 Staff Grade, and 2 Midwife Advanced Nursing Birthing Practitioners

5 Juniors

Rotas

Paediatrics

The paediatric rota is covered by the 7 Consultants, the 2 APNP's, the 2 ANNP's and the 2 Locum Doctors. The Juniors do not cover the on call.

Obstetrics

The obstetric rota works on a cycle of 5, 3 of the nights are covered by the 3 Registrars, the 4th night is covered by the Staff Grade, the 5th night is covered by the Consultant who then has the next day off.

This has been successful because the Consultants have agreed to share the on call night

Maintaining Skills

There is a limited amount of rotation with the Royal Infirmary of Edinburgh Hospital, a major centre for maternity services, where in excess of 6000 mothers-to-be have their babies each year.

However the consultants at the BGH consider that there is plenty of opportunity for maintaining skills simply in covering the day to day throughput at the hospital itself.

There are also 2 Midwife Assisted Birth Practitioners on the Unit who have undertaken further training to carry out forcep or ventouse (suction cap) deliveries if required

Recruitment

Recently recruited in obstetrics from a very good field of candidates.

Future Sustainability

There is every confidence amongst the lead clinicians and the hospital management of being able to sustain the 24/7 paediatric and maternity services in the future at the hospital whilst providing a very safe service.

Extra cost of sustaining service

Extra consultant time was needed when the model of care moved to utilising the Advanced Maternity Practitioners and this cost was in the region of £120,000 annually.

Safety Record

The Lead Consultants confirmed that the Borders General Hospital have an excellent safety record for both the Paediatric and the Maternity Services.

Dr Grays, Elgin – 1156 Births (visited by RDC in October 2013)

Operating Consultant Led Services



Part of NHS Grampian Dr Grays serves the population of West Grampian.

24/7 Obstetric service

24/7 Paediatric service
Level 1 Special Baby Care Unit

Staffing Paediatric

3.3 substantive consultants + 1 locum
No middle grades

Obstetric

4.8 Consultants
No middle grades

Plus 8 Junior Non-Specialist medical staff, comprising FY1 or 2, GP Trainees plus a Research Fellow from North-East Scotland Deanery based at Aberdeen University providing cross cover for both disciplines.

Additionally they are upskilling 5 of their Midwives who volunteered to take on aspects of an advanced neonatal and birthing practitioner's role with continuing training.

Rotas

Paediatric

The consultants work a system of Consultant of the Week and those others cover on call 1 in 4. The system gives them 1 clear week off every 6 weeks. All Consultants happily take part in the rota. The rota works well. There is a limited amount of rotation with the hospital at Aberdeen. The clinicians are very enthusiastic.

Obstetric

All obstetric and gynaecology medical and surgical care is delivered by Consultants with the support of non-specialist junior medical staff. This is different to Aberdeen where trainee obstetrician/gynaecologist support the service provided by Consultants and other Junior medical staff.

Patient Safety

Safety record is excellent and they have the best statistics in the region in terms for keeping c sections down to a minimum and their figures are 17-20%. The labour ward is a shared facility for women eligible for midwife led care during labour and birth and women who require obstetric input.

Recruitment

The last recruitment was for a general paediatrician and they had a good field. They haven't needed to recruit to the obstetric side recently.

Future Sustainability

NHS Grampian have just carried out a strategic review of maternity services in **2012**. It was a deep seated review, its key themes being about providing safe, effective and person centred care.

From that review NHS Grampian have decided to close some of their Birthing Units (similar to FMLU's) at Banff, Aboyne and Fraserburgh because of the low birth numbers and difficulty in maintaining Midwives skills but women from those areas will continue to be able to have a home birth.

The review concluded that Dr Grays will continue to provide a key strategic role in providing 24/7 Obstetric Consultant and Midwifery services into the future.

Extra cost of sustaining the service

Upskilling of midwives and occasional backfilling - £50,000 annual extra charge to the Training budgets at the Trust.

Patient Safety Record

The consultant-led service at Dr.Grays was only established 16 years ago when the freestanding midwife led unit that was there at the time was in danger of closing down because so many mothers-to-be were being transferred by emergency ambulance to either Aberdeen or Inverness Hospitals, and there were a large number of babies being born on route. Sadly of these a very small number died before they could get there.

Since then Dr Grays has had an excellent safety record.

Dumfries & Galloway Hospital – 1373 Births (visited by RDC in October 2013)

Operating Consultant Led Services



Serving a population of 150,000
24/7 Consultant led Obstetric Unit
Level 2 Special Care Baby Unit

24/7 Consultant Delivered (until 11pm) Paediatric Unit & Assessment Unit
Open Access and Acute Open Access

Staffing

Paediatrics

6.6 Consultants,
7 middle grades, (although it could be done with 6 middle grades) comprising 2 which are ST trainee doctors from the West of Scotland rotation.

(At present both posts are vacant but we have filled them with LAT locum appointments. The remaining posts are Specialty Doctor posts. We have two permanent doctors in post and between they make up almost 1 whole time equivalent. We have just appointed two new recruits from Europe, initially on short term contracts to see whether they have the necessary skills).

Obstetrics

5 Consultants, 1 always on call,
6 Middle Grades operating a rolling rota, available all the time, comprising 3 trainees,
2 Speciality Doctors, 1 teaching fellow + 2 associate specialists
5 Juniors. The junior tier cross cover with paediatrics at junior levels.

Rotas

Run compliant rotas

Paediatrics

5.6 consultants work on call. Consultants are paid generously to do the night shift.

Recruitment

2 new obstetric consultants this year – from a very good field of candidates.

Developing a good training programme

Maintaining skills

The daily throughput of patients provides more than sufficient experience to maintain skills

Future Sustainability

A new hospital in Dumfries is being built on a Greenfield site and opens in 2014 with its own maternity and paediatric wing based on providing a 24/7 consultant-led service so there is a definite and clear commitment for its future.

Extra cost of sustaining the service

Approximately the additional costs that they have incurred have been at the very maximum no more than £400,000.

Patient Safety Record

Dumfries and Galloway has an excellent safety record

Dorset County Hospital – 2000 Births (visited by RDC in October 2012)

Operating Part Consultant Led/Part Consultant Delivered Services



Part of Dorset County Hospital NHS Foundation Trust
Serving a population of 115,000

24/7 Consultant Obstetric Unit
Level 2 Special Care Baby Unit

24/7 Consultant Paediatric Unit

Staffing

Paediatric

7 Consultants
5 Middle Grade
9 Juniors

Obstetric

5.5 Consultants
8 Middle Grades comprising a mix of Speciality Doctors and Specialist Registrars
4 Juniors

Rotas

Paediatric

Dorset Hospital has 5 registrars who acts as the Middle Grade tier. They form part of the training scheme and they contribute to half of the out of hours cover and the other half is through a consultant resident on call, so there are 7 participating in the scheme each contributing about 4 PA's (programmed activities).

We tend to run 12 hour shifts so the day starts at 9.00am and most staff will finish at 5.00pm. Then there is an evening shift that people doing the long day stay until 10.00pm and the night staff come on at 9.30pm and will leave at 9.30am the next morning.

If there is a consultant resident they will just be on with an SHO and if a middle grade is scheduled that night there will be a consultant at home on call and a middle grade in the hospital and an SHO in the hospital.

The rota has been like this for 12 years and the Consultants chose to work like this.

We have a hot week consultant Monday to Friday 9.00am – 5.00pm, so there is one consultant covering the wards for a week at a time with no clinical commitment.

The evening cover is provided by everyone else but the consultant of the week because they are purely working 9.00am -5.00pm. They do not do any on call that week.

Obstetric

There are 5.5 full time Obstetric Consultants comprising 4 full time, 1 job share and 1 part time and they cover the labour ward on weekday mornings (8.45am - 1.00pm), a weekday afternoon (1.00pm -5.00pm) and then they do out of hours on call from 5.00pm - 8.30am the next morning.

There is a Consultant available within 30 minutes of the hospital.

There is a middle grade or registrar in the maternity unit overnight and there is a Consultant within 30 minutes. On Saturday and Sunday the Consultant is on call. There is a daily ward round and the Consultant is less than 30 minutes away if needed.

The Middle Grades run a shift system so there is always someone available on the ward. We do not have SHO's between 9.00pm – 9.00am. They were removed 3 years ago when we brought in the EWTD and that is when we moved to the shift system for SPR's because they are the more experienced grade of Doctors and with the support of the midwives who are a very highly qualified team they can usually manage with an on-call Consultant.

Maintaining Skills

All our obstetric doctors take part in a skills and drills training which is very robust and is delivered by the consultant lead for the labour ward. They have very robust training which they receive yearly. They also have other meetings, we review cases, they have meetings where CTG's are reviewed so they are updating and training within the Royal College guidelines for CSNT.

We do look after high risk women so their obstetric skills are kept up to date, and it is only patients with highly complex risks that go to the tertiary centre most suitable for their needs, otherwise all other problems stay with us.

For Paediatrics most of the training is delivered in-house and we do not have any rotations. We do have visiting consultants that a variety of clinics and in terms of our activity levels we think we have enough patients coming through the door.

We are also looking to have protected time for SCBU training and we are looking at rotating nurses if we can, so there are plans afoot.

Having a Physician of the week Consultant gives total continuity and the staff know who to go to. Again you always have that person there and your juniors get to work with every Consultant and they see everything in that week.

Recruitment

The question of Paediatric Consultant recruitment has never been a problem for us.

We had so many applicants last time we recruited from a high quality field for a Consultant Obstetrician and in doing so interviewed 6 candidates.

We have just advertised and actually recruited a Speciality Doctor, a clinical fellow post because we wanted something that was between the Speciality Doctor and the Consultant.

Future Sustainability

We are in the process of putting an assessment unit onto our ward - we have 2 assessment beds on the paediatric ward at the moment and we are planning to increase that to 4 and a cubicle and small treatment room.

We are confident we will continue both 24/7 paediatric and maternity services in the future.

Extra cost of sustaining the service

The consultant resident on call service for paediatric services costs around £300,000 annually.

Patient Safety Record

When we visited in 2012 we were advised that the patient safety record was very good.

Bassetlaw Hospital, Worksop – 1600 Births

Operating Consultant Led Services



Bassetlaw Hospital, Worksop, is one of the key hospitals in the Doncaster and Bassetlaw Hospitals NHS Foundation Trust. The hospital has 300 beds. Each year, the hospital treats around 33,000 patients along with 38,000 emergencies in the A&E Department.

24/7 Consultant Obstetric Unit
Special Care Baby Unit

24/7 Consultant Paediatric Unit

Doncaster and Bassetlaw Hospitals are quite similar to JCUH and The Friarage. Doncaster is the larger hospital with around 5500 paediatric admissions and Bassetlaw 2100 admissions.

There was a plan to cease consultant-led maternity and children's services at the hospital but following a critical review by the Scrutiny of Health Committee at Doncaster Council, it was abandoned.

The local NHS in North Yorkshire were aware of this situation in early 2012, and it seems to us that a visit to the Hospital by their Senior managers and clinicians to investigate the change of mind, and their plans as how they intend to continue in the future is long overdue.

Background:

Bassetlaw Childrens and Maternity Services underwent a review within the last 2 years in a similar way that The Friarage is under review now:

Reports on Maternity and Paediatrics were produced and a key thread which runs through both reports is that changes had to be made, simply doing nothing was not an option.

Crucially, the reports concluded that current children's and maternity services were safe but are not sustainable in their current form. They had to get to a point where local services were safe and sustainable into the future.

Information obtained via telephone conversation re Paediatrics

The solution found was to implement fully integrated paediatric rotas between Doncaster RI and Bassetlaw.

The first stage of this is now complete.

Rotas work in the following way:

Daytime 9-5pm there is a Consultant of the Week, this gives consistency of care. At night – Rostered Consultant working off site – currently from pool of Bassetlaw Consultants but working to fully integrate this over time.

Registrar or middle grade senior is on site at this time. There is always access to senior decision making.

In addition, Advanced Paediatric Life Support Skills have been undertaken by Anaesthetists who get accredited, supported by SHO's and GPVTS.

They are not accredited for middle grade training posts but they address this by employing Staff Grades, Clinical Research Fellows, they are linked with Sheffield University.

There are no problems recruiting as things are at this moment. All the paediatricians recruited are generalists first but with a specialism. If anything we find community paediatricians harder to recruit.

The key is to provide a balanced job plan to attract candidates.

Horton Hospital, Banbury – 1600 births and visited by the CCG and the SOHC in 2012

Operating Consultant Delivered Services



Part of Oxford University Hospitals NHS Trust. A large acute teaching trust made up of 4 hospitals - The John Radcliffe (7200 births annually), Churchill, Horton General and the Nuffield Orthopaedic Centre. The Horton General Hospital has 226 beds

24/7 Consultant Obstetric Unit
24/7 Consultant Paediatric Unit
Level 1 Special Care Baby Unit

Staffing

Paediatrics

16 WTE consultant with 12 WTE undertaking resident on call duties at the Horton
No Middle Grades but there are 2 Speciality Doctors (9.00am – 5.00pm)
8 Juniors

Obstetrics:

5 Consultants (as per the IRP/BHP outcome)
9 Middle Grades, comprising 1 WTE Associate Specialist and 8 Clinical Research Fellows which commenced from August 2013 following withdrawal of the trainees (1 post is currently vacant/to be taken up but is being covered via other arrangements)

A small amount of Specialist Registrar input is provided to the Horton GH for Gynae activities only as agreed with the Deanery as this offers some good training opportunities

Juniors – Unsure of the number and type.

Rotas

Banbury has never had middle grade accreditation in paediatrics but now runs a 24 hour service, not only for assessment, but in-patient beds as well without any middle grades.

As far as the Horton is concerned there are 16 general paediatric consultants shared between Banbury and the **John Radcliffe**, Oxford, of whom 4 are largely Banbury

based with some sessions in the Oxford Emergency department, 4 work only in Oxford and the other 8 do resident on call on both sites (resident when covering Banbury)

There are no middle grades. A second consultant is on call from home to cover the occasional need for the resident on call Consultant to accompany a child in an emergency ambulance journey to the John Radcliffe in Oxford.

In Obstetrics, middle grade training posts were removed in August this year and the service is provide by locally based consultants who only work in Banbury supplemented by Clinical Research Fellows.

The services have been up and running in its new consultant based form from August 2013 and the Oxford University Hospitals Trust have repeatedly expressed their total commitment to maintaining it.

Patient Safety

We understand the Horton General Hospital has a very good patient safety record.

Recruitment

There has not been any problem in recruiting good quality general consultants for the paediatric service.

Future Sustainability

The Oxford University Hospitals Trust have repeatedly expressed their total commitment to maintaining the 24/7 paediatric and maternity services at the Horton General Hospital.

Extra cost to sustaining the service

The South Tees NHS Hospitals Trust have apparently used the staffing structure at the Horton General Hospital to cost the option of maintaining 24/7 consultant services at the Friarage.

However the staffing structure at the Horton GH is hugely inflated compared to the staffing structures at the other small hospitals in this submission. Readers of this submission are cordially invited to look at the staffing structure and additional costs of those staffing structures at the small hospitals featured in the previous pages, and within Appendix 1.

This disparity is examined in the sections in the costs of the provision of services at the Friarage, and in our Model of future provision proposed in this submission.

South Tyneside, South Shields – 1600 births (visited by the CCG and the SOHC in 2012)

Operating Consultant Led Obstetric Services with 24/7 Paediatric Assessment Unit



24/7 consultant led obstetric service
24/7 Paediatric Assessment Unit

There are 3 tiers of medical staff, Consultants, Middle Grade and Junior in Paediatrics

They introduced a new way of working in 2013 with the 24/7 paediatric assessment unit replacing an inpatient paediatric service. Children requiring inpatient services go to Sunderland Royal Hospital or the Great North Children's Hospital at the Royal Victoria Infirmary, Newcastle.

A request for the Richmondshire District Council team assembling this submission to visit the Hospital in October 2013 was politely refused, disappointedly so, although no reason was provided as to why it was.

Princess Royal Hospital, Haywards Heath –2400 Births

Operating Consultant Led Obstetric Services with Advanced Neonatal Nurse Practitioners

There are no Paediatric Services based at the Hospital



Part of Brighton & Sussex Trust. A teaching hospital which operates on 2 sites, (Royal Sussex Hospital, Brighton - 3200 births) and Princess Royal, Haywards Heath, which is the smaller hospital. Haywards Heath is 12 miles from Brighton.

24/7 consultant led obstetrics

Level 3 neonatal unit staffed with consultants and Advanced Neonatal Nurse Practitioners

There are no paediatric facilities

There is a Paediatric Nurse in A&E and doctors will see any children who arrive at the A&E and treat as necessary, transfer or direct to Brighton.

Ambulances bypass Haywards Heath to Brighton where there is a fairly new Special Children's Hospital and dedicated Childrens A&E.

It would be interesting to discover if the South Tees NHS Hospitals Trust or the HRW CCG had investigated, or intend to investigate the model of care provided at the Princess Royal Hospital. It would be a model which if employed would at least retain 24/7 consultant-led maternity services at the Friarage Hospital.

Wansbeck General Hospital – 2700 Births and visited by the CCG and the SOHC in 2012

Operating Consultant Led Obstetric Services with Advanced Neonatal Nurse Practitioners

There are no Paediatric Services based at the Hospital



Part of Northumbria NHS Foundation Trust (other hospitals include Hexham General Hospital, North Tyneside General Hospital, Alnwick Infirmary, Berwick Infirmary & 6 Community Hospitals)

W

ansbeck is a District General Hospital with 12 Wards

Providing 24/7 Consultant Led Maternity Unit

Wansbeck has a Special Care Baby Unit (care delivered by 9 Advanced Neo-Natal Nursing Practitioners)

The Hospital operates a 24 hour A&E Department

There are Freestanding MLU's located at North Tyneside, Hexham, Alnwick and Berwick Hospitals

10 years ago Wansbeck was chosen as a pilot site for a Freestanding Special Care Baby Unit. That meant a leading team of skilled neonatal nurses has been providing cover for the 2,700 babies born at Wansbeck General Hospital every year, undertaking all the responsibilities, once allocated to doctors, including high-risk deliveries, and resuscitating and nursing sick babies, the team has won acclaim for its beacon work.

To become a Neonatal Nurse Practitioner involves a 3 year training programme. Wansbeck have trained their own nurses up to this highly skilled level.

There are 2 nurses at Wansbeck currently in training at the moment.

The Friarage General Hospital – 1260 Births

Operating Consultant-led Services



The Friarage is the smaller of two hospitals run by South Tees Foundation Trust. It has 209 inpatient beds and 24 day case beds and provides a range of inpatient and outpatient services including A&E, general medicine, trauma and orthopaedics, surgery, 24/7 consultant-led paediatrics and maternity services, pathology and diagnostics.

Present Model: Staffing and Rotas

Paediatric Staffing consists of:

5.5 WTE Consultant Paediatricians based at The Friarage but only 4.8 WTE participate on the on call rota.

0 Middle Grades

6 Juniors (2 from the Army and 4 GP Vocational Trainees)

Present Pediatric Rotas/Rotation

There is limited rotation to JCUH to help maintain skills. All Consultants at FHN complete an annual 2 week rotation to JCUH. JCUH based Consultants who have dual skills rotate to FHN 1 week per year, plus when extra cover is required and offer support if available. This does not improve demands for frequency of on call.

Obstetric Staffing consists of:

4 Consultants covering the service + 1 Associate Specialist giving same day cover back up.

6 Middle Grades

4 Juniors (2 from the Army and 2 GP Vocational Trainees)

Present Obstetric Rotas/Rotation

3 of the Consultants rotate to JCUH to conduct some gynaecology work to maintain sub-specialist skills and 3 JCUH based Consultants do some input into clinical commitments at FHN to support this. Only 4 consultants are on the out of hours on call rota. This means that at peak holiday periods consultants work a 1:2 rota.

Our Model

For the future provision of the paediatric & obstetric services at the Friarage Hospital

Opening Commentary

Clearly from all of the above examples, there is no one-size-fits-all solution, and hospitals are finding their own different ways to deliver 24/7 services which best suit them. They will undoubtedly have to keep reviewing their model and adapting it to meet their needs and fresh challenges that come along from time to time, but it is clear that consultant led services can be sustained in a variety of ways and at much lower cost level than the South Tees Hospitals NHS Trusts and the HRW CCG suggest they would be for the Friarage Hospital.

Even in the cases of South Tyneside, Wansbeck and Princess Royal Hospital where Paediatric Inpatient services are not provided, 24/7 Obstetric Services still are.

It is very demanding to have to assemble a Model for Future Provision of the 1st class Paediatric (ie Children's) and Obstetrics (ie Maternity) services at the excellent Friarage Hospital in Northallerton, as Councillors and Council officers we have no medical training whatsoever. Even knowing and understanding the acronyms and abbreviations in circulation within the NHS is an accomplishment, as it appears there are enough to fill a Dictionary.

We therefore apologise in advance if we make proposals in our Model for Future Provision that need a degree of refinement to fit in to the day-to-day business of operating a children's and maternity service at a District General Hospital. Whilst obviously in the 2 years the proposals of local NHS to downgrade the 24/7 consultant-led services at the Friarage have been in circulation, we have learnt a great deal, especially in the visits we have made to small hospitals in the West Country and Scotland, we still perhaps only have gifted amateur status in the subject matter under scrutiny.

What we can say is that we have all tried our very best as our motivation is genuinely to go the extra mile to retain the 24/7 consultant-led children's and maternity services, in a different form as it appears that no change is not an option, at the Friarage Hospital.

Why – because those services are held in the highest esteem by all and enjoy the utmost confidence within the communities served by the hospital, and at a time when bad news about the NHS nationally seems to be the daily fare on offer, we consider the Centre of Excellence that is our Friarage Hospital needs to be cherished and built upon for others to follow, rather than dismantled and re-established some 23 miles away at the (excellent) James Cook University Hospital on Teesside.

We understand that the local NHS, namely the HRW CCG and the South Tees Hospitals NHS Trust, have been charged by the Independent Reconfiguration Panel and the Secretary of State for Health, Jeremy Hunt MP, to test any solutions that come forward during the Consultation, fairly and exhaustively against the same process and level of detail that the 2 options they put forward in the Consultation underwent.

This will involve further research of our Model because clearly there are elements that need deeper or more knowledgeable examination than we have been able or capable of giving to what we are putting forward. However, the background evidence is supplied within this submission as well as comprehensive arguments to support our rejection of the 2 Options the local NHS have proposed.

If we could have accepted either of those options then there would have been no need to provide our own Model but, sadly, they are unacceptable for all the reasons that we suggest in this submission.

Our model draws heavily upon the visits we have made to a number of small hospitals, both very recently and last year, where we found each hospital facing the same challenges as the Friarage faces, serving the same mix of urban, provincial and rural/deeply rural communities over an extended catchment area that the Friarage does, and having approximately the same number of babies born each year as the Friarage does. Crucially they all have the same or very similar excellent patient safety records as the Friarage does.

They all have these key circumstances and factors in common, but where they differ from the Friarage is that all those involved are predicting a safe and sustainable future for at least the next 5 years for their 24/7 consultant-led children's and maternity services.

The question to answer, therefore, is that if these 6 hospitals (and others like them) can boldly continue in the future then why can't the Friarage ??

We commend our Model for the future provision of children's and maternity services at the Friarage as we are convinced its adoption will allow those key services to remain safe and sustainable in the future, for the benefit of the communities served by the hospital who rightly place such high value and confidence in them.

The Model

The starting point – it appears everybody agrees that No Change is not an Option.

Change in culture

From the outset, if our Model is to be successful, it needs to be fully embraced by the Consultants, clinicians, midwives, nursing staff, local GPs and the hospital management.

A feature of our visits was the absolute buy-in to what they were doing to keep the services going by all those involved in delivering them. They told us they were on a mission to keep the very best services for the local communities they serve accessible locally for the benefit of local people who need them.

The Consultation document suggests that it has been the clinicians who have been a catalyst for change at the Friarage. We would say that for our Model to be successful the enthusiastic buy-in from the teams involved in delivering the services at the other hospitals we visited must be evident at the Friarage.

In short there needs to be a change in culture at the hospital amongst the Consultants and the Management.

Key factors – Change in services

The 4 key factors – Any change in services must

- 1) Provide an intrinsically safe service for patients, expectant mothers, their babies unborn or newly born
- 2) Provide a sustainable service for at least the next 5 years
- 3) Be affordable in the context of the global budgets provided to deliver NHS services in North Yorkshire
- 4) Continue to enjoy the confidence and total support of the communities they are designated to serve

Patient footfall - Diversion Initiative

The South Tees NHS Trust have never positively encouraged mothers-to-be who normally use the JCUH, to use the excellent facilities at the Friarage Hospital, where the relative peace and quiet, along with its calm, relaxed, family-circle type of atmosphere provides the very best environment for the birth of their babies.

Instead many of these mothers-to-be have simply been accepted to book on at the JCUH where the facilities are operating at full capacity now, and have been described by the Head of Maternity Services as only “adequate” at best, and it follows that patient experience can only be average.

There are many communities between Northallerton and Middlesbrough, especially those south of Middlesbrough, which are equidistant to either hospital, or just a small handful of miles more to one rather than the other hospital.

A diversion of some of this cohort from the JCUH would relieve pressure on its facilities whilst providing a greater number of births at the Friarage to maintain the skills of its clinicians and midwives.

It is not unrealistic to suggest a target figure of 500 diverted births could arrive at the doors of the Friarage, given the geographical location and population of a number of

significant communities between Middlesbrough and Northallerton. This number, around 11% of the 4500 births per year at the JCUH, would make a huge difference there to its capacity difficulties, whilst adding real substance to the sustainability of the Friarage.

We have encountered resistance from the South Tees NHS Trust to this suggestion of patient diversion on the occasions it has been mentioned. However the Trust regularly encourages patients who live much nearer to the JCUH than they do the Friarage, for example, to take advantage of the elective orthopaedic services available in Northallerton.

Our Model is based on the South Tees Hospital NHS Trust undertaking genuine initiatives to promote and encourage additional patient footfall for the 24/7 consultant-led maternity services at the Friarage.

Rotation of clinical staff between the JCUH and the Friarage

Most of the small hospitals we visited engaged in rotation of its Consultants even though the rotas which they worked at their own hospitals were often tightly staffed.

Looking at the matrix of staffing rotas at the various hospitals (Appendix 1 to this submission) it appears the number of Consultants at both the Friarage and the JCUH are more generous and so there would be greater scope for this rotation to take place.

It has been suggested at various public meetings that rotating Consultants between the 2 hospitals would address the concerns around maintain key skills, and although these meetings have been advised that it does take place, it seems to be small-scale in nature and there is little appetite for it, especially from the Consultants permanently based at the JCUH.

Whilst a greater number of mothers-to-be using the Friarage envisaged in the patient footfall initiative already mentioned would assist in maintaining skills, our Model is none-the-less based on a high level of rotation taking place.

Royal Colleges Recommendations

Much has been made of the Royal Colleges although it is fair to say that the public are no nearer discovering who or what they are and what impact they can have on the day to day staffing rotas of 24/7 maternity and children's services. In truth the perception is of an obscure and hard to reach 'august' organisation operating behind closed doors but having the potential to be very influential on the business planning of hospital services involving clinicians.

We noted that most of the small hospitals we visited had listened to what the Royal Colleges recommended with regard to their 24/7 services, but said their position was

that they were only recommendations and they accorded them that status and nothing more.

What mattered to them was their hospital's safety record and the prospects for sustainability of the services into the future, and if they were satisfied on both counts with the rotas they were using, then they need go no further in meeting the Royal Colleges recommendations.

One of the lead Consultants we met said that the Royal Colleges recommendations on the minimum staffing on 24/7 rota was "pie in the sky, mere wishful thinking and totally unaffordable except by the very large teaching hospitals".

The South Tees Hospitals NHS Trust, and the HRW CCG both seem to feel obliged to slavishly follow the Royal Colleges recommendations, perhaps to a point on pedantry. If our Model is to be successful, it will need a more relaxed approach to the Royal Colleges recommendations.

As it is now, the Friarage' safety record is second to none, and sustainability is being quoted as an issue for the future rather than the present.

It is interesting to note that the JCUH does not have the correct number of clinical staff to meet the recommendations of the Royal Colleges at present, and some of the hospitals that the HRW CCG are suggesting patients might use as an alternative to the Friarage in the future are in a similar position.

Training Posts

There were very few training posts on the rotas of the small hospitals we visited. The hospitals had been innovative in finding a way around this, by the use of Speciality Doctors and Clinical Research Fellows from neighbouring Universities, for example.

Advanced Nursing Practitioners

Advanced Nursing Practitioners or ANPs (either neo-natal and/or for births) is part of our Model's solution to issue of the lack of middle grades in the Friarage's paediatric service, and along with the many other suggestions in our submission, this is where we can claim we are putting forward a unique (bespoke) solution to overcome this problem.

Some of the various hospitals we visited, plus the other hospitals mentioned in our submission, for example Wansbeck and the Borders General Hospital, are relying on Advanced Neo-Natal Practitioners or Advanced Birthing Practitioner to help deliver their children's and maternity services, working alongside Consultants and Junior Doctors in a consultant-led rota structure.

There is no evidence that the middle grades they are replacing or have replaced provided a safer service than these Advanced Nursing Practitioners, who are also known as Specialist Nurses.

Indeed the Borders General Hospital where extensive use is made of ANP's for both children's and maternity services demonstrated that in their case, there was a marginal improvement in the already very good safety record at the hospital of ANPs over the middle grades they have replaced.

In the main our investigations revealed that experienced midwives and paediatric nurses at the hospitals where ANPs feature had been invited or had volunteered to be upskilled into the higher status of an ANP. As ANPs are a relatively new concept there is not a flourishing recruitment market for them. Self-reliance on home grown talent has been the order of the day and it has worked well where it has been tried.

Borders General Hospital and Wansbeck consider it takes up to 3 years to train a midwife or paediatric nurse up to the skill level of an ANP. Having taken the decision to go down the route of ANPs the hospital started 4 years ago and now have a complement of them, as the staffing matrix at Appendix 1 shows clearly.

Our model envisages ANPs as Advanced Neo-Natal Practitioners in part taking the place of middle grades in the paediatric rota, and it requires the South Tees Hospitals NHS Trust to identify potential candidates amongst their own nurses and/or call for volunteers and embark on a training programme immediately. Whilst the training programme is being established it may be necessary to employ a Generalist Consultant paediatrician to backfill, and we understand from our enquiries that there are a reasonable number of quality Generalists available for recruitment at this time.

Our Model also sees the Trust commencing now on a training programme for Advanced Birthing Practitioners. Although the need for ANPs is less urgent in maternity, the South Tees Hospitals NHS Trust have been very slow generally to address the issue of succession planning and it would appear that sooner rather than later difficulties in recruiting replacement middle grades for the obstetric services may occur.

Up-skilling of midwives/paediatric nurses

As already observed in this submission, the cadre of midwives/paediatric nurses serving at the Friarage is absolutely first class in their skills, expertise, and caring approach to their patients. We suggest many of these, if selected or a call for volunteers was made, would readily step forward to be trained as ANPs.

Other may be prepared to be up-skilled to a higher level of expertise, but falling a little short of ANP status.

Dr.Grays Hospital at Elgin has made extensive use of their midwives and paediatric nurses in this way, and the extra skills they have taken on boosts the confidence level

of the whole team and enables it to make fewer demands on the Consultants on call from their homes.

Skill mix

It is noted that many of the hospitals we visited employ Speciality Doctors and Staff Grades to help fill their rotas. Others have used Clinical Research Fellows from local universities and teaching hospitals. Of course there are also the GPs in training and on foundation years to add into the rota.

Our model requires the maximum use of all the various grades and type of clinicians for the rotas in the future at the Friarage Hospital. Middle grades in paediatrics is known to be a difficult recruitment issue nationally, so the other small hospitals have simply found a way of overcoming this, safely, by an imaginative skill mix, and our model would require the same imagination to be shown at the Friarage.

This skill mix is considered by the small hospitals we visited to be an important advantage and an asset to a flourishing and sustainable rota.

Speciality Doctors are those that have reached the status level they wish to attain in the NHS and do not aspire to be consultants. Staff grades are we understand another term for Speciality Doctors.

We understand also that the rules on immigration has made it difficult to recruit Speciality Doctors from the reservoir of excellent Doctors available beyond the EU, and especially from the Asian sub-continent, and that there are some question marks around the skills level of EU Trained Doctors.

However, it is thought the NHS is negotiating an exception for Speciality Doctors in the Immigration Policy of the present Government.

Consultants on Call / Recruitment to the South Tees Hospitals NHS Trust

It will be essential for Consultants recruited to serve at the Friarage to be prepared to live within 20 minutes of the hospital. They must also be prepared to take part in an on call rota.

This limitation to where they can live has not prevented any of the smaller hospitals we have visited from recruiting excellent Consultants as and when they have been required.

It is difficult to consider the towns, villages and countryside within 20 minutes drive of Northallerton as being a likely deterrent to recruitment as they consist of some of the best residential areas North Yorkshire has to offer. Close by are 2 National Parks and an Area of Outstanding National Beauty plus the Heritage East Coast from Filey to Staithes.

Why there should be any barrier to recruitment, as the South Tees Hospitals NHS Trust suggests, remains a mystery to us.

The Bassetlaw model, as mentioned above, is worthy of consideration, especially in the way they recruit as a whole trust, and fully integrate their rotas.

Consultant Recruitment

None of the hospitals we visited had experienced any problem with recruitment so we would ask as part of our Model that the recruitment process at the South Tees Hospitals NHS Trust be reviewed as it appears to encounter difficulties that other Trusts elsewhere in the United Kingdom do not.

Young Persons Unit

Yeovil District Hospital has been innovative in establishing its Young Person Unit. Brief details are given above. If increasing the use of the in-patient facilities at the Friarage at little or no extra cost improves the sustainability of the Hospital, then the Young Persons Unit initiative should be seriously investigated, especially as it appears to add little by way of expenditure.

Our Model therefore would call upon the South Tees Hospitals NHS Trust to investigate establishing a similar Young Persons Unit at the Friarage.

Open Access / Acute Open Access

The vitally important 24/7 Open Access and Acute Open Access services for children with complex health conditions and needs would continue unchanged in our Model. Our proposed staffing structure would allow these highly regarded services to remain in operation as they are now.

Special Care Baby Unit (SCBU)

The vitally important Special Care Baby Unit (SCBU) service would continue unchanged in our Model. The 10 cots currently in use would remain in use. Our proposed staffing structure caters for the SCBU.

Consultant-led or Consultant-delivered

The model the South Tees Hospitals NHS Trust have costed at £2.7 million sees the Consultant-led service at the Friarage upgraded to a Consultant-delivered service, where a Consultant is always present in the hospital.

It is important to note that the (almost) perfect safety record at the Friarage is not the catalyst for this upgrade. The Friarage has climbed to the very pinnacle of what the local communities it serves would wish to see from its consultant-led children's and maternity services at its local hospital

A highly expensive 24/7 consultant-delivered service is the interpretation the local NHS has placed on providing a safe and sustainable future for the services at the Friarage, and indeed both the South Tees Hospitals NHS Trust and the HRWCCG have admitted in public that they are well ahead of their counterparts in requiring this significant step upwards in the status of the service.

Indeed it is an ultra safety first and risk free approach to service provision, easily exceeding the funding the National NHS has allocated the Trusts to provide these key services, and the question is: are they aiming their sights so high they actually destroy the very principles they seek – safety and sustainability ??

Our submission contends that they are in the arguments we have put forward in the preceding pages of this submission.

We have noted that no other small hospital we have visited has adopted the same approach, other than when directed by the National NHS at Horton General Hospital in Banbury to do so, from where presumably our local NHS have taken their lead from.

Strangely what is costed for the Friarage Hospital – a staffing rota meeting the Royal Colleges recommendations – is not available at the James Cook University Hospital or at the other hospital the HRW CCG are suggesting patients should use if they need to choose a consultant-led service in the event the Friarage services are downgraded.

Simply put, the configuration the local NHS has suggested is required at the Friarage to keep it safe and sustainable is merely an exercise in wishful thinking as it is unnecessary and extravagant to go to the level suggested, when the services currently in place, if adapted to the Model we are putting forward, will be more than sufficient to meet the objective of providing a safe and sustainable service – if the experience of other small hospitals in anything to go by and we think that it is.

And our Model can be provided at a fraction of the £2.7 million the local NHS suggested it would cost.

Cost of our Model

The local NHS has costed their proposals to retain a safe and sustainable 24/7 consultant-delivered service at the Friarage Hospital at £2.7 million. However as we examine in our Arguments on grounds of Cost, this is a figure for upgraded and unnecessarily extravagant services.

It is also misleading as the cost of not continuing services at the Friarage incurs a loss of patient income of around £2 million to the South Tees NHS Trust, a capital

investment to improve facilities at the JCUH variously estimated by its Management of between £1 million and £10 million, and requires an ongoing annual revenue charge of £250,000 for the proposed free shuttle bus service between the 2 hospitals and £250,000 for the augmented YAS ambulance service for emergency transfers from the freestanding Midwife led Unit to the JCUH and responses to mothers-to-be in labour from their homes to cover the greater distance to the JCUH as opposed to the Friarage.

Following on from the comments in the preceding paragraphs, and the evidence we have accumulated from our visits to other small hospitals, we estimate the extra cost of our Model to upgrade the Friarage to keep it safe and sustainable for the next 5 years will be in the region of

£200,000 annually

This submission compiled and authored by:

Councillor John Blackie

Leader of Richmondshire District Council

Councillor John Robinson

Chairman of the RDC Scrutiny Committee with Health within its remit

Mrs. Penny Hillary

RDC Scrutiny Support Officer

25th November 2013

Matrix

Hospital	No. of Paed Beds	Annual Admissions Paeds/ Neonates	Paed Cons	Paed Middle Grade	Paed Jnr Staff	No of SCBU Cots	Annual births	Obs Cons	Obs Middle Grade	Obs Jnr Staff
The Friarage	14	1889	5.5 (4.8 on rota)	0	6 comp: (2 MOD 4 GPVT)	10	1260	4 +1 Ass Spec	6	4 comp (2MOD 2 GPVT)
James Cook	30	6500	9.8	8 comp: ST3 or above	9 comp: GPVT's FT Drs & Sp Drs	12	4500	11	8	8
Memorial	?	?	9	?	?	?	2350 +½ of B. Au 150	8 1 locum +1 Ass Spec pt	10 SpR Comp: (6 ST4) (4 ST1-3)	7
North Devon	12	2503 (0-13) 416 (14-18) 240 neonates	7.6 1 CC	3 ST3 1 ST4 1 Locum 2 Sp Drs 2 CPaed	6 comp: 1 F1 2 GPVT 2 FTSTA 1 p/t F1	8	1641	6	7	6
Dorset Hospital			7	5	9		2000	5.5	8	4

Hospital	No. of Paed Beds	Annual Admissions Paeds/ Neonates	Paed Cons	Paed Middle Grade	Paed Jnr Staff	No of SCBU Cots	Annual births	Obs Cons	Obs Middle Grade	Obs Jnr Staff
Yeovil Hospital	24 (8 for young adults)	2351 (379 13% were young adults) + 230 neonates	6	7 comp: 2 Spec drs 3 ST4/5 2 LAT Drs (likely to become Sp Drs)	7	8	1500	5	7 compr: 1 Ass Sp 3 SpR 3 Tr Drs	7
Borders Hospital	11 Inc: 2 SStay 2 HDep		7	2 APNP's 2 ANNP's 2 Locum Drs for on call	4 comp: 1GPVT 3 SpR (ST4,5 &7)	8	1214	5.7	3 Registrars 1 ST GR + 2 MABP	5 FY2 OR GPVTS
Dumfries & Galloway Hospital	23		6.6	7 2 ST Train 5 Spec Drs		11	1373	5	6 comp: 3 Trainees 2 Sp Drs 1 TF +2 Ass Spec	5 Cross cover with paed
Dr Grays, Elgin	8		3.3 + 1 locum	0	*8 shared	4	1156	4.8	0	*8 shared
Horton, Oxford	18	2432	12	0 but 2 p/t Sp Drs 9-5pm	8	9	1700	5	8 CRF + 1 Ass Spec	

Hospital	No. of Paed Beds	Annual Admissions Paeds/ Neonates	Paed Cons	Paed Middle Grade	Paed Jnr Staff	No of SCBU Cots	Annual births	Obs Cons	Obs Middle Grade	Obs Jnr Staff
Bassetlaw	14	2100	Fully with	Integ Doncaster	Staffing RI	8	1600	HAVE EMAILED		
Wansbeck Hospital Ashington	No paed inpatient facilities		Use RVI consultants	9 ANNP's to care for babies in SCBU		12	2700	9	8 All trainee posts	8

CRF = Clinical Research Fellow

SpR – Specialist Registrar

Ass Sp = Associate Specialist

Tr Drs = Trust Doctors,

LAT Drs = Locum Appointment for Training Doctors

TF = Teaching Fellow

ST Train = ST Trainees

Spec Drs = Speciality Doctors

MASP – Midwife Assisted Birth Practitioners CC = Community Consultant C. Paed = Middle Grade Community Paediatricians

F Drs = Foundation Doctors

Fact Finding Visit to

**North Devon Hospital,
Dorset County Hospital
& Yeovil District Hospital**

October 2012

Report Author

**Cllr John Blackie
Leader, Richmondshire District Council**

Visit conducted by:

Cllr John Blackie – Leader, Richmondshire District Council
Cllr John Robinson – Chair or Scrutiny Committee 2, Richmondshire District Council
Penny Hillary – Scrutiny Officer, Richmondshire District Council

Abbreviations used in this report:-

NDH – North Devon Hospital, Barnstaple
DCH – Dorset County Hospital, Dorchester
YDH – Yeovil District Hospital
3 DGH – All 3 District General Hospitals visited

SCBU – Special Care Baby Unit

HRWCCG – Hambleton, Richmondshire & Whitby Clinical Commissioning Group

NYYPCT – North Yorkshire & York Primary Care Trust

Local NHS in North Yorkshire – (Collective term)
South Tees Hospitals NHS Foundation Trust + HRW CCG + NYY PCT

1.0 Background to the Visits

The Friarage Hospital, Northallerton is a small district general hospital serving a rural population of approximately 122,000 people over an area of 1,000 square miles.

It provides 24/7 consultant paediatric and obstetric services but this year those services have been the subject of a reconfiguration engagement exercise by the emerging Clinical Commissioning Group (CCG) following concerns by existing longstanding paediatric consultants at The Friarage who, as they near retirement, are worried that the service is not sustainable in the future in its present form. The CCG invited the services of the National Clinical Advisory Team (NCAT) to consider the options for any future reconfiguration.

The options for paediatrics that the Trust had discussed at this point in time were as follows:

- Option 1:** Do nothing
- Option 2:** Operate as a small and remote paediatric unit
- Option 3:** 5 day working ward
- Option 4:** Paediatric day unit model, 5 or 7 day service
- Option 5:** Close all inpatient services with the provision of enhanced outpatient services (emergency as well as routine), increased specialist clinics and see and treat facility
- Option 6:** Close all inpatient services with provision of outpatient services only (urgent as well as routine)
- Option 7:** No paediatric provision at FHN

The Trust stated that its preferred option was Option 5.

As changes to 24/7 paediatrics at The Friarage would have an immediate impact on the 24/7 consultant maternity service, Richmondshire District Council expressed its strong opposition to the potential loss of these vital services and began to research small hospitals similar to The Friarage around the UK to see if, as the South Tees Trust and CCG lead us to believe, other small hospitals are also facing an unsustainable position in their futures.

2.0 June 2012 - Small Hospital Questionnaire:

In June/July this year Richmondshire District Council sent a survey to 19 small hospitals around the UK where the Maternity Units had births of 1600 or less asking both the paediatrics and obstetric departments a small number of questions around the following issues:

- Numbers of Consultants
- Numbers of middle grade doctors
- Methods of rota and delivery of out of hours service
- Maintenance of skills
- Recruitment
- Training Post potential reductions
- Maintaining Services

17 of the 19 hospitals replied to the survey. Their responses were collated and made available to the CCG and South Tees Trust during the engagement exercise in a bid to show that these 17 small units were operating in a variety of ways and were not predicting an unsustainable future for themselves and, therefore, it was considered

The Friarage could also work out its own unique solution to retaining the services, albeit in potentially a new format.

However, in September, at the end of the engagement process the CCG's report and proposals for consultation did not include the proposal to keep 24/7 consultant services, despite the overwhelming support for this option during the engagement process.

In light of this, Richmondshire District Council announced that it would be doing some further face to face research with a number of small hospitals in the south-west, namely Barnstaple, Dorchester and Yeovil that had been identified as being similar in terms of size, admissions and rurality to compare their outlook on services and how they meet the challenges that The Friarage say they cannot continue to meet.

An overview of both the Friarage Hospital and the three hospitals visited appears as Appendix 1 to this Report.

The evidence gathered in reply to the questions we asked during a total of over 7 hours of discussions at the three hospitals is shown in note format as Appendix 2 to this Report.

3.0 Key Conclusion

The following points were made to us, often repeatedly, during the course of our 7+ hours of extended discussions at the 3 DGHs, and appear in the 40+ pages of the transcripts of the recordings made of these discussions. They are therefore **a montage of the loud and clear messages** given to us at the 3DGHs by their Consultants and their Senior Management.

We have therefore assembled the following summary of what said to us, in one form or another, during our discussions at each hospital, and consider the comparison with the situation with the local NHS in North Yorkshire forms the key conclusion from our visits to the 3 DGHs.

'We are absolutely determined to retain the 24/ 7 consultant-led maternity and children's services and the Special Care baby unit at our hospitals. This determination is shared by the consultants, very resolutely endorsed by our local GPs whose patients we serve, and is strongly supported by the PCTs and the emerging Clinical Commissioning Groups.

Why – because we are here to serve our local communities, we want to serve our local communities; they deserve nothing less and are right to expect to have our services locally rather than miles and miles away.

We also fear that the distances to the next nearest hospital will, if our services are downgraded, eventually end in a tragedy, potentially a death, for an expectant mother, her baby, or even the family in an accident caused by driving too fast in an emergency on a road unsuited for high speed or in hostile weather conditions.

We run a safe service, our key consideration, any issues that come along, we face up to them and then overcome them. We are confident of keeping our services here, local communities will suffer if we do not.

We will be here in 5 years time – and well beyond'.

It is disappointing that the sheer commitment and dedication of all those involved towards the local communities the 3 DGHs serve, so demonstrably obvious during the hospital visits we made, and the concerns about the safety of those forced to travel should the key services be downgraded, is not apparently shared by their counterparts amongst the key players in local NHS in North Yorkshire.

Would that the enthusiasm we saw on our visits be evident in South Tees NHS Hospitals Trust, the emerging Hambleton, Richmondshire and Whitby Clinical Commissioning Group, the North Yorkshire and York PCT, and the Consultants at both hospitals, along with the individual GPs across the catchment area whose patients are served by the Friarage Hospital.

The bright future for the retention of the key services in the 3 DGHs is as a result of their Consultants and Senior Management being ever willing to be flexible in overcoming the new challenges as they come along so that they can continue to serve their local communities.

Their spirit and determination is hugely to be admired. It is important however to recognise the key role played by the full support of the local GPs, their emerging CCGs, and the PCTs in realising their commitment.

4.0 Overcoming the barriers to future service provision

Many of the barriers that the local NHS in North Yorkshire say will prevent the continuance of the 24/7 consultant-led maternity and children's service at The Friarage in the future, do not appear to be anything other than obstacles that can be, or are being, surmounted in delivering safe and sustainable services at the 3 DGHs we visited.

We drew these conclusions on the key issues supposed to be facing the Friarage, as identified by the local NHS in North Yorkshire.

1. Rotas -

The 3 DGHs have satisfactorily overcome the national issue of the shortage of Middle Grades, likely to be further intensified by the reduction in training posts in the future, by designing bespoke rotas of their consultants, the use of Speciality Doctors, and clinical research graduates from local universities. The rotas in some cases have been in existence for several years, and all those involved appear to be very comfortable with them.

2. Maintaining skills –

The consultants at the 3 DGHs insist that there is sufficient caseload of the type the need to experience or are likely to see presenting at the hospitals themselves, coupled with in-house training, to maintain their skills.

This does not prevent them for topping up their skill mix, often during the annual study leave each consultant is allocated, by occasional visits to the tertiary hospitals in the region, where they are always welcome.

3. Sub-specialisation -

The trend suggested towards sub-specialisation by the local NHS in North Yorkshire does not appear to be evident amongst the Consultants and Doctors at the 3 DGHs, where they willingly accept that the context of the service they deliver deems their roles to be those of general clinicians.

4. Recruitment -

The very recent and past experience of the 3 DGHs is that there are no problems whatsoever in the recruitment of the consultants they need to sustain a safe service. First rate appointments have been easily made from fields of quality candidates.

Speciality Doctors and clinical research graduates have also been recruited to each of the 3 DGHs with little difficulty, and there appears to be no shortage of high quality midwives available as evidenced in a recent recruitment drive at the North Devon Hospital in Barnstaple.

5. Royal Colleges Guidance -

Royal College recommendations on minimum levels of Consultant cover for a 24/7 rota are treated as such at the 3 DGHs, simply recommendations not to be slavishly and prescriptively implemented.

The 3 DGHs use as their benchmark for whether their maternity and paediatric services are adequately staffed by Consultants and Senior Doctors is whether Clinicians and Management at the individual hospitals assess their services as safe, not what the Royal Colleges recommend as minimum levels to provide a safe service.

In arriving at their in-house assessment on safety, in an assessment process that is continually re-visited, they take into account any external review of the services by key organisations and statutory regulators.

All 3 hospitals assess their staffing levels as providing a safe service, whilst delivering a cost effective solution for operating 24 / 7 consultant-led maternity and paediatric services in small hospitals. The PCTs and the emerging CCGs for each of the hospitals have not raised any concerns about the safety of these services.

6. Affordability -

The 3 DGHs currently operate an affordable service, whilst acknowledging that small units lack the economies of scale of their larger counterparts so the cost of the services they provide must always be kept under review.

It appears that the PCTs and their emerging successor organisations, the CCGs, have accepted the special circumstances which the 3 DGHs have to contend with, and have agreed to finance their services on the basis that they offer local services for the benefit of the local communities they serve, and that the alternatives which involve extended travelling distances compromise patient safety.

7. Midwife-Led Units -

All 3 DGHs felt that establishing a Midwife-led unit at their hospitals was simply the next stage in the eventual withdrawal of all birthing facilities at their hospitals.

In 2005 in the South Tees NHS Hospitals Trust Official Report on the Clinical Futures project at The Friarage Hospital in discussing the possibility of establishing a Midwife led unit there stated that *“there is no certainty that such a service would be well used...the economics of running this service model and the reduction in choice for patients make this option inherently unattractive”*.

8. Open Access -

It was seen by all 3 DGHs that the children with complex medical needs that require Open Access to the 24/7 paediatric services, whilst small in number, and their parents, stood much to lose in any downgrading of the service, places both parents and their children in jeopardy in view of the additional distances involved, and cause an unacceptable level of mental stress given the frequency they have to attend their local hospital.

5.0 Recommendations

- 5.1** The local NHS in North Yorkshire, with their stated objective to leave no stone unturned in their pursuit of resolving the challenges faced at the Friarage, should as a matter of urgency visit the 3DGHs in the South West, to establish whether the way they operate and will continue to operate their 24/7 consultant led maternity and children's services can offer a unique solution in retaining, perhaps in a different format, these services at The Friarage Hospital.
- 5.2** If a solution can be found then it should feature in the forthcoming statutory consultation on these services at the Friarage Hospital which currently has been suspended awaiting the outcome of the deliberations of the North Yorkshire County Council Scrutiny of Health Committee.
- 5.3** This Report should be included amongst the documents forwarded to the Secretary of State in the event of a referral by the NYCC Scrutiny of Health Committee, and if an Independent Reconfiguration Panel is established then the Report be also forwarded to the Panel along with a request that it should visit the 3 DGHs in the South West as part of its review.

Cllr John Blackie

Leader of Richmondshire District Council

Cllr John Robinson

Chairman – Scrutiny 2 (Health) Committee
Richmondshire District Council

Overview of the individual Hospitals			
Hospital	Geographic Location	Population covered	Services
<p>The Friarage Hospital, Northallerton, North Yorkshire</p> <p><i>**Please see the table below for the clinical staffing rotas of the Friarage Hospital and the James Cook University Hospital, Middlesbrough</i></p> <p>Clinical Safety Accreditation: South Tees NHS F.Trust = Level 1 Maternity units FHN + JCUH = Level 2</p>	<p>Provides services over 1000 square miles including parts of the Yorkshire Dales, the A1 corridor to the east and across to the coastal town of Whitby and its surrounding villages.</p>	<p>Catchment population of 142,000</p>	<p>Hospital offers a range of inpatient and outpatient services 225 inpatient beds</p> <p>Obstetrics - 1260 births per year Level 1 SBCU 10 Cot (transfers to level 2/3 James Cook)</p> <p>Paediatrics -14 beds for both inpatient and assessment 1889 Overnight stays in childrens ward</p>
<p>North Devon District Hospital, Barnstaple, Devon</p>	<p>Provides services over 950 square miles to North & Eastern Devon areas.</p>	<p>Catchment population of 184,000 (population of 2 District Councils account for 94% of patient flow), remaining 6% come from neighbouring commissioning area of the rest of Devon, Cornwall and Somerset.</p>	<p>Hospital offers full range of acute services. 341 inpatient beds Works with hospitals in Taunton on vascular network, Derriford on neonatal network and Royal Devon & Exeter on cancer network.</p> <p>Obstetrics - 1600 births per year, Level 1 SBCU 6 cots and 2 high dependency cots (transfers babies to Level 2 and 3 Units at Truro and Plymouth).</p> <p>Paediatrics - 15 beds including 2 bed assessment unit and 2 high dependency beds 2900 Overnight stays in childrens ward</p> <p>In 2008, ranked as 'best performing' for maternity care in the most comprehensive review ever of 148 trusts across England by the Independent Healthcare Commission.</p>

<p>Dorset County Hospital, Dorchester, Dorset</p>	<p>Provides services to residents of West Dorset, North Dorset, Weymouth and Portland.</p>	<p>Catchment population of 215,000 Dorset is a medium sized county with a smaller than average sparsely distributed and mainly rural population.</p>	<p>Hospital offers full range district general, acute services.</p> <p>435 inpatient beds Provides renal services for patients throughout Dorset and South Somerset</p> <p>Obstetrics 2000 births per year, Level 2 Neonatal (Level 3 Units at Southampton and Portsmouth)</p> <p>Paediatrics - 4000 Overnight stays in childrens ward</p>
<p>Yeovil District Hospital, Yeovil, Somerset</p>	<p>Provides services to South Somerset, North & West Dorset and parts of Mendip.</p>	<p>Catchment population of 185,000 (population of 2 District Councils account for 94% of patient flow), remaining 6% come from neighbouring commissioning area of the rest of Devon, Cornwall and Somerset.</p>	<p>Hospital offers full range of acute services. 345 inpatient beds</p> <p>Obstetrics - 1500 births per year, Level 1 SBCU (transfers babies to Level 2 and 3 Units as required in Taunton and Bristol)</p> <p>Paediatrics – 16 beds and 7 side rooms 2,700 overnight stays in childrens ward (this accounts for about 50% of all admissions to the entire hospital)</p> <p>November 2012 - The Midwifery Team has achieved UNICEF Baby Friendly Accreditation.</p>

	Friarage Hospital				James Cook Hospital			
	Paediatrics		Obstetrics		Paediatrics		Obstetrics	
Junior	4 GPVTS 2 Military	6 wte	2 GPVTS 2 Military	4 wte	2 FY1 1 FY2 3 GPVTS 2 ST trainees	8 wte	1 FY1 1 FY2 1 GPVTS 4 ST trainees	7 wte
Middle	0	0	5 SPR 1 Trust doctor	6 wte	2 community 7 SPR	9 wte	8 ST 3-7 1 Gynae onc	9 wte
Consultant		5.4 wte		4 wte 1 associate specialist (not on call)		9.8 wte		11 wte

Key =
GP VT : GP vocational trainee
FY 1,2 : Foundation Year trainees
ST : Speciality Trainee
SPR : Specialist Registrar

EVIDENCE

Topics discussed at the meetings, including questions asked and a summary in note form of the replies

Rotas

Q1: Can you explain how you rota and cover 24/7 paediatric and obstetric services?

Q2: To deliver 24/7 cover what staffing do you have?

North Devon Hospital (NDH)

Maternity

6 consultants – a week on call each (full 24/7 on call provides 40 hour labour ward cover). When not on call consultants cover normal duties Monday - Friday. One consultant works less programmed activity to provide annual leave and emergency cover as required.

5 staff grade fully qualified speciality doctors (this the equivalent of a registrar) - non training posts, increasing number to 7 soon

Commentary - Consultants changed the rota in 2009 and are very comfortable with the way it works, as under the rota they have one week off every six weeks.

Speciality Doctors – these are Doctors who are the equivalent of Middle Grades. Many speciality doctors have reached the level they want to attain, retain the necessary experience to stay there, whilst others will continue on a career path to be a consultant.

Midwives - 33 whole time equivalents provide 24/7 cover. Funded to be staffed at 1 to 28 in line with the DoH guidance.

Paediatrics

7.6 consultants, each taking their turn to work until 10.00 pm, with one covering 24/7.

Middle grade rotas (which include speciality doctors) established 3 years ago when North Devon PCT funded 3 additional consultants.

Dorset County Hospital (DCH)

Maternity

5.5 full time maternity consultants, with one covering out of hours Monday-Friday 5.00 pm – 8.00 am the next morning. Consultant on call from home (less than 30 minutes time from the hospital) provides cover overnight at weekends

One 'hot week' consultant works Monday-Friday 9.00 am – 5.00 pm with the others in the team providing on call cover.

8 full time middle grades including a number of speciality doctors.

Paediatrics

7 Consultants – Consultants either resident on call (i.e. sleeping in the hospital) or at home provide overnight cover. The consultants who are resident on call cost £300,000 per year extra to those residing at home.

Commentary - Consultants are very comfortable with rota which has been in operation for 12 years

5 middle grades – a mix of registrars and speciality Doctors.

Yeovil District Hospital (YDH)

Maternity

6 consultants, 6 middle grades, 7 Junior Doctors

Paediatrics

6 consultants on rota. Overnight an on call consultant is available residing 20 minutes or less from the hospital.

Commentary – Consultant's rota has worked very satisfactorily this way for 7 years.

7 middle grades – a mix of registrars and speciality doctors, plus 6 junior doctors

3 DGH - Working relationships Clinicians / Management

All 3 hospitals visited confirmed that working relations between the management and the clinical staff were in the range: Very good – Excellent.

Status of the Consultant posts

Q3: Are your consultant posts recognised by the appropriate colleges?

3 DGH

All Consultant posts are recognised by the appropriate Royal Colleges and Deaneries.

Maintaining Skills

Q4: How do you ensure that your consultants and doctors maintain skills?

NDH

There is limited rotation with Bristol. The maternity lead Consultant has allocated one programmed activity to attend there for specialist work. There is also some limited rotation with Exeter.

2 Consultants are fairly expert in their fields of specialist operation, so other consultants visit NDH.

Elective Caesarean sections represent between 20 to 25% of births at the hospital.

Consultant interview – We are responsible for maintaining our skills, and we consider we see a varied enough case mix here not to have to rotate other than occasionally. I arrange to go to Bristol from time to time which is my choice. Consultants have 10

days study leave annually and are welcomed to broaden their experience at tertiary hospitals in the South West

SCBU – Level 1 neo-natal

DCH

For both maternity and paediatrics in-house skills and drills regular training arranged which includes review of recent cases, and ensuring they continue to meet Royal Colleges guidelines for clinical negligence. There is also SCBU in-house training with rotation to larger maternity centres included.

Caseload provides sufficient experience to maintain skills

SCBU - Level 2 neo natal

YDH

Sufficient number of patients present to maintain skills and it is considered that some of the very speciality cases will never come to the YDH so it is unnecessary to be up-skilled about them. All junior doctors do rotate to the larger centres.

SCBU – Level 1 neo-natal

Sub-speciality interests / Speciality clinics

Q5: Do your consultants have sub-speciality interests or are there speciality clinics in the hospital?

3 DGH

Consultants at each of the 3 hospitals have a variety of sub-speciality interests and hold clinics / see patients with conditions that meet this interest.

All 3 hospitals hold speciality clinics where visiting Consultants from the tertiary centres see patients.

Consultant interview (YDH) – Paediatric clinicians all start as general consultants, and some subsequently specialise. Our consultants are all classified as general consultants, and patients with very complex conditions are transferred to the tertiary centres at Bristol or Southampton.

Recruitment of Consultants / Doctors – Results of recent trawls

Q6: In terms of recruitment of consultants and doctors, how easy do you think it is to recruit, and when was the last time you were recruiting? What was the trawl in terms of number of applicants and quality?

NDH

Consultants – No problems whatsoever.

General Paediatric Consultants – Recruitment exercise in early 2012 produced a field of 18 applicants, of which 11 were exceptionally good. Excellent appointment made.

Specialist Maternity Consultants – Limited field in recent 2012 recruitment exercise, but quality was very good. Excellent appointment made.

Speciality Doctors – A recent 2012 recruitment exercise attracted a very good field on candidates

Midwives – A recent 2011 recruitment drive attracted 54 applicants, which were shortlisted to 12 of a very high quality, of which 8 were appointed.

A regular return to practice Midwife Course produces 2 - 3 midwives a year, and there is an excellent recruitment source via graduates and trainees from Plymouth University.

The midwife staffing complement is now up to full numbers, as per the DoH guidelines.

Head of Midwifery was recruited in mid 2012 – there was a small field of quality applicants but an excellent appointment has been made.

SCBU – Recruitment of SCBU nurses was very difficult in 2010, but overcome by recruiting new graduates in conjunction with Plymouth Hospital, and training them in the necessary skills in-house on site and with rotation to the tertiary centres.

The recent co-location of the children's in-patient ward unit with the SCBU has encouraged the bolstering of SCBU skills from the paediatric nurses.

DCH

Consultants – No problems whatsoever.

A recent 2012 recruitment of a maternity consultant produced 6 quality applicants at interview, and a successful appointment was made.

YDH

Consultants – No problems whatsoever.

Maternity – There has been satisfactory recruitment to all Consultants posts that have become vacant in recent years.

Middle grades – Recruitment is largely dependant on the Deanery, but speciality doctors are also recruited with no difficulty.

Royal College recommendations on clinical staffing required for 24 / 7 cover

Q7 : In your future plans will you be bound by the recommendations of the royal colleges. If not, how are you accommodating the thrust of their advice?

NDH

Runs with one Consultant in Paediatrics below the Royal Colleges calculated number with no difficulties.

Maternity manages with 6 consultants, and it works very well.

Consultant interview - Maternity just works well as it is. Unaware that the Royal Colleges are requesting any increase in the number of consultants in the future to cover a 24/7 rota. We are all very happy with the rotas in both maternity and paediatrics as they are.

DCH

Advised by the Royal Colleges that it meet guidelines for units under 2500 births, as it provides the required 40 hours of consultant cover. However the Royal College recommendations suggest a minimum of 7 consultants are required to run the maternity service, but there is no intention to increase the number of consultants.

YDH

Consultant interview - Considers Royal Colleges recommendations are no more than recommendations, and their guidance for minimal numbers of consultants on 24/7 rotas are fanciful, and unaffordable for small hospitals.

3 DGH

All 3 hospitals visited use as their benchmark for whether their maternity and paediatric services are adequately staffed by Consultants and Senior Doctors is whether Clinicians and Management at the individual hospitals assess their services as safe, not what the Royal Colleges recommend as minimum levels to provide a safe service.

Accordingly all 3 hospitals assess their staffing levels as providing a safe service, whilst delivering a cost effective solution for operating 24/7 consultant-led maternity and paediatric services in small hospitals.

Reduction in training posts

Q8 : Is the reduction in training posts an issue?

3 DGH

All 3 DGH's consider this may well turn into an issue at their hospitals but it is too soon to know how large an issue it will be. Certainty that some training posts will remain at their hospitals, but unsure how many.

Like all other challenges that come along for small hospitals, the 3 DGH's say it will be faced at the appropriate time, and there is confidence it will be overcome.

Safety and Sustainability of the Services in the future

Q9 : Have any concerns been expressed about safety and sustainability of the service in the future? If there have been concerns, what are they and how are you dealing with them?

All 3 DGH

No concerns have been raised with them by external organisations and agencies, or amongst themselves, about the safety of the maternity and paediatric services they currently provide.

NDH

No concerns about safety at the hospital.

Health Care Commission (the predecessor of the Care Quality Commission) rated the maternity service one of the best in the country.

Network links between Bristol, Plymouth and Truro Hospitals are fantastic. Transfer of Level 2 and 3 neo-natal babies nearly always by road but network consultants talk

you through the journey. Lower than national average returns for still births over the last 3 years.

DCH

No concerns about safety at the hospital. Very robust risk analysis all undertaken in-house

Very highly rated maternity service with excellent facilities, and rated the best small hospital maternity service in 2009

8 still births a year, this below the national average.

Consultant interview - Important that you can recognise deterioration and potential for deterioration in a patient and have a good network with tertiary hospitals offering specialist care for the condition. We do have this network in place and we are always ready to transfer a patient when we need to.

YDH

No concerns about safety at the hospital.

Level 2 Clinical Negligence Insurance Cover has been achieved. Still births are at a level that reflect national averages.

CCG + PCT concerns about Safety / Sustainability

Q10 : Has the local CCG or the PCT raised any concerns about safety and sustainability?

NDH

North Devon PCT had serious concerns if NDH was to be reduced to ambulatory care. Distance to the next nearest hospitals are huge - 50 miles from Exeter, 70 miles from Taunton, and both Plymouth and Bristol are each 2 hours drive away. The PCT happily funded 3 additional Paediatric consultant posts 3 years ago as any downgrading of the service in view of the geographic isolation was considered unsafe.

Has good working relationships with the PCT and the emerging CCG. No concerns have been raised about safety and sustainability by them

NHS Devon has a deficit of £12 million this year to address, but has no intention of securing savings by downgrading maternity and children's services at the NDH.

DCH

Dorset PCT very supportive and values the quality of the services provided although it is financially constrained.

Emerging CCG 100% supportive of maintaining all maternity and paediatric services at the DCH, but urges vigilance around cost and quality. Individual GPs that operate within the CCG area thoroughly endorse this support.

Affordability now / in the future

Q11 : Is the service you are providing affordable now and will it be in the future?

NDH

Economies of scale are not available when operating a smaller unit. However NDH afford the services because of its geographical isolation and the special circumstances it operates within, and it is a key priority for the communities the hospital serves. Both the PCT and the emerging CCG recognise the importance of maintaining the 24/7 consultant-led the services at the NDH

DCH

It is affordable now but there is keen awareness that finance will be a key consideration in the future.

YDH

Paediatrics operates within budget.

Impact of ceasing consultant operated services

Q12: What would happen if you had to cease the consultant operated units?

NDH

If the consultant operated unit was closed here some mothers would have to travel 60 miles and this threatens very seriously the safety of the mother and her expected baby. It would be a disaster for our local communities, and a tragedy just waiting to happen.

DCH

The likely replacement, a Midwife-led service would not serve our population at all well. It would be one step from being closed altogether.

YDH

Not prepared to contemplate what would be totally unacceptable.

European Working Time Directive (EWT D)

Q13: What are your views on the European Working Time Directive?

NDH

Speciality Doctors work outside of the EWT D, all others sign up to it.

DCH

Consultants have not signed the EWT D. The Directive has been a disaster for hospitals keen to provide 24/7 in-patient care for conditions requiring urgent and immediate attention. DCH has managed to overcome it by having a night core of midwives trained to assist with C sections.

YDH

EWT D has created havoc with the 24/7 rotas but the hospital has overcome them.

Open Access for children with complex medical needs

Q14: How do you handle children with complex medical needs for needed but basic out of hours medical treatment / intervention / monitoring such as enemas, iv anti-biotics?

Q 15: How do you address Open Access for such children

3 DGH

All 3 hospitals operate Open Access for children with complex needs to the paediatric service 24 / 7. This includes provision for admittance as an in-patient to the children's ward, and arranging for the parents to stay near their children whilst they are in hospital.

NDH

If Open Access was lost in any downgrading of the paediatric service, it would place both parents and their children using the service in great jeopardy in view of the additional distances involved, not only seriously compromising the safety of all concerned, but also the unacceptable level of mental stress given the frequency people who have Open Access visit their local hospital.

Trend recently has been to address the complex needs of children with Open Access in their own houses by deploying the Community Rapid Response teams.

Consultants living close to the hospital

Q16: Are your consultants located within 20 minutes from the hospital?

3 DGH

All our Consultants live within 20 minutes of the hospital.

Attendance figures for Paediatrics over the weekend

Q17: What are your attendance figures for paediatrics over a weekend? Does it get quieter?

NDH

Admissions to the Paediatric ward September 2011 – August 2012

Monday	468
Tuesday	477
Wednesday	454
Thursday	491
Friday	426
Saturday	320
Sunday	302

Total 2938

The health communities cared for at the hospital include holiday makers in what is an area dependent on tourism, residential schools and a very large Royal Marine base at Chivenor, 3 miles away.

DCH

Approximately 4000 admissions per year to the paediatric ward. Pattern of attendances similar to NDH, with the same slight reduction for the weekends.

However considered absolutely essential to operate on both Saturday and Sunday.
YDH

Very little difference between Monday to Friday attendance / admissions. Slight reduction over the weekend but still significant numbers being admitted to the paediatric ward.

Q18 - Catchment Areas

Please see the Table included in the Report

Q19 – Home Births

3 DGH

Home births in the individual catchment areas of each hospital are at around 4% of the total births handled by the maternity service.

NDH

Given the geographic isolation of North Devon, if services were downgraded to a midwife-led unit, the number of home births would have to reduce as the nearest consultant-led maternity unit if problems arose during birth would be as far as 60 miles away, threatening the safety of both the mother-to-be and her child. This would undoubtedly limit patient choice.

Prediction for the future of the Services

Q20: Will these services still be operating in 5 Years time

3 DGHs

The following summary points were made to us, often repeatedly, during the course of our 7+ hours of extended discussions at the 3 DGHs, and appear in the 40+ pages of the transcripts of the recordings made of these discussions. They are therefore a **montage of the loud and clear messages** given to us at the 3DGHs by their Consultants and their Senior Management.

Consultants / Midwives + Management – Joint Response

We are absolutely determined to retain the 24/ 7 consultant-led maternity and children's services and the Special Care baby unit at our hospitals. This determination is shared by the consultants, senior medical staff, midwives, nursing staff on the wards, very resolutely endorsed by our local GPs whose patients we serve, and is strongly supported by the PCTs and the emerging Clinical Commissioning Group.

Why – because we are here to serve our local communities, we want to serve our local communities, they deserve nothing less and are right to expect to have our services locally rather than miles and miles away.

We also fear that the distances to the next nearest hospital will, if our services are downgraded, eventually end in a tragedy, potentially a death, for an expectant mother, her baby, or even the family in an accident caused by driving too fast in an emergency on a road unsuited for high speed or in hostile weather conditions.

We run a safe service, our key consideration, any issues that come along, we face up to them and then overcome them. We are confident of keeping our services here, local communities would suffer if we do not.

We will be here in 5 years time – and well beyond.

North Yorkshire County Council

Scrutiny of Health Committee

14 June 2013

Children's and Maternity Services at the Friarage Hospital, Northallerton – Current Situation

Purpose of Report

1. The purpose of this report is to update the Scrutiny of Health Committee on developments relating to Children's and Maternity Services at the Friarage Hospital, Northallerton.

Introduction

2. Members will recall that the Scrutiny of Health Committee referred this matter to the Secretary State for Health in December of last year. For reference purposes the letter from County Councillor Jim Clark to the Secretary of State is attached as APPENDIX 1.
3. In his response to Councillor Clark of 23 January 2013 the Secretary of State announced that he had asked the Independent Reconfiguration Panel (IRP) to undertake an initial review and that he had asked the IRP to report to him by no later than 22 February 2013. The IRP is the independent expert on NHS service change in the United Kingdom. Set up in 2003, its role is to advise the Secretary of State for Health on contested proposals for health service change.
4. At the meeting on 22 March 2013, when the Committee met to review progress, agreement was reached with Dr Vicky Pleydell, Clinical Chief Officer from NHS Hambleton, Richmondshire and Whitby Clinical Commissioning Group (HRWCCG) that no formal consultation should be launched before 1 July 2013. It was also agreed that, should a consultation go ahead over the summer months, the usual 12 week period should be extended to a 16 week period to allow for the holiday period.
5. On 23 May 2013 the Secretary of State wrote Councillor Jim Clark enclosing the letter which he had received from the IRP. The IRP concluded that there is a need to take action around the issues facing children's and maternity services at the Friarage Hospital in Northallerton and that a consultation should now go ahead. The relevant correspondence is attached as APPENDIX 2.
6. Dr Vicky Pleydell has indicated that she welcomes the IRP's conclusions and that the Secretary of State has given the go-ahead to start the public consultation.
7. From this Committee's perspective it is significant that the Secretary of State highlighted:

“Legal advice received by the CCG and PCT advised that consultation should not take place on any option that cannot be delivered.

The IRP would not wish to contradict any such advice on matters of law, only to observe that it has seen similar advice in other cases.

However, the Panel considers that the draft document produced in preparation for formal consultation and shared with your Committee could usefully be adapted to satisfy all requirements.

In such circumstances, a clear explanation of the case for change is required. If it is considered that option 1 is not viable, it is important to demonstrate *why* it is not viable – by providing suitably detailed analysis to show what it would mean in terms of sustainability, affordability and quality.

The consultation may also wish to invite new options and not limit respondents to those listed. Any new options put forward can be evaluated post-consultation in line with the agreed criteria.”

8. Dr Pleydell has indicated that the HRWCCG now wants to start the formal consultation as soon as possible. However, it is mindful of the ‘Securing Quality in Health Services’ (SQHS) project which has been commissioned by clinical commissioning groups in the Durham and Tees Valley and is examining clinical quality standards in acute hospital services in the area, including children’s and maternity services. Dr Pleydell also indicated her commitment to continue to work with the Committee on this matter.
9. Against this background the Dr Pleydell has indicated that it would be unwise to start the consultation on developments at the Friarage until it is clear what impact the SQHS project will have on services commissioned on behalf of residents in North Yorkshire.
10. Dr Pleydell and Jill Moulton, Director of Planning, South Tees Hospitals NHS Foundation Trust will be attending the meeting to provide more information on the SQHS project, including its scope, timescales and how it might impact on any proposed consultation on changes to children’s and maternity services at the Friarage Hospital.

Recommendations

11. Dr Pleydell be invited to summarise how the recommendations from the IRP to the Secretary of State will be taken forward, including:
 - a) providing evidence of the legal advice the CCG has received that consultation should not take place on any option that cannot be delivered;
 - b) providing evidence as to why option 1 would not be viable, including suitably detailed analysis to show what it would mean in terms of sustainability, affordability and quality.
 - c) describing how the CCG intends to respond to the IRP’s comment that a consultation document “could usefully be adapted to satisfy all requirements”;
12. Dr Pleydell be invited to report on the outcome of the SQHS project at the earliest opportunity.
13. Jill Moulton be invited to summarise how the South Tees Hospitals NHS Foundation Trust will ensure children’s and maternity services at the Friarage Hospital are sustainable until the outcome of the SQHS project is known and/or a formal consultation (which takes into account the IRP’s comments) has been completed.

Bryon Hunter
Scrutiny Team Leader
County Hall, NORTHALLERTON

29 May 2013

Background Documents: None

County Councillor Jim Clark
(Harrogate/Harlow Division)

74 Green Lane
Harrogate
North Yorkshire
HG2 9LN

Tel: 01423 872822

E-mail: cllr.jim.clark@northyorks.gov.uk

20 December 2012

Rt Hon. Jeremy Hunt MP
Secretary of State for Health
Richmond House
79 Whitehall
London SW1A 2NL

Dear Secretary of State

Proposed Reconfiguration of Children's and Maternity Services at the Friarage Hospital, Northallerton

Please accept this letter as formal referral to you of the proposals by NHS North Yorkshire and York (NHS NY&Y) to close the 24/7 consultant-led children's and maternity services at the Friarage Hospital, Northallerton. The referral follows on from the meeting of the North Yorkshire Scrutiny of Health Committee (SoHC) on 22 November 2012¹ when it was resolved unanimously that I should refer these proposals to you.

The referral is made in accordance with the provisions set out in the Health and Social Care Act (2001) (as amended) and the associated regulations² (specifically regulation 4(7)) and current Department of Health guidance³.

It is important to note that the SoHC is seeking a full review of these proposals by the Independent Reconfiguration Panel (IRP) and is requesting you to agree this approach.

You will note in written evidence⁴ submitted with this letter that the Rt. Hon. William Hague MP, as the local Member of Parliament, sees this as the only way

¹ https://www3.northyorks.gov.uk/n3cabinet_scru/health_agendas_/20121122agenda/2012-11-22-Agenda.pdf

² http://www.legislation.gov.uk/uksi/2002/3048/pdfs/uksi_20023048_en.pdf

³ http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4066238.pdf

⁴ https://www3.northyorks.gov.uk/n3cabinet_scru/health_reports_/20121122_/williamhaguempl/williamhaguempl.pdf

to settle the gulf between the arguments put forward by the local NHS underpinning their proposed downgrading of the services and the arguments and public support underpinning their retention at the Friarage Hospital.

The referral focuses on 3 main aspects:

- 1) A reduction in the quality of these NHS services;
- 2) Significantly reduced patient accessibility;
- 3) Compromising the reputation and credibility of the local NHS in the eyes of the public by excluding from the proposed public consultation the option that had attracted their overwhelming support in an extensive engagement programme.

It is important to note that Mr. Hague has given his unswerving support for retaining the healthcare services proposed to be downgraded although he makes clear it may have to be on the basis of finding a unique solution, and so their provision would potentially be in a different format.

Mr. Hague led a family rally and march of some 4,000 men, women, children and babies in May of this year organised to demonstrate the support amongst local people for the retention of the 24/7 consultant-led services.

The background and the main events together with references to key documents over the last year relating to the proposed reconfiguration are detailed below.

In July 2011, South Tees Hospitals NHS Foundation Trust approached NHS Hambleton, Richmondshire and Whitby Shadow Clinical Commissioning Group (CCG) 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. NCAT published its report⁵ early in 2012.

Whilst the NCAT report suggested that no change was not an option for the services under review at the Friarage Hospital, it also confirmed that the services currently provided there were 1st class, and the hospital was loved by the 150,000 residents it serves across a huge 75 mile wide rural and deeply rural catchment here in North Yorkshire, from very nearly to Pickering in the North York Moors, across the Vale of York, to the remote areas of Upper Swaledale and Upper Wensleydale in the Yorkshire Dales.

The NCAT report also raised concerns about the future provision and sustainability of 24/7 consultant-led maternity and children's services at the Darlington Memorial Hospital, a hospital suggested by the local NHS to provide an alternative if these services at the Friarage were downgraded. If services at the Darlington Memorial Hospital were subsequently downgraded, having lost those at the Friarage, this would consign expectant mothers-to-be from a local deeply rural population of some 5,000 people to journeys of approximately 50 to 70 miles from the Upper Dales in the Yorkshire Dales National Park to access a 24/7 consultant-led maternity service.

⁵<http://www.northyorkshireandYork.nhs.uk/HRW/BoardMeetings/2012-13/2012Sep17/Appendix%203%20NCAT%20Report.pdf>

It is understood this would place these communities the furthest away of all communities of a comparable size in all England from consultant-led maternity services.

The extended length of such journeys, especially given the hostile weather conditions prevalent for many months of the year in the Yorkshire Dales, present a significant threat to the safety of both the mother-to-be and her expected baby, and indeed the local NHS has predicted it could be likely to increase the number of emergency births en route to a hospital, as the distance and the time taken to travel would exceed that available for the impending birth of the baby.

The NCAT report led to a decision to carry out an engagement process or “conversation” with local patients, the public, NHS partners, the Local Authority, the voluntary sector and other stakeholders about the problems the paediatric service faces. It was also decided that the engagement process would include the future of maternity services at the Friarage as there are fundamental links between paediatrics and maternity services in terms of sustainability.

The engagement process included 9 public meetings held across Hambleton and Richmondshire between April to June 2012. At each of these meetings, 7 of which I personally chaired, we heard from managers and clinicians that there is currently a first class service but there are problems in sustaining it at this level. The overwhelming view from the public was that a consultant led service should be retained. The engagement exercise culminated in a comprehensive report⁶.

NCAT carried out a second visit to the Friarage Hospital in August and published their second report⁷ in September. It again concluded that no change was not an option but it did recognise the overwhelming public support for retention of a consultant led service.

On 25 September 2012 the Board of NHS NY&Y considered a report “Proposed Reconfiguration of Paediatric and Maternity Services at Friarage Hospital, Northallerton”⁸ with a view to agreeing the options to be included in the formal consultation. The report outlined options for the reconfiguration of paediatric and maternity services:

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

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

⁶<http://www.northyorkshireandYork.nhs.uk/friarage/index.htm>

⁷[http://www.northyorkshireandYork.nhs.uk/friarage/docs/Friarage%20report%20following%20visit%2021-8-12%20-%20final%20version%20\(2\).pdf](http://www.northyorkshireandYork.nhs.uk/friarage/docs/Friarage%20report%20following%20visit%2021-8-12%20-%20final%20version%20(2).pdf)

⁸<http://www.northyorkshireandYork.nhs.uk/AboutUs/PublicBoardMeetings/2012Sep25/Item%207%20The%20Friarage%20Proposed%20Reconfiguration.pdf>

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

At that meeting the Chief Executive of NHS NY&Y advised the Board that legal advice had been sought and the conclusion reached was that the consultation should not be on a single option nor on an option that could not be delivered. The minutes⁹ from the meeting indicate that on the basis of this evidence and the guidance from the Strategic Health Authority's Service Change Assurance Process, the Board of NHS NY&Y agreed to consult on Options 2 and 3 only.

The Board concluded that Option 1 was not feasible given that significant investment would be required to increase the staffing levels to address the issues around quality and safety, and that even if additional investment was made, the service would not be clinically sustainable due to staffing and recruitment issues. At that stage NHS NY&Y's intended start date for the consultation was 1 November 2012.

However the approach of the NHS NY&Y did not allow any public scrutiny of the costings that the South Tees NHS Foundation Trust had put forward in sustaining the consultant-led services, nor any scrutiny of the trust's assertion that recruitment of the necessary high quality consultants would be very difficult, if not impossible. Evidence was available at the time, and subsequently confirmed, that the costings may not need to be as high as the local NHS was putting forward and that recruitment was not the obstacle it was being suggested.

This evidence came forward in a survey¹⁰ conducted by overview and scrutiny at Richmondshire District Council of the 19 smallest hospitals in the United Kingdom operating 24/7 consultant-led maternity and paediatric services. The survey received a very high response rate of 17 replies and a follow up face to face fact finding visit¹¹ to 3 of the hospitals, all located in the West Country.

This evidence was submitted to the SoHC by the District Council's Health Scrutiny Committee which has been a partner of ours on a number of scrutiny reviews. Very nearly all the 51,500 residents of Richmondshire would be detrimentally affected by the proposals to downgrade services at the Friarage Hospital.

On 23 October 2012 NHS NY&Y decided unilaterally to postpone the start date of the consultation. It took the view that to embark upon such an expensive and time consuming exercise would have been inappropriate if, as seemed likely, the SoHC resolved to refer the proposed options to you. The Accountable Officer for the CCG wrote to me on 26 October 2012 confirming the consultation had been postponed¹².

It is important to note that the SoHC was not consulted about the postponement and indeed the first I heard of it as its Chairman was when the press contacted me as a result of following up a press release issued by the CCG.

⁹ <http://www.northyorkshireandyork.nhs.uk/AboutUs/PublicBoardMeetings/2012Oct23/09.12%20BoardMins.pdf>

¹⁰ https://www3.northyorks.gov.uk/n3cabinet_scru/health_reports/20121109/hldcfhnsmallhos/dcfhnsmallhospi.pdf

¹¹ https://www3.northyorks.gov.uk/n3cabinet_scru/health_reports/20121109/05rdcsmallhospi-2/05rdcsmallhospi.pdf

¹² https://www3.northyorks.gov.uk/n3cabinet_scru/health_reports/20121109/04lettertocounc/04lettertocounc.pdf

The SoHC met on 22 November 2012 to hear first hand the views and concerns expressed by members of the public on the draft proposals to be included in the (now postponed) consultation document for services at the Friarage Hospital. The document was made available to the Committee by the CCG so the Committee could confirm the next steps in terms of its continued involvement in this matter.

There was a standing room only audience of just under 200 present, which heard a number of very moving and telling contributions from mothers who considered their lives, or the lives of their babies, might have been lost if the 24/7 consultant-led services had not been available at the Friarage Hospital, in view of the distance to the next nearest hospital offering these services as being proposed in the draft consultation.

In most of these contributions it was clear that the Special Care Baby Unit (SCBU) played an absolutely key role.

It also heard from a number of parents with children who had very complex medical needs that were able to take advantage of the Open Access for their children offered at the Friarage.

Both the SCBU and Open Access during the evening / overnight hours and all weekend would be lost if the downgrading proposals were implemented.

The SoHC, having heard these contributions, and taking into account the evidence it had already heard, including the evidence that had recently come forward from Richmondshire District Council as outlined above, and the detrimental implications flowing from any downgrading of the services, resolved unanimously that I should refer the proposals to you as Secretary of State for Health.

A key issue underpinning the Committee's decision is that the loss of a consultant led children's and maternity service at the Friarage will lead to a significant reduction in the quality of services that children, their parents and expectant mothers will receive.

Since the original Lord Darzi Review in 2008 (and which has been reinforced in the Health and Social Care Act 2012) quality in the NHS is seen as:

Clinical Effectiveness

Quality care is care which is delivered according to the best evidence as to what is clinically effective in improving an individual's health outcomes;

Safety

Quality care is care which is delivered so as to avoid all avoidable harm and risks to the individual's safety; and

Patient Experience

Quality care is care which looks to give the individual as positive an experience of receiving and recovering from the care as possible, including being treated according to what that individual wants or needs, and with compassion, dignity and respect.

These quality dimensions are the very same factors on which Option 1 scored highest in the CCG's own scoring methodology:

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

Criteria	Highest Score
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Ref: CCG's Business Case report, page 108

A consultant led service scores highest in all 3 aspects of quality. It also scores highest in Equity of Access.

In addition to these issues relating to quality the Committee could not ignore the strength of public concerns expressed over the proposed loss of consultant led children's and maternity services at the Friarage Hospital:

- On 26 May 2012 a march involving some 4,000 people and led by the Rt. Hon. William Hague MP took place from County Hall to the Friarage Hospital.
- A petition on the social networking site Facebook has been signed by over 10,000 people.
- A petition led by the Northern Public Services Alliance has 800 signatures.
- A petition by the Marske Women's Institute raised 750 signatures
- A number of parish councils and both Hambleton District Council¹³ and Richmondshire District Council¹⁴ have expressed opposition to the proposal
- The County Council¹⁵ called for no stone to be left unturned in an effort to retain the existing consultant led serves at the Friarage Hospital.

¹³ <http://www.hambleton.gov.uk/Hambleton%20District%20Council/Committees/Council/210212.pdf>

¹⁴ <https://www.richmondshire.gov.uk/pdf/121023%20Council%20Minutes%20-%20Draft.pdf>

¹⁵ https://www3.northyorks.gov.uk/n3cabinet_cc/minutes_/20120215countyc/20120215countyc.pdf

- The option overwhelming supported by the public during the extensive public engagement programme staged by the local NHS was going to be excluded from the proposed statutory consultation.

In his letter to me your Cabinet colleague, Mr Hague MP, encouraged the SoHC to refer the matter to you. He stated, “A rigorous, independent and thorough analysis by the IRP will help bring some much needed clarity to the issue”.

The Richmondshire District Council fact finding visit to the 3 small hospitals operating 24 / 7 consultant-led maternity and children’s services in the West Country showed that unique solutions to the national challenges faced by continuing to run these services in the future could be overcome by bespoke solutions when coupled with a determination by the clinical staff and management to provide locally accessible services.

Against this background of such united opposition and the fact that the CCG's own survey shows there would be a significant reduction in the quality of service that children and expectant mothers would receive if the proposals are implemented, led the Committee to conclude they do not meet the health needs of the local community. Consequently, we resolved unanimously to refer the proposals to you.

The Committee accepts that no change is not an option but calls for more work to be done to find a unique solution to the problems being encountered. It does not appear that the necessary innovative thinking has been undertaken by the local NHS to overcome the challenges faced at the Friarage to retain the services proposed for closure in the way that it has been undertaken elsewhere. This could include overcoming the recruitment and costs of committing to a fully staffed rota of consultants at the Friarage as has been possible at other similar hospitals, most notably the Horton Hospital in Banbury, North Devon Hospital, Dorset County Hospital and Yeovil District Hospital. Another option might be to do more work to explore fully the feasibility of introducing Advanced Neonatal Nurse Practitioners as has been possible at the Wansbeck Hospital. But there may be other options.

Finally, I hope that colleagues in the NHS locally will recognise that this referral is made to you in the spirit of co-operation with them and with a view to enlisting the help of the IRP to find a unique solution to the problems facing children’s and maternity services at the Friarage Hospital.

If you need any further information please do not hesitate to contact me or Bryon Hunter (contact details below).

Yours sincerely

County Councillor Jim Clark
Chairman – North Yorkshire County Council Scrutiny of Health Committee

Copies to:

The Rt Hon. William Hague MP

County Councillor John Weighell, Leader - North Yorkshire County Council (NYCC)

Richard Flinton - Chief Executive, NYCC

County Councillor Clare Wood - Portfolio Holder for Health and Adult Services, NYCC

Helen Taylor, Corporate Director Health and Adult Services, NYCC

All Members of the North Yorkshire Scrutiny of Health Committee

Kevin McAleese CBE - Chairman, NHS North Yorkshire and York

Chris Long - Chief Executive, NHS North Yorkshire and York

Dr Vicky Pleydell - Shadow Accountable Officer, Hambleton, Richmondshire and Whitby Clinical Commissioning Group

Jill Moulton - Director of Planning, South Tees Hospitals NHS Foundation Trust

Tony Clark, Managing Director, Richmondshire District Council

Phil Morton, Chief Executive, Hambleton District Council

Bryon Hunter - Scrutiny Team Leader, North Yorkshire County Council

Contact Details: Chief Executive's Office, County Hall,
Northallerton, North Yorkshire, DL7 8AD

Telephone No: 01609 532898

E-mail Address: bryon.hunter@northyorks.gov.uk

*From the Rt Hon Jeremy Hunt MP
Secretary of State for Health*



POC1_783322

Councillor Jim Clark
Chairman
North Yorkshire County Council
Health Scrutiny Committee
74 Green Lane
Harrogate
North Yorkshire
HG2 9LN

*Richmond House
79 Whitehall
London
SW1A 2NS*

*Tel: 020 7210 3000
Mb-sofs@dh.gsi.gov.uk*

23 MAY 2013

Dear Mr Clark,

RECONFIGURATION OF CHILDREN'S AND MATERNITY SERVICES AT THE FRIARAGE HOSPITAL (PART OF SOUTH TEES HOSPITALS NHS FT) – REFERRAL FROM NORTH YORKSHIRE COUNTY COUNCIL'S HEALTH SCRUTINY COMMITTEE AND INITIAL IRP ADVICE

I refer to your letter of 20 December 2012 referring proposals regarding the reconfiguration of children's and maternity services at the Friarage Hospital in Northallerton, I asked the Independent Reconfiguration Panel (IRP) for its initial advice.

I refer also to your subsequent letter of 25 February 2013 in which you ask for my decision following the Panel's advice ahead of purdah for local elections.

The Panel has now completed its initial assessment and shared its advice with me.

A copy of that advice is appended to this letter and which will be published today on the Panel's website at www.irpanel.org.uk

In order to make my decision on this matter, I have considered the concerns raised by your Committee, and have taken into account the Panel's advice.

IRP advice

As you will be aware, the IRP offers its advice to me on a case by case basis, taking account of the specific circumstances and issues of each referral. In this instance, the Panel does not consider that a full review would add any value at this stage.

In providing its advice, the Panel is clear about the challenges faced by the NHS in providing health services in remote locations are not to be underestimated.

I know The Friarage serves a largely rural population dispersed across a wide geographical area, and while activity levels, both for paediatrics and maternity services are low compared to most hospitals in England, the availability of these consultant-led services is greatly valued by the local population.

It is clear that “no change” is not an option is widely accepted.

However, the process of bringing about change has stalled at a point before local consultation has taken place.

Your Committee referred to me on the grounds where it believes proposed changes at The Friarage are not in the interests of the local health service.

In your referral letter, you asked me that “a full review of the proposed changes be undertaken by the Panel”.

However, it is routine practice for the Panel to provide me with an initial assessment before deciding whether they believe the referral and associated case for change warrants a full review as part of its advice.

As part of its initial assessment, the Panel observed that your Committee and the local NHS appear to have worked well together up to this stage in developing an effective pre-consultation engagement phase and by exploring options for change. I would expect this good work to continue in the best interests of patients.

Given the evident concerns about sustainability of the current position, the process now needs to be allowed to continue through formal local consultation, consideration of feedback, refinement of proposals and, ultimately, the decision-making process.

With regard to the content of formal local consultation, the Panel understands your Committee has indicated a preference for consultation to include option 1 (sustaining a consultant-led paediatric service and maternity unit).

I understand the local Clinical Commissioning Group and Primary Care Trust maintain this option is not viable and as a result should not be included.

Legal advice received by the CCG and PCT advised that consultation should not take place on any option that cannot be delivered.

The IRP would not wish to contradict any such advice on matters of law, only to observe that it has seen similar advice in other cases.

However, the Panel considers that the draft document produced in preparation for formal consultation and shared with your Committee could usefully be adapted to satisfy all requirements.

In such circumstances, a clear explanation of the case for change is required. If it is considered that option 1 is not viable, it is important to demonstrate *why* it is not viable – by providing suitably detailed analysis to show what it would mean in terms of sustainability, affordability and quality.

The consultation may also wish to invite new options and not limit respondents to those listed. Any new options put forward can be evaluated post-consultation in line with the agreed criteria.

The Panel recognises that further challenges may lie ahead once the consultation phase has been completed. But, at this stage, it is important that formal consultation is conducted and completed in a way that engages all interested parties in a fair, open and rigorous process that seeks the best possible solution.

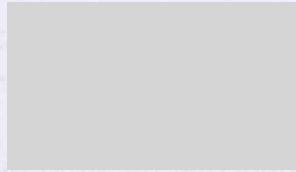
Conclusion

The Panel recommends that local consultation should now take place.

However, it is important that local consultation is conducted and completed in a way that engages all interested parties, including your Committee in a fair, open and rigorous process that seeks the best possible solution and I support that recommendation entirely.

I support the Panel's initial assessment in full and expect the local NHS to move to consultation and to ensure that your Committee as well as other key stakeholders are fully involved.

Yours sincerely



JEREMY HUNT

The Rt Hon Jeremy Hunt MP
Secretary of State for Health
Richmond House
79 Whitehall
London SW1A 2NS

22 February 2013

Dear Secretary of State

REFERRAL TO SECRETARY OF STATE FOR HEALTH
Reconfiguration of children's and maternity services at the Friarage Hospital,
Northallerton
North Yorkshire County Council Scrutiny of Health Committee

Thank you for forwarding copies of the referral letter and supporting documentation from Cllr Jim Clark, Chairman, North Yorkshire County Council Scrutiny of Health Committee (SoHC). NHS Yorkshire and Humber provided initial assessment information. A list of all the documents received is at Appendix One.

The IRP has undertaken an initial assessment, in accordance with our agreed protocol for handling contested proposals for the reconfiguration of NHS services. The IRP considers each referral on its merits and its advice in this case is set out below. **The Panel concludes that this referral is not suitable for full review.**

Background

The Friarage Hospital, Northallerton (FHN) is part of the South Tees Hospitals NHS Foundation Trust (STFT). The Trust provides paediatric and maternity at both the James Cook University Hospital (JCUH) in Middlesbrough and at FHN. The two hospitals are around 22 miles apart. FHN serves a largely rural population, Northallerton lying between the North York Moors and the Pennines with York some 30 miles to the south.

Children's and maternity services are provided on an integrated basis with common standard operational procedures and policies, managed on both sites by the STFT Division of Women and Children. The children's services ward at FHN has 14 beds used both for inpatient stays and as an assessment facility. There are around 1,900 inpatient stays a year on the ward. Children requiring emergency surgery and trauma surgery are transferred to JCUH. The maternity service offers obstetric and midwifery-led care with around 1,200 births a year. Pregnant women requiring specialist care are transferred to JCUH. There is a 10-cot special care baby unit. Newborn babies requiring high dependency and intensive care are also transferred.

In July 2011, STFT published a report highlighting concerns about paediatric services at FHN. Discussions began with NHS Hambleton, Richmondshire and Whitby Shadow Clinical Commissioning Group (CCG) regarding the future sustainability of the service. The National Clinical Advisory Team (NCAT) was invited to visit in December 2011 to review the clinical case and consider options for reconfiguring children's services within the Trust.

NCAT's report was published in January 2012. The report concluded that *"the present low volume inpatient service is unsustainable for reasons of maintaining a workforce with the right skills, affordability and potentially clinical safety"*. It commented that the Friarage Hospital is *"loved by its local community"* who *"would wish to see a vision for the hospital which would see it sustainable into the future"*. It recommended that the Trust proceed with work to redesign paediatric services and to develop a sustainable vision for maternity services within a larger piece of work describing *"a vision for FHN as a small hospital serving the community of Northallerton and beyond, which is of high quality, sustainable and affordable"*.

NHS North Yorkshire and York (PCT Cluster) – on behalf of themselves, the CCG and STFT – undertook extensive pre-consultation engagement between April and June 2012, in which seven options for future services were outlined. Public meetings were held across Hambleton and Richmondshire and conversations were held with local patients, the public, staff, NHS partners, local authorities, voluntary sector and other stakeholders. The SoHC, notably through the Chairman, were involved throughout.

During this period, a fact-finding exercise was conducted to explore with other NHS organisations issues being faced by paediatric and obstetric services and arrangements under consideration for future service delivery. This included visits to other hospitals undertaken in conjunction with local councillors. In June-July 2012, a survey was carried out by Richmondshire District Council of small hospitals with maternity units, the results of which were shared with the CCG and STFT.

During August 2012, Gateway review was completed and NCAT invited to undertake a further review. NCAT's report, published in September 2012, concluded that the case for change remained the same as when NCAT had visited previously.

On 17 September 2012, the shadow governing body of the CCG held an extraordinary meeting to consider an option appraisal of paediatric and maternity services at FHN. The meeting described how the option appraisal process had been undertaken and discussed three options for future provision of services. The shadow governing body agreed the clinical case for change and recommended that the PCT Board (NHS North Yorkshire and York) consider proceeding to public consultation (on the three options discussed) including the CCG clinically preferred option – see option 2 below.

The NHS Yorkshire and York (PCT Cluster) Board met on 25 September 2012 to consider a report *Proposed reconfiguration of paediatric and maternity services at Friarage hospital,*

Northallerton with a view to agreeing options for inclusion in a formal consultation. The report outlined three options for the reconfiguration of services:

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

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

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

The Board agreed that the clinical case for change had been demonstrated. Taking account of legal advice that consultation should not take place on an option that could not be delivered, the Board agreed that consultation should take place on options 2 and 3 subject to the NHS North of England Service Change Assurance Process.

The Board met again on 23 October 2013 and, aware of indications that the SoHC intended to refer the matter to the Secretary of State for Health, opted to pause the consultation process. A press release was issued and all stakeholders, including the SoHC, were subsequently advised of the decision.

The SoHC met on 22 November 2012 and resolved unanimously to refer the matter to the Secretary of State. The CCG Chair and SoHC Chair met on 26 November 2012 to discuss the way forward. The Clinical Chief Officer Designate of the CCG wrote to the SoHC Chair on 30 November 2012 to re-affirm the commitment to continued close working, clarity about use of evidence, providing clear and comprehensive information and transparency in dealings with stakeholders and the public.

Formal referral of the matter was made by the SoHC in a letter of 20 December 2012 to the Secretary of State.

Basis for referral

The referral letter of 20 December 2012 states that:

“The referral is made in accordance with the provisions set out in the Health and Social Care Act (2001) (as amended) and the associated regulations (specifically regulation 4(7)) and current Department of Health guidance.”

IRP view

Independent Reconfiguration Panel

Tel: 020 7389 8045/6

E Mail: info@irpanel.org.uk

Website: www.irpanel.org.uk

With regard to the referral by the North Yorkshire County Council Scrutiny of Health Committee, the Panel notes that:

- FHN serves a geographically isolated population across north Yorkshire
- The hospital is greatly valued by the local population – the CCG has made clear its commitment to maintaining a hospital at FHN
- While consultant-led paediatric and maternity services are available in Middlesbrough, Darlington, Harrogate and York, transport, access and future sustainability of alternatives services are issues for local residents
- Workforce issues, affordability and potential safety concerns have been cited as the main drivers behind the clinical case for change
- Two NCAT reviews have supported the case for change
- The SoHC accepts that no change is not an option but has called for more work to be done to find a unique solution to the problems being encountered
- The process is currently suspended pending the outcome of referral to the Secretary of State – formal consultation on proposals has yet to take place
- Both the SoHC and the local NHS are committed to continued close working and a spirit of co-operation

Conclusion

The IRP offers its advice on a case-by-case basis taking account of the specific circumstances and issues of each referral. **The Panel does not consider that a full review would add any value at this stage.**

The challenges faced by the NHS in providing health services in remote locations are not to be underestimated. The Friarage Hospital, Northallerton serves a largely rural population dispersed across a wide geographical area. While activity levels - both for paediatrics and maternity services - are low compared to most hospitals in England, the availability of these consultant-led services is greatly valued by the local population.

That no change is not an option is widely accepted. However, the process of bringing about change has stalled at a point before formal consultation has taken place. The SoHC and local NHS appear to have worked well together up to this stage in developing an effective pre-consultation engagement phase and exploring options for change. Given the evident concerns about sustainability of the current position, the process needs to be allowed to continue through formal consultation, consideration of feedback, refinement of proposals and, ultimately, decision-making.

With regard to the content of the formal consultation, the IRP understands that the SoHC has indicated a preference for the consultation to include Option 1 - sustaining a consultant-led paediatric service and maternity unit. The CCG and PCT maintain that this option is not viable and should not, therefore, be included. Legal advice received by the CCG and PCT advised that consultation should not take place on any option that cannot be delivered. The IRP would not wish to contradict any such advice on matters of law, only to observe that it has seen similar advice in other cases.

However, the Panel considers that the draft document produced in preparation for formal consultation and shared with the SoHC could usefully be adapted to satisfy all requirements. In such circumstances, a clear explanation of the case for change is required. If it is considered that Option 1 is not viable, it is important to demonstrate *why* it is not viable – by providing suitably detailed analysis to show what it would mean in terms of sustainability, affordability and quality. The consultation may also wish to invite new options and not limit respondents to those listed. Any new options put forward can be evaluated post-consultation in line with the agreed criteria.

The Panel recognises that further challenges may lie ahead once the consultation phase has been completed. But, at this stage, it is important that formal consultation is conducted and completed in a way that engages all interested parties in a fair, open and rigorous process that seeks the best possible solution.

Yours sincerely

Lord Ribeiro CBE
Chairman, IRP

APPENDIX ONE

LIST OF DOCUMENTS RECEIVED

North Yorkshire County Council Scrutiny of Health Committee

- 1 Letter of referral from Cllr Jim Clark to Secretary of State for Health, 20 December 2012

NHS Yorkshire and Humber

- 1 IRP template for providing initial assessment information
Attachments:
 - 2 Travel impact assessment
 - 3 Friarage engagement report
 - 4 Gathering evidence from different parts of the country
 - 5 Letter to North Yorkshire County Council Scrutiny of Health Committee from Dr Vicky Pleydell, Clinical Chief Officer Designate, Hambleton, Richmondshire and Whitby Clinical Commissioning Group, 30 November 2012
 - 6 Notes of public engagement meetings
 - 7 Friarage referral letter – GP version
 - 8 Poster for public
 - 9 Equality impact assessment
 - 10 SHA letter of approval and conditions to proceed, November 2012
 - 11 Gateway review
 - 12 NCAT report, 12 December 2011
 - 12 NCAT report, 21 August 2012
 - 13 Assessment against the four tests for service change
 - 14 Health needs assessment
 - 15 Travel impact survey
 - 16 Draft consultation document
 - 17 PCT Board minutes, 25 September 2012
 - 18 CCG Extraordinary Board meeting, 17 September 2012

Other information received

- 1 Letter to IRP from The Rt Hon William Hague, MP for Richmond (Yorks), 20 February 2013

RDC EXTRAORDINARY COUNCIL

20.11.13

RESOLUTION

- 1) Richmondshire District Council does not feel that the HRWCCG or the South Tees NHS Foundation Trust have taken on board the concerns of the public and their overwhelming desire to maintain 24/7 consultant led maternity and paediatric services albeit in an alternative form in their consultation.
- 2) Richmondshire District Council do not consider either of the two options in the consultation document meet the healthcare needs of the local communities in Richmondshire
- 3) Richmondshire District Council commends the model of future provision of 24/7 consultant led paediatric and maternity services in a different format and requests the local NHS to review its submission both exhaustively and fairly in public.

C McKeon
Monitoring Officer
20.11.13