NHS
Northern England
Clinical Senate

North West Specialised Commissioning

Review of North West Women & Children's Transformation Programme

FINAL Version 1. July 2022

Clinical Senates are independent non-statutory advisory bodies established to provide clinical advice to commissioners, systems and transformation programmes to ensure that proposals for large scale change and service reconfiguration are clinically sound and evidence-based, in the best interest of patients and will improve the quality, safety and sustainability of care.

Consideration of the implementation of the recommendations is the responsibility of local commissioners, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of access. Nothing in the review should be interpreted in a way which would be inconsistent with compliance with those duties.

Northern England Clinical Senate

Version Control

Document Version	Date	Comments	Drafted by
Draft v0.1	June 2022	Initial draft report	J Unwin
Draft v0.2	June 2022	Refinement of report to include Chair's comments	Andrew Cant
Draft v0.3	June 2022	Inclusion of draft Chair's foreword	J Unwin
Draft v0.4	June 2022	Inclusion of panel comments	J Unwin
Draft v0.5	June 2022	Inclusion of comments to neonatology section	J Unwin
Draft v0.6	June 2022	Final revision by Chair	Andrew Cant
Final 1.0	July 2022	Final revision following feedback from commissioners	J Unwin

1. Chair's Foreword

In December 2021, the Northern England Clinical Senate was approached by the North West Specialised Commissioning Women and Children's Transformation Programme to provide assurance on potential new models of care associated with specialised paediatric services. When the panel received the pre-review briefing pack the focus of the review necessarily changed to become one of reassurance and advice that the programme was heading in the right direction, reflecting the status of the developing case for change.

The North West Specialist Commissioning team are to be commended for seeking to ensure the highest standards for Paediatric Critical Care, Paediatric Surgery, Neonatal care and the diagnosis and treatment for children with cancer, in keeping with national standards and guidance.

It is encouraging to see that the programme team has already involved stakeholders and developed an innovative way of gathering patient views and sharing information. It is also encouraging to see that the team is working on a full equality, health inequality impact and risk assessment which will be needed to inform any further development of the programme given the marked levels of deprivation and inequalities within the region.

It is positive that there has been, in some areas at least, significant data collected and the team is encouraged to ensure that this is replicated across all service areas being reviewed.

It is evident that there is a clear wish to ensure care is provided as close to home as possible so long as this does not compromise the quality of that care. The team also recognise that reviews of services in Liverpool and the potential for new hospitals being built in the northern part of the North West will also need to be considered as they work further on these service developments.

I would like to sincerely thank the programme team for their work up to and during the virtual review on 26 May, 2022 and we wish you well with the next steps in the Women and Children's Transformation Programme.

I would also like to take this opportunity to thank the panel of expert clinicians who assisted with this review. I very much appreciate their enthusiasm and diligence in reviewing the information provided to us and for their excellent contributions during the Senate review session.

Prof Andrew J Cant
Chair
Northern England Clinical Senate

2. Introduction

The Northern England Clinical Senate was first, by North West Specialised Commissioning approached in December 2021to review the Women and Children's Transformation Programme's case for change for certain specific specialised children's services. The Clinical Senate was asked to review and comment on:

1. the appropriateness of the clinical evidence base and national guidance used to develop the potential models of care
2. the extent to which the potential models are likely to be:
    a) sustainable
    b) in line with the drivers for change
    c) able to meet demand for the in-scope services
    d) appropriately clinically resourced in the context of current workforce challenges
    e) appropriately clinically resourced in the context of likely future workforce availability
3. the alignment of other interdependent services required to make the models effective and safe
4. the robustness of the risk assessment associated with the proposed models and the appropriateness of any mitigations identified
5. any additional information or suggestions that the programme may find helpful in improving the quality of the potential models or would aid effective implementation once a decision is made
6. the extent to which health inequalities have informed and been incorporated into the development of the potential models of care
7. the Equality Impact Assessment to ensure that all relevant issues have been included

2.1 Process of the Review

The Senate formed an independent expert clinical panel from the Northern England Clinical Senate Council as well as additional experts in paediatric anaesthesia, paediatric critical care and paediatric oncology.

The draft case for change was provided to the panel on the 20 May 2022 and it was clear that the task of the Senate Panel was a pre-cursor to the request outlined in the terms of reference. The panel members were asked to provide an expert and independent view on what the programme needed to consider to build a compelling case for change and to advise on the key next steps to develop it further. A further review to assess the clinical case for change against the criteria within the terms of reference will need to be undertaken at a later date.

All panel members were invited to attend a pre-review meeting ahead of the formal review to give reflections on the information that had been received.

The full review session took place virtually via Microsoft Teams on 26 May 2022. The details and short biographies of the full panel can be found in Appendix 1. The agenda for the day is included in Appendix 3 and the terms of reference for the review are in Appendix 4.

3. Services within the scope of this review

The North West regional specialised commissioners are responsible for planning and commissioning specialised services, including women and children's services, for the populations of Cheshire and Merseyside, Greater Manchester and Lancashire and South Cumbria.

The North West Women & Children's Transformation Programme was developed in response to a number of national documents; the Neonatal Critical Care Review, Paediatric Critical Care and Surgery in Children Review, and the development of new national service specifications regarding Children's Cancer Principal Treatment Centres and Paediatric Oncology Shared Care Units. The purpose of the transformation programme is to review the in scope services in the North West region as a whole and to develop a plan that would ensure that the services fulfil the requirements of the national reviews as well as delivering the best care possible to the population across the North West.

The services in scope are children's services commissioned by North West specialised commissioners:

- Neonatal Services
- Paediatric Critical Care
- Paediatric Oncology and
- Surgery in Children (also commissioned by local Clinical Commissioning Groups in the regions) and its interdependencies.

The following services are **out of scope (**but any interdependencies with the in-scope services will be considered):

- Maternity Services
- Teenagers and Young Adults
- Long Term Ventilation of Children

4. Case for Change - Service Specific Views

On the review of the information provided by the programme team and in the discussion with staff in the panel session, the Clinical Senate set out the following observations in regard to the current status of the case for change in describing the in-scope services and the possible next steps to take to develop the programme further.

4.1 Paediatric Critical Care and Children's Surgery

The Senate panel considered paediatric critical care and children's surgery together however it is the medical paediatric critical care services that is the subject of this review.
The Senate heard that there was an intent to increase the amount of non-specialised paediatric surgery taking place within the district general hospitals (DGH) in the region which would create capacity for the tertiary centres to focus on more rare and complex conditions; this would also mean more children would receive care closer to home.

Level 3 paediatric critical care, or paediatric intensive care, and the full range of children's surgical services is provided from two tertiary centres within the region, Alder Hey Children's Hospital in Liverpool and the Royal Manchester Children's Hospital in Manchester.

The number of DGHs providing paediatric inpatient and day case surgery and up to Level 2 (high dependency care) critical care for children, and those providing level 1 critical care only is:

Region	Paediatric Inpatient and day case surgery units	Paediatric Day Case Surgery only units	Paediatric Critical Care level 2	Paediatric Critical Care level 1 only
Greater Manchester	7	0	7	
Lancashire & South Cumbria	5	2	5	2
Cheshire & Merseyside	7	1	7	1

Paediatric critical care levels 1 and 2 are high dependency care with level 1 care being provided from a paediatric ward environment and level 2 care usually provided in a level 2 centre.

The panel was pleased to hear that the Paediatric Critical Care, Surgery in Children, Long term Ventilation Operational Delivery Network (ODN) is clearly very involved in the review of services and the panel felt that its local knowledge of practice around the region will be essential in highlighting the changes that are required.

The panel members observed that at this time there are insufficient data and information available from which they could assess the current status of the services. More data and information on which surgical procedures are being carried out at each site, including tertiary sites, and by whom as well as the levels of critical care being provided, and to which patient groups, especially given the large number of DGHs that appear to be providing level 2 critical care, are essential information for developing the programme.

The information presented to the panel focussed on the DGHs in the region and whilst this was found to be appropriate and helpful, the panel felt it was also important to delineate the capacity of the tertiary centres in delivering level 2 and 3 critical care.

Long term ventilation of children is out of scope of this review, however there will need to be some consideration and alignment of programme work where any service reconfiguration is being considered. The programme team is also encouraged to broaden the scope of the transformation programme to include a review of level 1 high dependency care, as nationally this is known to be an area under relentlessly increasing pressure and this is integral to the services under consideration, particularly when seasonality is factored into capacity and demand modelling.

The panel appreciated the large amount of information presented on indices of deprivation for the region and the programme team are encouraged to consider location specific inequality data to inform their thinking further.

The programme team asked a specific question about whether the Senate panel could advise on the age limits for offering surgery in either a DGH or a tertiary centre: the view of the panel is that

to apply strict age limits is difficult as there are so many variables to take into consideration and evidence to support age cut offs is sparse. However, the panel can offer examples of how another region approached this:

The Yorkshire and Humber ODN reflects how there can be variation of practice within ICSs within one ODN. For example, during the Covid-19 pandemic, the South Yorkshire and Bassetlaw ICS agreed that all children under 16, that required emergency surgery, would be treated in the tertiary centre whilst, in West and North Yorkshire, it was left to each DGH to decide on the lower age they were happy to deal with. Sheffield Children's Hospital is a stand-alone children's hospital, whereas Leeds Teaching Hospital is part of a larger tertiary centre, in part explaining the differences in capacity. Furthermore different DGHs will have different capabilities and resources and so be able/willing to undertake surgery in differing age groups. There may be parallels with Alder Hey and Manchester Children's Hospital respectively, which allow for difference in practice.

What the ODN has learnt is that if the provision works and the outcome for children is not worse, then different standard operational policies are acceptable. This may differ between elective and emergency provision, but both the advantages and disadvantages (for example having specialists all in one centre against the potential loss of anaesthetic experience elsewhere) must be examined for each centre to ascertain which is the best approach to use.

4.2 Children's Surgery and Paediatric Critical Care - Recommendations

4.2.1 Paediatric Critical Care

The programme team is encouraged to carry out a mapping exercise of the high dependency activity in the region to understand the type of activity that is taking place within each of the units. Once this activity information is available it will inform the programme team of how it could potentially manage the activity going forwards.

There is a need to proactively collect data through the winter months to understand the nature of the high dependency work being undertaken and where, and the impact of seasonality.

It may be beneficial for the local ODN to work with a more established ODN in another region to understand the approaches taken and the lessons learned.

Whilst the panel understood that the transport service was out of scope, it is a key interdependency that will need to be re-evaluated as decisions are taken about the locations of high dependency units.

4.2.2 Children's Surgery

To inform the programme further it is recommended that site visits to the DGHs be undertaken to establish the current status against relevant Royal College standards, as applicable:

- which paediatric surgical and anaesthetic services are currently being delivered from each unit [1,2]
- surgical and anaesthetic outcomes for children's surgery [1,2]
- the current workforce dealing with children and its skills and abilities [1,2]
- the desire, ability, and capacity to undertake more children's surgery
- the health needs of the local populations

The programme team is encouraged to engage with the paediatric surgical and anaesthetic workforces to map not only their current practice, their past experience and future plans for paediatric services but also their willingness and perceived capability to take on new paediatric volume. The mapping should also consider any obstacles to providing safe paediatric surgical and anaesthesia care in the DGHs.

1 https://www.rcseng.ac.uk/library-and-publications/rcs-publications/docs/standards-for-childrens-surgery/
2 https://www.rcseng.ac.uk/library-and-publications/rcs-publications/docs/standards-for-non-specialist-emergency-surgical-care-of-children/

The panel recommended the use of the Guidelines for the Provision of Paediatric Anaesthesia Services[3] from the Royal College of Anaesthetists when considering setting up delivery of paediatric anaesthesia care.

The programme team is encouraged to not seek to standardise and homogenise the paediatric surgical offering in all DGHs and to make a choice as to which units will offer paediatric services locally and which won't.

Any decentralisation of paediatric surgery and high dependency care from the tertiary centres to the DGHs in the region may lead to a requirement for additional paediatric workforce and additional support to be provided to allow time for training and development to achieve the necessary skills and competencies. There will also be a requirement to robustly monitor and benchmark the surgical outcomes for children.

A hub and spoke model of working with specialist surgical and anaesthetic staff providing outreach into the DGHs may provide a solution to the overall ambition of the programme. However, in this model there would need to be consideration of the availability and skill set of the wider paediatric workforce, not solely the surgeon and anaesthetist but also nurses and ODAs with expertise in caring for children.

The Senate panel felt that the transformation programme would benefit from a keen and enthusiastic paediatric anaesthetist being involved to work with their colleagues in driving forward the case for change.

A three tier system whereby alongside the tertiary centres, some DGHs offer broader and more specialised children's surgical services than other DGHs may also provide a solution. However, experience of systems that have adopted this model is that the acute paediatric pathways may follow the elective model with the DGHs not offering elective surgery also being unable to sustain acute paediatric surgical care for even older children.

4.3 Neonatology

The panel heard about the number of neonatal cots across the region and the suggestion that there may be too many cots with too little critical care activity to meet minimum standards set out within Neonatal Critical Care Review[4] and Ockenden[5] to maximise health care outcomes within a number of Neonatal Intensive Care Units (NICU), Local Neonatal Units (LUN) and Special Care Baby Units (SCBU). The programme team proposed to review the current service configuration depending on population flows, geography, estate and workforce to maximise patient outcomes.

The panel was pleased to see that the programme team have access to a large amount of neonatal data from across the network and from that data it was good to see that the majority of small babies are being delivered in the right place.

The data presented to the panel showed that across the region there are 7 NICU, 12 LNU, 2 SCBU and one surgical centre (Alder Hey children's hospital) that has 9 HDU cots.

3 https://rcoa.ac.uk/gpas/chapter-10
4 https://www.bapm.org/articles/155-neonatal-transformation-review-report-published
5 https://www.gov.uk/government/publications/final-report-of-the-ockenden-review

Region	Number of NICUs	Number of LNUs	Number of SCBUs	Surgical Centre
Greater Manchester	3	5	0	0
Lancashire & South Cumbria	2	2	1	0
Cheshire & Merseyside	2	5	1	1

The neonatal experts on the panel observed that it appears there are not enough cots designated as Special Care Baby Units (SCBU) but that there are too many Local Neonatal Units (LNU), evidenced by low occupancy rates (30-40%) in some LNUs. Of the 12 LNUs in the region it was found that 2 do not meet the current standards to be designated as a LNU and 10 will not meet future standards. 4 of the 7 Neonatal Intensive Care Units (NICU) do not meet the standards required to attract a NICU designation. This situation would be further worsened with the reconfiguration of care in Wales that would see a reduction in NICU demand from that area.

However, to make an assessment regarding the number and location of NICU cots the panel highlighted the need for more detailed information on locality and geographical issues in the region so as to propose the siting and size for a NICU based on health or travel needs, as opposed to purely demand.

The data presented to the panel appeared to show a striking difference in the capacity and demand for cots, with some units appearing to be running very much under capacity which suggested that there was an issue of cot and unit designation that needed to be resolved.

The panel were not presented with any travel impact assessment information of possible reconfiguration options, which will be most important as the programme is developed. Furthermore, in the light of the overall deprivation and health inequality data, options for the reconfiguration of services will need to be carefully considered in the light of local deprivation data and health inequality information so as not to worsen health inequalities in the local populations.

It was clear from the presentation on the day of the review that there is clear awareness and steps have been taken to promote staff retention and development, which is very positive. However, the panel members expressed some concern about whether the smaller units with little activity can sustain and maintain experience and expertise.

The panel noted the somewhat less than usual position of Alder Hey hospital which whilst a major paediatric surgical centre, is not on the same site as a maternity unit. This will require a unique solution given this unit will not be able to fulfil the standards required to satisfy NICU designation status, most notably activity in terms of the number of Neonatal intensive care bed days per annum.

4.3.1 Neonatology - Recommendations

The panel agreed that there are too many cots in the region with not enough of the right cots in the right places and this needs to change to ensure safety and quality of care.

The neonatologists on the panel did not have access to a complete set of data including site specific travel times, workforce numbers and births, and so could not comment on the siting of units, however having reviewed network data on activity, number of cots and the Neonatal Critical Care Review thresholds, they suggest that:

7 NICUs could become 4 or 5 NICUs (2 or 3 would become LNUs)
12 LNUs could become 8 or 9 LNUs (3 or 4 would become SCBUs)

The panel recommends that the programme should refine the data it is considering to help map out which services should be located where. It would be helpful if the data were site specific and include the neonatal standards, workforce, number of births, clinical outcomes, cot capacity, local geography, transport options and travel times, parent accommodation and health inequalities.

Health inequalities and deprivation are important factors that need to feature as part of the plans for service re-configuration with mitigations put in place, as necessary.

SCBU activity and provision requires a specific focus.

4.4 Paediatric Oncology

The Senate panel heard that there are two principle treatment centres (PTC) for delivery of paediatric oncology services in the area covered by the North West Children's Cancer ODN and these are supported by 6 standard level paediatric oncology shared care units (POSCU).

The programme team acknowledged that the case for change for paediatric oncology was much less developed but the ambition of the programme was to provide a wider range of oncological care to children closer to home, so that children did not have to travel so often to a PTC for cancer treatment. The means of doing this would be to potentially offer an enhanced level of care from some of the existing POSCUs and the Senate panel was asked whether this was considered to be appropriate.

The panel felt that it was a notable ambition to provide care closer to home and the question of whether it would be feasible to offer and maintain safe, enhanced care from a POSCU depended on a range of factors:

- There would be an essential requirement for an enthusiastic clinician to take ownership of the POSCU who had supportive colleagues to provide cover, particularly out of hours at the hospital where the enhanced POSCU would be sited.

- There would be a need for well-educated and well-trained nurses who can deliver the same level of care as in the PTC, and assure families of, quality of care. If standards of care in an enhanced POSCU do not reflect the standards in a PTC there is a significant risk families may elect to travel to the nearest PTC for all their child's care rather than attend the POSCU.

- The programme team will need to consider the demand from patients for such a service and whether it would be feasible to deliver the enhanced offer. Distances that patients will need to travel to gain access to the POSCU or PTC will need to be mapped and

understand so as to ensure the maximum number of patients gain the maximum advantage in travel time.

- Safe chemotherapy delivery requires very good pharmacy services and robustly connected IT systems and software packages to ensure good governance.

- The initial focus of an enhanced POSCU should be on delivering supportive care and certain oral and intravenous chemotherapy regimens with intrathecal injections remaining at the PTCs.

The panel members felt that it could be feasible for two enhanced POSCUs to be developed within the region and that a cost benefit analysis may be helpful to determine the deliverability of this.

The programme team is encouraged to consider that there may be a need to carry out a whole system review of oncology services to see whether there needs to be a redistribution of cases in the light of other pressures and service developments.

5. Conclusion

It was clear to the panel that the programme team have undertaken a large amount of work in developing the outline principles for the services within the scope of this review, but that more work is required to develop a compelling clinical case for change.

For paediatric critical care there is a need to map out in more detail the need for high dependency care across the region. The nationally recognised increase in demand for high dependency care for children will need to be considered more carefully in the light of further data mapping, as will the willingness and ability of DGHs to offer various levels of elective surgery.

At present there appear to be too many neonatal cots, with utilisation varying considerably from site to site, with what appears to be an excess of local neonatal cots, and too few special care cots.

There is a clear desire to further develop Paediatric Oncology Shared Care Units, which is most appropriate, but more detailed work on the availability of the necessary infrastructure and expertise is needed.

APPENDICES

Appendix 1

LIST OF INDEPENDENT CLINICAL REVIEW PANEL MEMBERS

Professor Andrew J Cant, Chair - Northern Clinical Senate, Consultant in Paediatric Immunology & Infectious Diseases, The Newcastle upon Tyne Hospitals NHS Foundation Trust.
Andrew Cant is Chair of the Northern England Clinical Senate, an arm's length body of NHS England whose senior doctors and nurses give independent critical scrutiny to major service changes and developments. Andrew is Professor of Paediatric Immunology at Newcastle University and as a Specialist Paediatrician, set up one of two national centres to treat children with rare immune disorders by stem cell and gene therapy. The Unit receives worldwide referrals. An international expert in his field, he set up 5 thriving research groups as well as serving as President to two International Medical Societies, leading major pan-European medical scientific projects and instigating the successful bid for an EU reference network for Rare Immune Disease, then co-ordinating exchange of knowledge, training and uprating of services for patents with these conditions across the EU. He led the creation of the Great North Children's Hospital and the network of regional and national medical services it delivers.

Dr Sharon English, Consultant in Neonatal Medicine, Leeds Children's Hospital, Leeds Teaching Hospitals NHS Trust.
Consultant in neonatal medicine at Leeds Children's Hospital since 2004 with seven years' experience as clinical lead. Perinatal hospice doctor at Forget Me Not Children's Hospice in Huddersfield since 2019. Neonatal operational delivery network locality lead for West Yorkshire and Harrogate. Established expertise in healthcare management and perinatal palliative care. Member of the Yorkshire and Humber Clinical Senate since 2014. Expert adviser for the NICE Centre for Guidelines (CfG), NHS England QST peer reviewer

Dr Sundeep Harigopal, Consultant Neonatologist, Newcastle upon Tyne Hospital NHS Foundation Trust.
Sundeep is a Consultant Neonatologist in Newcastle upon Tyne and works with Newcastle University with over 25 years of experience in the field of neonatology and paediatrics. He did his medical training and post-graduation in paediatrics in India before moving to the United Kingdom. He undertook specialist training in neonatology in Liverpool and Manchester. Sundeep's broad interests include system changes, quality improvement and research. He is currently the Clinical Lead for Northern Neonatal Network and successfully led the reconfiguration of neonatal intensive care services in the North of England, development of the standalone Northern Neonatal Transport Service and is currently leading the implementation the National Neonatal Critical Review across the North East of England. He has played a key role in collaborative work with the maternity network leading to the development of Local Maternity and Neonatal System. He has experience as an external expert in neonatal service reviews. As a member of the National Neonatal Clinical Reference Group, he advices National Health Service on clinical commissioning policies. He also advices the Maternity Transformation Project through his role in the Infrastructure and Oversight Group. In his role as Neonatal lead for the Maternity and Neonatal Safety Improvement Programme, he leads quality improvement programmes by developing methods to implement proven interventions across North East of England. His research interests include respiratory mechanics of high flow oxygen and severe bronchopulmonary dysplasia as well as MRI in brain injury and has undertaken research and published in these areas. He also has a special interest in training and is the regional programme director for national neonatal grid training and runs and an international neonatal fellowship programme in Newcastle.

Tracy Barker, Lead Nurse for Family Care Division at Chesterfield Royal Hospital.
I am the most senior Paediatric Nurse at the trust and represent the voice of children at Board level. Within the division I represent Paediatric and Neonatal acute and specialist community

services, Children's Community therapists operational delivery, Scientists within the Children's Hearing services, CAMHS services including a Tier 4 Eating disorders MDT service, and Women's Health Nursing staff (as professional Nurse representation and support).
External to the trust I represent Child Health services within the local clinical networks, commissioning and expert advisory groups

Dr Rachel Agbeko, Consultant in Paediatric Intensive Care at the Great North Children's Hospital, The Newcastle upon Tyne Hospitals NHS Foundation Trust.

Clinical Lead for the Paediatric Critical Care Operational Delivery Network North East North Cumbria
Trained in Paediatrics and Paediatric Intensive Care in The Netherlands (Rotterdam, Sophia Children's Hospital), Canada (Toronto Sickkids) and the UK (London, Great Ormond Street Hospital).
Consultant positions in General Paediatrics (The Netherlands) and Paediatric Intensive Care (Newcastle, since 2010)
Past roles: Great North Children's Hospital Research Unit Lead, Great North Children's Hospital Quality Improvement Lead & Associate Clinical Director.
Currently also Senior Editor for Archives of Disease in Childhood

Dr Simon Bailey, Professor of Paediatric Neuro–Oncology (and consultant paediatric oncologist) The Great North Children's Hospital and University of Newcastle upon Tyne, head of the Paediatric Oncology Department.

His undergraduate medical training was at the University of Cape Town. Initial clinical experience was gained at Groote Schuur and Red Cross Children's Hospitals before postgraduate Paediatric and training in the United Kingdom and a year in New Zealand. He trained in paediatric oncology in Newcastle upon Tyne and became a consultant in 2001. He has a PhD awarded in 1999 and is a Fellow of the Royal College of Paediatrics and Child Health.
His research interests include the use of molecular testing to stratify treatment of children with brain tumours and delivery of risk adapted protocols to resource challenged countries including a very close link with the Queen Elizabeth Central Hospital in Blantyre, Malawi. He is the CI for the SIOPE high risk medulloblastoma trial, chair of the National Cancer Research Institute Paediatric Brain Tumour group and chair of the SIOPE Paediatric Embryonal Brain Tumour group.

Dr Chris Perry, Consultant in Paediatric Anaesthesia, Great North Children's Hospital, Newcastle

Paediatric anaesthesia consultant in Newcastle. Special interests include paediatric vascular access, spinal deformity surgery, and environmental impacts of anaesthesia. Currently lead for the GNCH paediatric lines service and lead the implementation of electronic patient record rollout for Anaesthesia. Fellowship in Adelaide Women's and Children's Hospital.

Dr Gill Davies, Lead Clinician, Paediatric Anaesthesia, Leeds Children's Hospital

I am a Consultant Paediatric Anaesthetist and Lead Clinician at Leeds Children's Hospital
I have sub-specialist interests in difficult airways, major general/thoracic and acute pain

Dr Mike Richards, Consultant Paediatric Haematologist, Leeds Children's Hospital.

Associate Medical Director, Leeds Teaching Hospitals NHS Trust.
Honorary Senior Lecturer, University of Leeds.

Dr Jeff Perring, Medical Director and Responsible Officer, Sheffield Children's NHS Foundation Trust

Dr Jeff Perring qualified in 1988 from the University of Liverpool Medical School. Following qualification he undertook training in Anaesthesia and Paediatric Intensive Care before being appointed as a Consultant Paediatric Intensivist at Sheffield Children's Hospital in 2002. He has

been closely involved in regional paediatrics through the development of a Yorkshire and Humber inter hospital transport service for infants and critically ill children and as clinical lead for the Paediatric Intensive Care Operational Delivery Network. For five years he was a council member and vice chair of the Yorkshire and Humber Clinical Senate and has worked with the Health Service Executive in the Republic of Ireland in the development of a national inter hospital transport service. In 2018 Dr Perring was appointed Executive Medical Director at Sheffield Children's NHS Foundation Trust.

Mr Gareth Hosie
Clinical lead for Northeast and Cumbria Surgery in Childhood Operation Delivery Network, Northern Clinical Senate member.

Mr Ian Sugarman
I have been a Consultant Paediatric Surgeon at Leeds Teaching Hospital NHS Trust sine 1999, having been trained in Southampton and Great Ormond Street Hospital. Whilst having a long interest in neonates and neonatal surgery, my main area of subspecialisation is Paediatric Colorectal surgery and have been Lead Clinician both for Paediatric Surgery but also Paediatric Gastroenterology. I am one of five Clinical Leads in the Yorkshire and Humber ODN. I have always been heavily involved in our national association (British Association of Paediatric Surgeons) to which I became President in July 2022.

Appendix 2

PANEL MEMBERS' DECLARATION OF INTERESTS

Mr Ian Sugarman is a Paediatric Surgeon based in Leeds Teaching Hospitals NHS Trust, and during 2021 worked for one session per month at the Royal Manchester Children's Hospital. He is also the President Elect of British Association of Paediatric Surgeons and recently led a review into the GIRFT report on Paediatric Surgery.

The Chair of the review considered these interests and felt that the associations were positive and could bring a benefit to the review process.

Appendix 3

ITINERARY FOR THE REVIEW

Time	Item	Attendees
09:00	Senate review panel pre-meet	Senate panel members only
09:30	Welcome and introductions	Senate, North West (NW)Women & Children Transformation Board Members and Operational Delivery Network (ODN) representatives
09:40	Terms of Reference for today	Senate, NW Women & Children Transformation Board Members and ODN representatives
09:45	Strategic Overview & Introduction to the programme Andrew Bibby	Senate, NW Women & Children Transformation Board Members and ODN representatives
10:00	Presentation of North West Women & Children's Case for Change – overarching Nicola Adamson	Senate, NW Women & Children Transformation Board Members and ODN representatives
10:20	Break	
10:30	Presentation of North West Women & Children's Case for Change – Surgery in Children & Paediatric Critical Care (with Q & A) Joanna McBride/Andrea Doherty	Senate, NW Women & Children Transformation Board Members and ODN representatives
11:15	Senate Panel Discussion	Senate panel members only
11:45	Presentation of North West Women & Children's Case for Change – Neonates (with Q & A) Louise Weaver-Lowe/Phil Rigby	Senate, NW Women & Children Transformation Board Members and ODN representatives
12:45	Senate Panel Discussion	Senate panel members only
13:15	Lunch	
13:45	Presentation of North West Women & Children's Case for Change – Paediatric Oncology (with Q & A) Adam Hebden/Andrea Doherty	Senate, NW Women & Children's Transformation Board Members and ODN representatives
14:15	Senate Panel Discussion	Senate panel members only
14:45	Break	
15:00	Senate Panel – Initial Feedback	Senate, NW Women & Children's Transformation Board Members and ODN representatives
15:30	Close	

NHS
Northern England
Clinical Senate

CLINICAL REVIEW

TERMS OF REFERENCE

TITLE: North West Women & Children's Transformation

NHS England and NHS Improvement – North East and Yorkshire

Sponsoring Organisation: NHS England – North West Specialist Commissioning

Clinical Senate:

NHS England & Improvement regional office: North East and Yorkshire

Terms of reference agreed by: Prof Andrew Cant

on behalf Northern England Clinical Senate and

Andrew Bibby, Regional Director of Health and Justice and Specialised Commissioning (North West) on behalf of Specialised Commissioning and Health & Justice Senior Leadership Team

on behalf of sponsoring organisation

Date: 25/04/2022

Clinical Review Team Members

- Review Chair – Prof Andrew Cant
- The Clinical review team is made up of:

  Neonatology
  Dr Sundeep Harigopal
  Dr Sharon English
  Paediatric Surgery
  Mr Gareth Hosie
  Mr Ian Sugarman
  Paediatric Critical Care
  Dr Jeff Perring
  Dr Rachel Agbeko
  Paediatric Anaesthetics
  Dr Chris Perry
  Dr Gillian Davies
  Paediatric Oncology
  Prof Simon Bailey
  Dr Mike Richards
  Paediatric Nursing
  Tracy Barker

Aims and Objectives of the Clinical Review

The Clinical Senate has been asked by the North West Women & Children's Transformation Programme (Specialised Commissioning) to provide an independent clinical assessment of potential models of paediatric services in the North West to determine whether they fulfil the requirements of:

- the national service specification for paediatric oncology
- the Neonatal Critical Care Review for neonates
- the Paediatric Intensive Care Unit (PICU) and Surgery in Children review.

Specifically, the Senate is asked to:

8. To assess the appropriateness of the clinical evidence base and national guidance used to develop the potential models of care (and rule out those deemed not to be suitable for implementation)

9. To give an independent view on the extent to which the potential models are likely to be:

    f) sustainable

    g) in line with the drivers for change

    h) able to meet demand for the in-scope services

    i) appropriately clinically resourced in the context of current workforce challenges

    j) appropriately clinically resourced in the context of likely future workforce availability

10. To assess the potential models of care and the alignment of other interdependent services required to make the models effective and safe

11. To test the robustness of the risk assessment associated with the proposed models and the appropriateness of any mitigations identified

12. To provide any additional information or suggestions that the programme may find helpful in improving the quality of the potential models or would aid effective implementation once a decision is made

13. To assess the extent to which health inequalities have informed and been incorporated into the development of the potential models of care
14. Assess the Equality Impact Assessment to ensure that all relevant issues have been included

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

To provide independent clinical assurance to Specialised Commissioners with respect to best practice, quality and safety, sustainability and equity of access on the potential models of care/options, which may be subject to a public consultation.

Scope of the Review

The review will cover the following service/specialty areas and alongside interdependencies that are commissioned by Specialist Commissioners in the North West:
Neonatal Services
Paediatric Critical Care
Paediatric Oncology

And the following services commissioned by Specialist Commissioners and Clinical Commissioning Groups in the region:
Surgery in Children and its interdependencies

The following services are **out of scope (**but any interdependencies with the in-scope services will be considered):
Maternity Services
Teenagers and Young Adults
Long Term Ventilation of Children

Methodology

- The clinical review team will review the case for change and all data and information provided by the programme team. The review team will hold a pre-review meeting once the information has been received to prepare the panel for the review which is due to take place on 26 May, 2022.

- The review panel will receive a presentation of the case for change by members of programme team. The presentation will be followed by three sessions one of which will focus on neonatal services along with supporting services such as high dependency care. The second focussed session will consider paediatric surgery and critical care along with supporting services and the third will focus on paediatric oncology. These sessions are to clinically test out the case for change and potential models of care.

- Key members of the programme team will be supporting the review process and will be present, as required, for the Panel presentation and discussions.

Timeline

The North West Women & Children's Transformation Case for Change is currently under development. It is due for review by North West Specialist Commissioning Senior Leadership on Monday 16th May 2022. Once agreed by this group it will then be shared with the North East Clinical Senate (before Friday 20th May 2022). Once informal feedback has been received from the NE Clinical Senate the Case for Change may then be submitted for NHSE Gateway 1 Assurance by mid-June 2022.

Report

The draft Senate report will be shared with the North West Specialist Commissioning Senior Leadership team for factual accuracy purposes, by 10 June 2022.

Factual accuracy checks will be undertaken by the North West Specialist Commissioning Senior Leadership team and shared with the Northern England Senate Manager by 15 June 2022.

The final report will be completed by 22 June 2022.

Clinical Senate Internal Reporting arrangements

- The clinical review team will report to the Northern England Clinical Senate Council which will oversee the governance of the conduct of the senate review panel process

Communication and Media Handling

- The arrangements for any publication and dissemination of the clinical senate assurance report and associated information will be decided by the sponsoring organisation

Resources

- The Northern clinical senate will provide administrative support to the review team
- North West Women and Children's Transformation will provide a named lead to coordinate the advance circulation of documentation and data as well as support the arrangements for the necessary discussion and visits

Accountability and Governance

- The clinical review team is part of the Northern England Clinical Senate accountability and governance structure
- The Northern England 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

Functions, Responsibilities and Roles

The **sponsoring organisation** will:

- provide the clinical review panel with the question to be addressed, together with relevant background and current information, identifying relevant best practice and guidance. Background information will include relevant data and activity, internal and external reviews and audits and any other additional background information requested by the clinical review team
- respond within the agreed timescale to the draft report on matter of factual inaccuracy
- undertake not to attempt to unduly influence any members of the clinical review team during the review process

Clinical senate council and the sponsoring organisation will:

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

The senate council will:

- appoint the clinical review team (this may be formed by members of the senate, external experts, and / or others with relevant expertise) and agree the review chair
- will endorse the terms of reference, timetable and methodology for the review
- consider the review recommendations and report (and may wish to make further recommendations)
- provide suitable support to the team and
- submit the final report to the sponsoring organisation

The senate review team will:

- undertake its review in line the methodology agreed in the terms of reference
- provide the sponsoring organisation with a draft report to check for factual inaccuracies
- keep accurate notes of meetings

Clinical review team members will undertake to:

- commit fully to the review and attend all briefings, meetings, interviews, panels etc that are part of the review (as defined in methodology).
- contribute fully to the process and review report
- ensure that the report accurately represents the consensus of opinion of the clinical review team
- 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
- undertake to be objective and not unduly influenced by any 3rd party