Clinical Senate
Yorkshire and the Humber

"An independent source of strategic clinical advice for Yorkshire and the Humber"

Clinical Senate Review

for

The Working Together Programme

on

Non-Specialised Children's Surgery and Anaesthesia

Part 2

Final Version
January 2016

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Yorkshire and the Humber Clinical Senate
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Version Control

Document Version	Date	Comments	Drafted by
Version 0.1	14th December 2015	Based on working group discussions by telephone and email	Joanne Poole
Final Version	25th January 2016	Report ratified at the January Senate Council meeting	Joanne Poole

1. Chair's Foreword

1.1 The Senate welcomes the opportunity to review the proposed service specification for non-specialised children's surgery and anaesthesia to assist commissioners in developing a model that can deliver a safe and sustainable service. The Senate are agreed that this specification does offer a complete document detailing the best practice guidance to deliver a high quality children's surgical service. Moving this specification from the description of aspirational standards to a working clinical model is essential in the next stage of discussions.

2. Summary Recommendations

2.1 The Senate agrees that the service specification is complete, draws on the best practice guidance and comprehensively describes the standards needed to deliver a high quality non specialist children's surgical service.

2.2 The Senate also considered the more contentious issue of the delivery of the service. The specification does not contain the operational description of the model of service. If the process by which providers engage and move forward with this specification is not well managed there is a risk that the required level of change will not be achieved.

2.3 The Senate advises that the specification is shared with providers with a clear message that this is about re-modelling current services so that they are sustainable and equitably delivered within a network hub and spoke type model. Commissioners will need a structured approach to the discussion with providers to move this specification from aspirational standards to the nuts and bolts of what can be provided by whom, how and where.

2.4 The Senate accepts the need for the Working Together programme to move forward on their smaller geography. The concerns about creating artificial boundaries across the centre of Yorkshire and the Humber remain and this risk will need managing as the commissioner discussions progress.

2.5 Public engagement is very important in this change process to ensure the public understand the rationale for the service change and have opportunity to engage with the proposals.

3. Background

Clinical Area

3.1 The Working Together Programme for the review of non-specialised children's surgery and anaesthesia is a collaboration of Health Commissioning Organisations, 8 Clinical Commissioning Groups and NHS England across South Yorkshire and Bassetlaw, North Derbyshire and Wakefield.

3.2 Nationally, the Royal College of Surgeons have highlighted the issues and challenges facing the provision of children's surgery in district general hospitals. Challenges identified by stakeholders locally (surgeons, anaesthetists, and Trust managers and commissioners) are the key drivers for the South Yorkshire, Mid Yorkshire and North Derbyshire (SYMYND) Working Together Programme and were explored in the Case for Change and Public Health Needs Assessment provided to the Senate. The Senate agreed that the Case for Change clearly demonstrated the need to change the way in which the service is delivered to provide a clinically safe and sustainable service. The report on these documents can be accessed at www.yhsenate.nhs.uk

3.3 The commissioners are now building upon their previous work and have developed a service specification which providers will be asked to self-assess against. An assessment panel will then consider all intelligence to develop options to transform children's non specialised surgical services.

Role of the Senate

3.4 The Senate was approached by the Working Together Programme to provide independent clinical advice on their draft service specification. The specific question the Senate was asked to address is:

> *"Could the Senate review and advise on the completeness of the service specification as a comprehensive high quality children's surgical service incorporating best practice guidance"*

3.5 The Senate advice will inform the content of the final specification which will be used in the next stage of provider engagement. Ultimately, the outcome of the provider self-assessment against this specification will inform the potential options for the future configuration of the service.

Process of Review

3.6 The Senate received the draft service specification (version 5) on the 11th November and an updated draft (version 6) on the 20th November 2015. The Terms of Reference for the review were agreed on the 19th November 2015.

3.7 Commissioners requested early feedback from the November Senate Council meeting (on version 5) and this was provided on 24th November 2015. During this time work also commenced to draw back together the original Working Group, the membership was largely confirmed by the 25th November. At this point, the Working Group received the draft service specification (version 6), the Council feedback and the review Terms of Reference. The Senate Working Group had a number of 1:1 discussions and a teleconference with commissioners on the 11th December to clarify outstanding questions formed from those discussions. The report was drafted by the Working Group following those discussions and submitted to the Working Together Programme on the 17th December. The report will remain in draft until the commissioners have commented on the report and it is ratified by the Council at their January meeting.

4. Evidence Base

4.1 The Case for Change, the Public Health Needs Assessment and the Best Practice document considered in the earlier Senate review all contain reference to the evidence base for non-specialised children's surgery and anaesthesia. The Evidence Base is also listed in this service specification. The Senate Working Group felt that these documents offered a very thorough review of the evidence base and for this reason it is not repeated within this document.

4.2 The Senate has noted that the Children's Surgical Forum Standards for the Non-Specialist Emergency Care of Children are currently out to consultation and when published will supersede the 2013 standards.

5. Recommendations

5.1 The Senate was asked specifically to review and advise on the completeness of the service specification as describing a comprehensive, high quality children's surgical service incorporating best practice guidance. The Working Group agreed that the service specification is complete, draws on the best practice guidance and comprehensively describes the standards needed to deliver a high quality non specialist children's surgical service.

5.2 The Senate also considered the more contentious issue of the delivery of the service. The Senate recognises that it is extremely difficult to design a service that overcomes the issues with surgical staffing. The standards within the specification could be read as aspirational and there could be opportunity for being clearer on which standards are essential and which are developmental. Currently, the specification does not contain the operational description of the model of service. If the process by which providers engage and move forward with this specification is not well managed and led by the commissioners, the Senate were concerned that it would not result in the delivery of a new clinical model of service.

5.3 In order to achieve the change required, commissioners will need to provide strong leadership in the next stages and communication and support between providers will be key. The specification needs to be shared with providers with a clear message that this is about re-modelling current services so that they are sustainable and equitably delivered within a Network hub and spoke type model. Providers need to be encouraged and supported in meeting the standards where possible within the Network model. The support of the specialist institution, in this case Sheffield Children's Hospital, is an important component of the change. Commissioners will therefore need a very structured approach to the discussion with providers to move this specification from aspirational standards to the nuts and bolts of what can be provided by whom, how and where.

5.4 The Senate had opportunity to discuss the next steps with commissioners and were supportive of the plans for provider engagement and self-assessment and also supportive of the intention for the feedback to be facilitated. This next stage of assessment and discussion needs to result in a suggested operational model within

the Working Together geography. This will need to be supported with clear guidelines for referral, transit and treatment.

5.5 The Senate considered the issue of the geography. Our previous report on the Case for Change advised of the need to proceed on a Yorkshire and the Humber basis where possible, as we need to avoid artificial boundaries across the centre of Yorkshire and the Humber, confusing pathways between providers. The Senate understands that the Working Together Programme did try and develop the specification on this wider geography but could not reach agreement on some basic questions about the thresholds for referral. The Senate therefore, accepts the need for the Working Together Programme to move forward on their smaller geography. The inclusion of Mid Yorkshire within the geography still raises questions about their pathways into their tertiary centre at Leeds, who are not part of this programme. The Senate understands that commissioners have noted this as a risk and are monitoring this within their risk log and taking actions to mitigate against this.

5.6 It is important for commissioners to remember the impact on families. The next stages cannot lose focus on the cost of travel and parking and the stress of being at a distance from your family support. Public engagement is very important in this change process and the Senate understands that there is an event planned in January 2016.

5.7 Commissioners may want to consider the following specific points in the specification.

i. Overall presentation: In the presentation and discussion with providers, it may help to change the flow of the document and set this out in terms of standards and requirements for participation in the Network, individual Trust governance and leadership before moving on to core standards for the delivery of emergency services and elective services. This is a style issue expressed by some members of the Working Group.

ii. There are occasions within the specification where the requirement for providers to actively participate in a Network could be made clearer. For example:

- Within section 2.3
- Under Network (page 7) it states that “organisations participating in the network” which could suggest that this is optional for the providers
- Under Network Arrangements (page 11) commissioners may want to state that each provider should have an agreed Network lead within their organisation
- Appendix 3 – there is no mention of the need for each organisation to have a network lead and for that person to represent their organisation at network meetings

iii. Page 1, first line of the second paragraph:. Is this a quote from the Children’s Surgical Forum? If not, is it possible to specify what is meant by the ‘very young’?

iv. Page 2, first paragraph: Would this paragraph benefit by being presented as a table?

v. Page 6, paragraph 2.5: What is “Good Practice”. Shouldn’t the programme of audit be set out within the terms of the contract or within this specification? Key indicators

are complications, readmissions and deaths. Commissioners may want to consider using age bands e.g. 0 -5, 6 – 10, 10+ as this is helpful when auditing the service.

vi. Page 7, second paragraph: Is this suggesting a Multi-Disciplinary Team for all individual cases, many of which are very straightforward e.g. tooth removal, gromits.

vii. Page 9, first bullet point: This suggests that the child is stabilised, deferring further treatment if clinically appropriate, until the local surgeon is available the next morning. It is advised to state that the stabilisation is accompanied by a telephone conversation with the local surgeon rather than waiting until the surgeon is available the next day.

viii. Page 14: There is a section wrongly entitled as pre-operative care which relates to emergency surgery.

ix. Page 15: Refers to all hospitals having access to radiology, haematology, biochemistry and microbiology. Clarity is needed on that access – to support sites offering emergency surgery this needs to be available 24/7.

x. Page 15, On Call: This section refers to a consultant surgeon with expertise. It may be helpful to state that a consultant surgeon will be supported within the network arrangements to manage emergency surgery and provide 24/7 support.

xi. Page 16, interdependencies with other services: Should this table also include paediatric HDU?

xii. Page 18: Refers to the number of cases who exceed the 6 hour threshold of surgical fixation for torsion of testes. It should be made clear that this 6 hours commences from the decision to operate.

xiii. Page 19: It was an observation from the Working Group that there are not specific measures for all of the specialties e.g. dental.

xiv. Page 19: first 2 points regards appendectomies – the Working Group felt these could be made clearer, the language is currently quite confusing.

xv. Page 19, Appendix 1: Under general paediatric surgery and urology, it lists irreducible inguinal hernia as non-elective clinical presentations. Advice is that this should be provided by a specialist centre and should therefore be removed from the list.

6. Summary and Conclusions

6.1 The Yorkshire and the Humber Clinical Senate concludes that:

- The service specification is complete, draws on the best practice guidance and comprehensively describes the standards needed to deliver a high quality non-specialist children's surgical service.

- There is a more contentious issue of the delivery of the service. The specification does not contain the operational description of the model of service. If the process by which providers engage and move forward with this specification is not well managed, there is a risk that the required level of change will not be achieved.

- The Senate accepts the need for the Working Together Programme to move forward on their smaller geography. The concerns about creating artificial boundaries across the centre of Yorkshire and the Humber remain and this risk will need managing as the commissioner discussions progress.

- Public engagement is very important in this change process to ensure that the public understand the rationale for the service change and have opportunity to engage with the proposals

APPENDICES

Appendix 1

LIST OF SENATE WORKING GROUP MEMBERS

The Working Group developed for this review consists of:

Senate Council Members

Jon Ausobsky, Consultant Surgeon, General Surgery, Bradford Teaching Hospitals NHS Foundation Trust (Chair of this Working Group)

Senate Assembly Members

Jean Gallagher, Citizen Representative

Co-opted Members

Gareth Hosie, Chair of the Northern Children's Surgery Network and Consultant Paediatric Surgeon, Newcastle upon Tyne Hospitals NHS Foundation Trust

Lisa Daniels, Paediatric Anaesthetist Lead of the Northern Paediatric Anaesthesia Network and Consultant Paediatric Anaesthetist, Newcastle upon Tyne Hospitals NHS Foundation Trust

Richard Stewart, Council Member Royal College of Surgeons of England, Deputy Chair Children's Surgical Forum

Appendix 2

PANEL MEMBERS' DECLARATION OF INTERESTS

Working Group Members Declaration of Interests

No conflicts of interest declared

Senate Council Members Declaration of Interests

Richard Parker, Jeff Perring and Sewa Singh declared conflicts at the Council meeting.

Appendix 3

TERMS OF REFERENCE

Sponsoring Organisation: The Working Together Programme, Collaboration of Health Commissioning Organisations 8 CCGs and NHSE across South Yorkshire and Bassetlaw, North Derbyshire and Wakefield.

Terms of reference agreed by: Chris Welsh on behalf of Yorkshire and the Humber Clinical Senate and Will Cleary- Grey, Director of the Working Together programme

Date: 18th November 2015

1. CLINICAL REVIEW TEAM MEMBERS

Clinical Senate Review Chair: Jon Ausobsky, Yorkshire and the Humber Senate Council member and Consultant Surgeon, General Surgery, Bradford Teaching Hospitals NHS Foundation Trust

Citizen Representative: Jean Gallagher

Clinical Senate Review Team Members:

Name	Job Title	Contact Information
Gareth Hosie	Chair of the North Paediatric Surgery Network	gareth.hosie@nuth.nhs.uk
Lisa Daniels	Consultant Paediatric Anaesthetist, GNCH Paediatric Anaesthetist lead, North Paediatric Surgery Network	lisa.daniels@nuth.nhs.uk
Richard Stewart	Council Member Royal College of Surgeons of England, Deputy Chair Children's Surgical Forum	richard.stewart@nuh.nhs.uk

2. AIMS AND OBJECTIVES OF THE REVIEW

Question: Could the Senate review and advise on the completeness of the service specification as a comprehensive high quality children's surgical service incorporating best practice guidance.

In their advice the Senate has also been asked to consider the implications of this specification being developed for the Working Together geography rather than the whole Yorkshire and the Humber geography. This is in recognition that developing the specification for the smaller geography would allow greater detail on the thresholds and levels of care to be included.

Objectives of the clinical review (from the information provided by the commissioning sponsor):

The advice will inform the content of the final specification. Once the specification is finalised a number of questions will be asked of providers to gauge their capability to deliver provision as set out in the specification. An assessment panel will consider all intelligence (business intelligence, workforce census), deliverability and develop options to transform non specialised surgical services for children.

Scope of the review: To focus on the service specification to assess whether a service commissioned against this specification would provide a high quality, safe and sustainable service.

3. TIMELINE AND KEY PROCESSES

Receive the Topic Request form: 11th November

Agree the Terms of Reference: end November

Receive the evidence and distribute to review team: evidence received 11th November. Panel largely appointed by 18th November and service specification distributed on that date

Provide early verbal feedback: draft specification provided to the Council meeting on the 19th November and early points for commissioner consideration will be provided verbally following that meeting.

Teleconferences: to be confirmed. Working group teleconference to be arranged week commencing first week of December with a teleconference with commissioners to be organised the second week of December.

Draft report submitted to commissioners: 17th December. Commissioners will be given 2 weeks to comment on the draft.

Senate Council ratification; 19th January

Final report agreed: Due to the timing of the Council meeting we cannot confirm the final report until the after the 19th January. If changes are made to the 17th December draft by the Council commissioners will be given a further opportunity to comment. Commissioners can use the draft to inform the discussions planned for January.

Publication of the report on the website: end January

4. REPORTING ARRANGEMENTS

The clinical review team will report to the Senate Council who will agree the report and be accountable for the advice contained in the final report. The report will be given to the sponsoring commissioner and a process for the handling of the report and the publication of the findings will be agreed.

5. EVIDENCE TO BE CONSIDERED

The review will consider the following key evidence:

- Service Specification for Children's Non-Specialised Surgery and Anaesthesia Version 6

The review team will review the evidence within this document and supplement their understanding with a clinical discussion.

6. REPORT

The draft clinical senate report will be made available to the sponsoring organisation for fact checking prior to publication. Comments/ correction must be received within 10 working days.

The report will not be amended if further evidence is submitted at a later date. Submission of later evidence will result in a second report being published by the Senate rather than the amendment of the original report.

The draft final report will require formal ratification by the Senate Council prior to publication.

7. COMMUNICATION AND MEDIA HANDLING

The final report will be disseminated to the commissioning sponsor, provider, NHS England (if this is an assurance report) and made available on the senate website. Publication will be agreed with the commissioning sponsor.

8. RESOURCES

The Yorkshire and the Humber clinical senate will provide administrative support to the clinical review team, including setting up the meetings and other duties as appropriate.

The clinical review team will request any additional resources, including the commissioning of any further work, from the sponsoring organisation.

9. ACCOUNTABILITY AND GOVERNANCE

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

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

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

10. FUNCTIONS, RESPONSIBILITIES AND ROLES

The **sponsoring organisation** will

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

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

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

Clinical senate council will:

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

Clinical review team will:

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

Clinical review team members will undertake to:

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

END

Appendix 4

BACKGROUND INFORMATION

The evidence received for this review is listed below:

- Working Together Programme – Service Specification for non-specialised children's surgery and anaesthesia for both elective and non-elective care. Version 6