NHS
East Midlands
Clinical Senate

Clinical Senate Review of Newark Hospital Urgent Treatment Centre

Report of the Independent Clinical Senate Review Panel

November 2023

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Glossary of abbreviations

ACP	Advanced Clinical Practitioner
A&E	Accident and Emergency
ARRS	Additional Roles Reimbursement Scheme
CT	Computerised Tomography
ED	Emergency Department
ENP	Emergency Nurse Practitioner
GP	General Practitioner
ICB	Integrated Care Board
ICS	Integrated Care System
IPC	Infection Prevention and Control
MDT	Multi-Disciplinary Team
MIU	Minor Injuries Unit
OOH	Out of Hours
PBP	Place Based Partnership
PCN	Primary Care Network
SFH	Sherwood Forest Hospitals NHS Foundation Trust
UTC	Urgent Treatment Centre
WTE	Whole Time Equivalent

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1. Foreword by Professor Ashley Dennison, Clinical Review Panel Chair

Clinical Senates have been established as a source of independent and objective clinical advice and guidance to local health and care systems, to assist them to make the best decisions about healthcare for the populations they represent.

Clinical Senates are minimally staffed and built on the voluntary engagement and goodwill of local clinicians and other health and care professionals to ensure that the wider NHS can benefit from this expertise and experience.

We would like to thank the NHS Nottingham and Nottinghamshire ICB and Sherwood Forest Hospitals NHS Foundation Trust for engaging with the Clinical Senate to bring independent, external advice to support decision making in respect of maintaining the current model of delivery at Newark Hospital's Urgent Treatment Centre, which was initially implemented during the Covid-19 pandemic in 2020. We would like to thank all colleagues who presented on the day and supported the Clinical Senate's visit. The panel found the conversations with presenters and staff during the morning and afternoon sessions very valuable.

Many thanks must also go to our clinical review panel for their participation and commitment and whose expertise was drawn from both the East Midlands and West Midlands Clinical Senates, which ensured that the full potential of the independent clinical advice could be maximised.

We wish the system success with its ongoing engagement and transformation plans, and we would be happy to offer further assistance in the future if required.

Professor Ashley Dennison

Clinical Senate Chair

2. Clinical Senate Review Panel summary and key recommendations

The Clinical Senate wish to thank all who gave their time to take part in this review. The panel clearly saw the passion and determination of all the Newark hospital staff to maintain high quality care in the Urgent Treatment Centre which supports the local environs, and this was commended. The information provided and conversations which took place during the day were candid and insightful and this was greatly appreciated by the panel.

There had clearly been a great deal of high-quality work undertaken by the sponsoring organisations prior and subsequent to requesting the Senate Review. It was also appreciated by the panel that work will continue utilising the feedback from the engagement sessions and the advice and recommendations from the Senate's clinical review. In addition, going forwards there will be financial and resource factors to incorporate into discussions prior to making a formal and final decision.

The clinical review panel were encouraged by what they heard from both the sponsoring organisations' senior clinical and executive representatives and the staff working within the unit. Having this opportunity to engage with staff working in the Urgent Treatment Centre was felt to be essential to ensure the panel were able to make a full assessment and gain a real understanding of all the relevant issues and opportunities facing the Newark Hospital staff. The panel would again like to formally thank all those involved for their commitment and professionalism, to their patients and colleagues alike, as well as their open and honest responses to the questions raised by the clinical review panel.

The Clinical Senate panel concluded that the Urgent Treatment Centre should permanently close overnight. It also provided detailed advice and guidance to the ICB and Trust around the current and potential future clinical models at Newark Hospital which it believes will best serve the local population.

3. Background and advice request

3.1 Description of current service model

The Urgent Treatment Centre (UTC), which is located at Newark Hospital, is currently open between 9.00am and 10.00pm. These opening hours have been in place on a temporary basis since March 2020, when the impact of the Covid-19 pandemic exacerbated issues particularly with sustainably staffing of the UTC and raised a number of concerns regarding clinical safety.

The sponsoring organisations recognise that continued temporary arrangements do not provide the certainty that Newark residents expect or ensure the urgent care provided is high quality, safe and sustainable. The ICB and Trust are now considering all the possible options regarding opening hours of the UTC in the future.

The sponsoring organisations remain committed to ensuring that the care they deliver is of the highest quality (supported by outstanding ratings in a number of National benchmarking league tables) and is safe and sustainable including the urgent care services for Newark and the surrounding areas. The Newark Urgent Treatment Centre is a key component of the urgent and emergency care available to the local populace – alongside NHS 111, community pharmacies, out of hours and same day GP appointments, 999 and A&E. It delivers everything that the national NHS specification for UTCs mandates[1].

3.2 Case for change

Even prior to the Covid-19 pandemic, it was difficult to recruit staff to work overnight at the UTC and even more difficult to retain these staff on a sustainable basis and there were nights when the service had to be closed at very short notice due to a lack of staff. Although the pandemic intensified these issues, the underlying challenges remained. The Trust and ICB believe that recruiting the staff needed to run the UTC overnight safely and sustainably would continue to be very difficult, probably indefinitely, and would not be an appropriate use of their highly skilled practitioners or resources.

[1] This section is extracted from the written evidence submission to the Clinical Senate.

Over the past four years, there have been more than 100,000 visits to the UTC at Newark Hospital (data from April 2019 – May 2023). Of these visits, more than 70% are from the Newark area and on average this means there are 1,448 attendances each month from patients registered with Newark GPs.

During the time the UTC has been closed overnight there has not been a significant increase in people from Newark attending alternative out of hours urgent care services or A&E overnight. In fact, more people are choosing to use the UTC within daytime hours, on average an additional 500 visits per month, especially in the first hour of opening (09:00 - 10:00). Even with this increased activity, the UTC continues to perform well within the national 4-hour target. Daytime hours have historically been significantly busier for the UTC even when it was open overnight. Daytime attendance usually averaged 4 to 6 patients per hour as opposed to 2 patients in total overnight (1 between 01:00 and 07:00).

What are the proposals and options?

Based on the experience of the current opening times in place since March 2020, considered together with the wide range of alternatives for urgent care that are now available and the way that local people are accessing these services, the sponsoring organisations are committed to continuing to provide a 13 hour opening period and believe that will provide a safe, sustainable and effective service and will make the best use of their local staffing and financial resources.

The national specification from NHS England for Urgent Treatment Centres is for them to be open for at least 12 hours a day, which the Newark UTC currently exceeds. There is no evidence to suggest that any patient has come to harm due to the UTC being closed overnight for the past three and a half years. The clinical staff, both the appropriately trained medical staff and the emergency nurses, believe that the current opening hours are safe and sustainable.

For the above reasons, the sponsoring organisations do not believe that re-opening the UTC overnight is appropriate. However, before making any decision regarding any permanent arrangements, they are gathering feedback from the local population

and stakeholders to inform the decision-making process and fully examine and develop all the potential options. Their listening exercise focussed on asking for views on which opening hours would best meet local need and about patients' experiences of using the UTC and other out-of-hours urgent care services.

By taking this insight into account, alongside a range of other clinical and finance information and including the advice from the East Midlands Clinical Senate, the sponsoring organisations will be able to finalise their proposals for options on the future permanent opening hours in a way that best ensures a high quality, safe, sustainable UTC service that meets the needs of the local population.

3.3 Scope and limitations of review

The Clinical Senate review team in its preparation requested a variety of documentation and information to ensure the panel had a full understanding of the proposals and potential short and long-term impact. A large amount of information was made available by the sponsoring organisations, collated, and presented in one detailed, structured document for ease of navigation by the panel. This was well received and commented on by all panel members and further demonstrated the sponsoring organisations commitment to the process.

Specifically, the clinical review team was asked to review the information provided by the sponsoring organisations, combined with the presentations, discussions, and site visit on 18th October 2023 in order to address the four key questions within the agreed Terms of Reference:

1. To assess the appropriateness of the clinical evidence base and national guidance used to develop the proposals.

2. To give an independent view on whether the proposals are:

    - in line with the national specification for urgent treatment centres
    - an appropriate interpretation of the national specification for the Newark population

3. To give an independent view on the extent to which the proposals are likely to be:
    - sustainable
    - in line with drivers for change
    - able to meet demand for urgent care services
    - appropriately resourced in the context of current workforce challenges

4. To provide any additional information or suggestions that the programme may find helpful in improving the quality of the proposed models or would aid effective implementation.

4. Methodology and governance

4.1 Details of the approach taken

The sponsoring organisations, NHS Nottingham and Nottinghamshire ICB and Sherwood Forest Hospitals NHS Foundation Trust, engaged with the Clinical Senate on 14th August 2023 and it was agreed that a full day face to face review would be required (9.30am to 4.30pm) to consider the current model of delivery which has been in place since March 2020, and the proposed permanent change to the opening hours of the Urgent Treatment Centre at Newark Hospital. Panel members and patient representatives were identified from membership of the East Midlands and West Midlands Clinical Senates.

A draft report was sent to the panel members and the sponsoring organisations to check for matters of accuracy. The final report was submitted to the Senate Council (and ratified on 9th November 2023).

This report was then submitted to the sponsoring organisations, NHS Nottingham and Nottinghamshire ICB and Sherwood Forest Hospitals NHS Foundation Trust, on 10th November 2023.

The East Midlands Clinical Senate will publish this report on its website once agreed with NHS Nottingham and Nottinghamshire ICB and Sherwood Forest Hospitals NHS Foundation Trust. The anticipated publication date is 31st December 2023.

4.2 Original documents used

The full list of documents provided by the sponsoring organisations for the clinical review can be found in Appendix B. The documents covered the clinical case for change and various elements of service provision and was submitted to the Clinical Senate, in line with the agreed Terms of Reference, on 29th September 2023 and shared with the panel via the Clinical Senate's Document Management System (DMS) forthwith.

1. Newark UTC Clinical Senate Evidence Pack 18.10.23 FINAL V3.pptx

5. Key findings from the clinical review

The Clinical Senate panel Chair opened the day with thanks to the sponsoring organisations for hosting the clinical review team. The Chair extended thanks to the review panel for dedicating their time to attend and sincere appreciation to the sponsoring organisations for the significant amount of work that was evident to the panel in the breadth and volume of evidence submitted.

The Chair handed over to the sponsoring organisations to share their presentation with the panel.

The Locality Director for Bassetlaw and Mid-Nottinghamshire Place Based Partnership opened the presentation explaining how the Urgent Treatment Centre at Newark Hospital is and will continue to be an important and vital part of the local health and care landscape and there is a commitment to its long-term success. They welcomed what the Clinical Senate's views would be on the current model of operation and opening hours of the service (9am to 10pm), which have been in place since March 2020 on a temporary basis. This is considered an important contribution to enable the system to gather as much information as possible which will enable it to make an informed decision regarding any permanent change with particular consideration to ensuring that the chosen solution is sustainable.

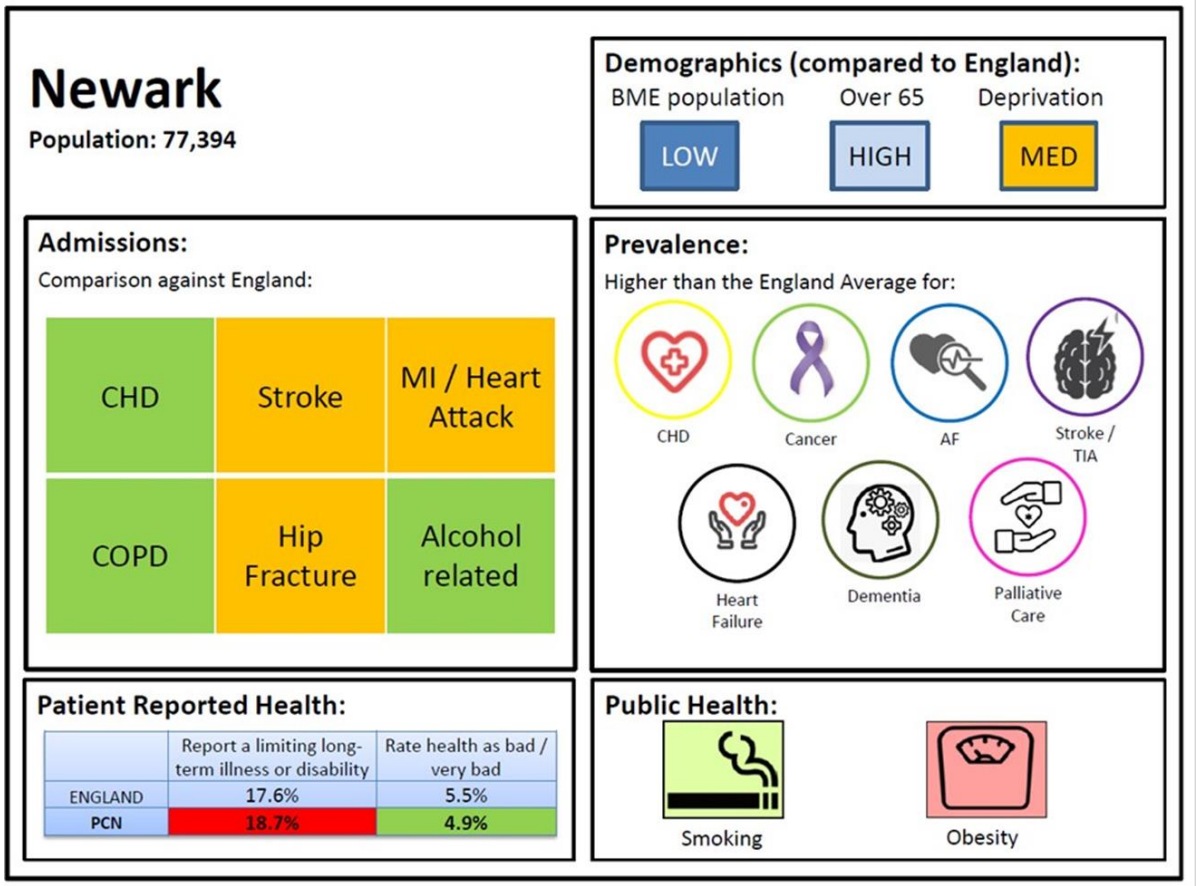
The panel received further information on the Mid-Nottinghamshire geography, demography, and make-up of the health system locally, the important points from which were:

With a combined annual budget of £3.6 billion for the commissioning and provision of health and care services for a 1.3 million population, the partners collaborate at:

- 'Neighbourhood level' through 23 primary care networks (PCNs) covering populations between 30,000 and 50,000
- 'Place level' through four Place-Based Partnerships (PBPs) serving populations of 120,000 to 350,000
- 'Provider collaboratives at scale' which produce benefits for their 5 NHS providers working together

- A whole ‘system’ (ICS) level

The presentation continued with information received from the Chief Medical Officer of the ICB explaining to the panel some of the headline statistics around the population health of Newark. The infographic below was presented and provides useful, clear information:



Key points raised included:

- The area having a large number of the population who are over 65 years of age.
- The level of deprivation is comparable to the national average.
- Long-term illness or disability rates in the Newark area are higher than the national average.
- Frailty was recognised as an increasing issue and one major area of focus for the future.

The panel then heard from the Director of Strategy and Partnerships at Sherwood Forest Hospitals NHS Trust, who highlighted how Newark Hospital has been voted

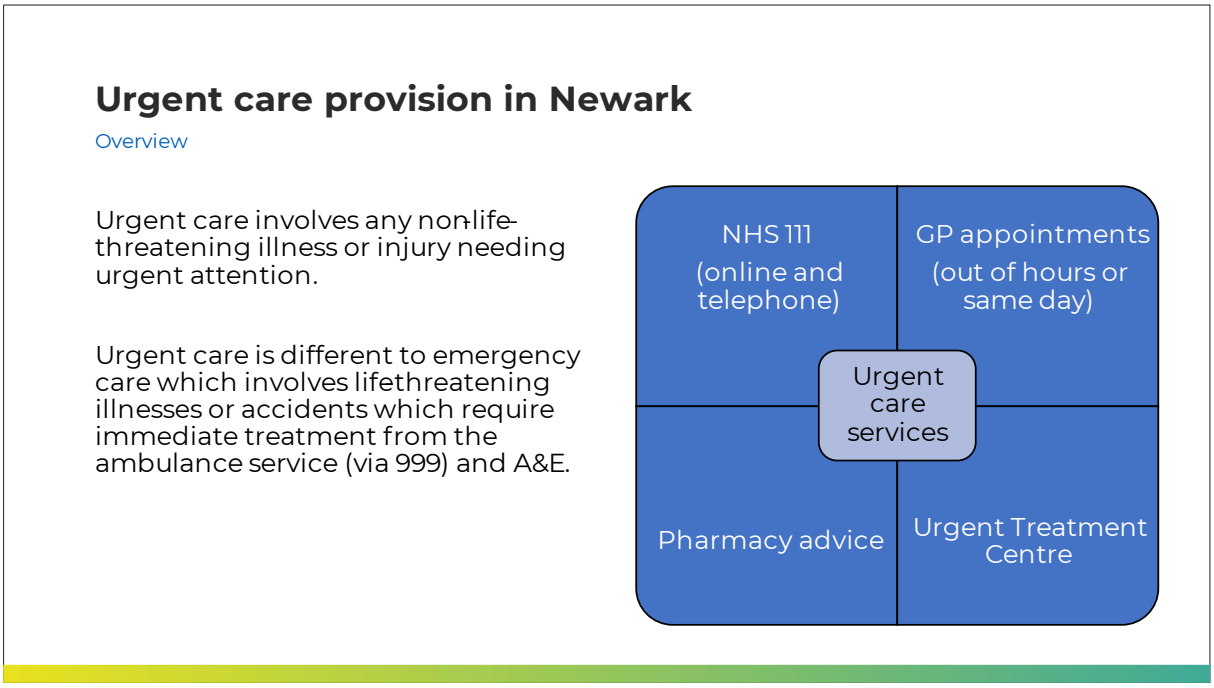
second in the UK for staff morale and the best acute hospital five years in a row, with a proud culture and drive to be a great District General Hospital. The basis for the vision is Newark Hospital's present use of and proposed improvement of its facilities to provide additional elective care capacity with a £5 million investment in an operating theatre block.

The range of services has expanded considerably in recent years:

- Introduction of a One Stop Breast Cancer Pathway service.
- Additional car parking with work underway for 80 extra spaces.
- Implementation of an additional operating theatre and upgrades to the existing minor operations facilities.
- Introduction of gynaecology procedures.
- A new state-of-the-art soundproof hearing booth to help conduct more accurate hearing tests.
- Refurbished endoscopy and CT scanning units.
- Site upgrades to improve experience for patients and staff.
- Development of a wider Health and Wellbeing offer working within the Mid-Nottinghamshire area. This involves working with partners within the education sector, the District Council, the YMCA (Young Men's Christian Association), and volunteers, to build the hospital site as a valuable community asset.

Coming back to the Chief Medical Officer, the panel heard how attendances at the acute sites have remained steady for several years and are not increasing, with admissions also following this trend. Presently the main pressure comes from an increased length of stay for patients. Continuing, the panel heard that increases in the local population reflected in housing growth was likely to have an impact on local service provision including health and education and producing further challenges. A focus on reducing health inequalities will be needed with appropriate targeting of resource. Newark UTC is considered part of the wider strategy and Newark Hospital Programme within the Nottinghamshire area. There is provision for an Out of Hours (OOH) GP Service which operates from the Newark Hospital site, from 6.30pm until 10pm on weekdays and 9am to 10pm on weekends, but it is presently separate from the UTC. Outside of these times cover is provided by NEMS GP Out of Hours Service (NEMS Community Benefit Services Limited) who operate from King's Mill

Hospital in Mansfield. The slide below helps to explain the differences between urgent and emergency care:

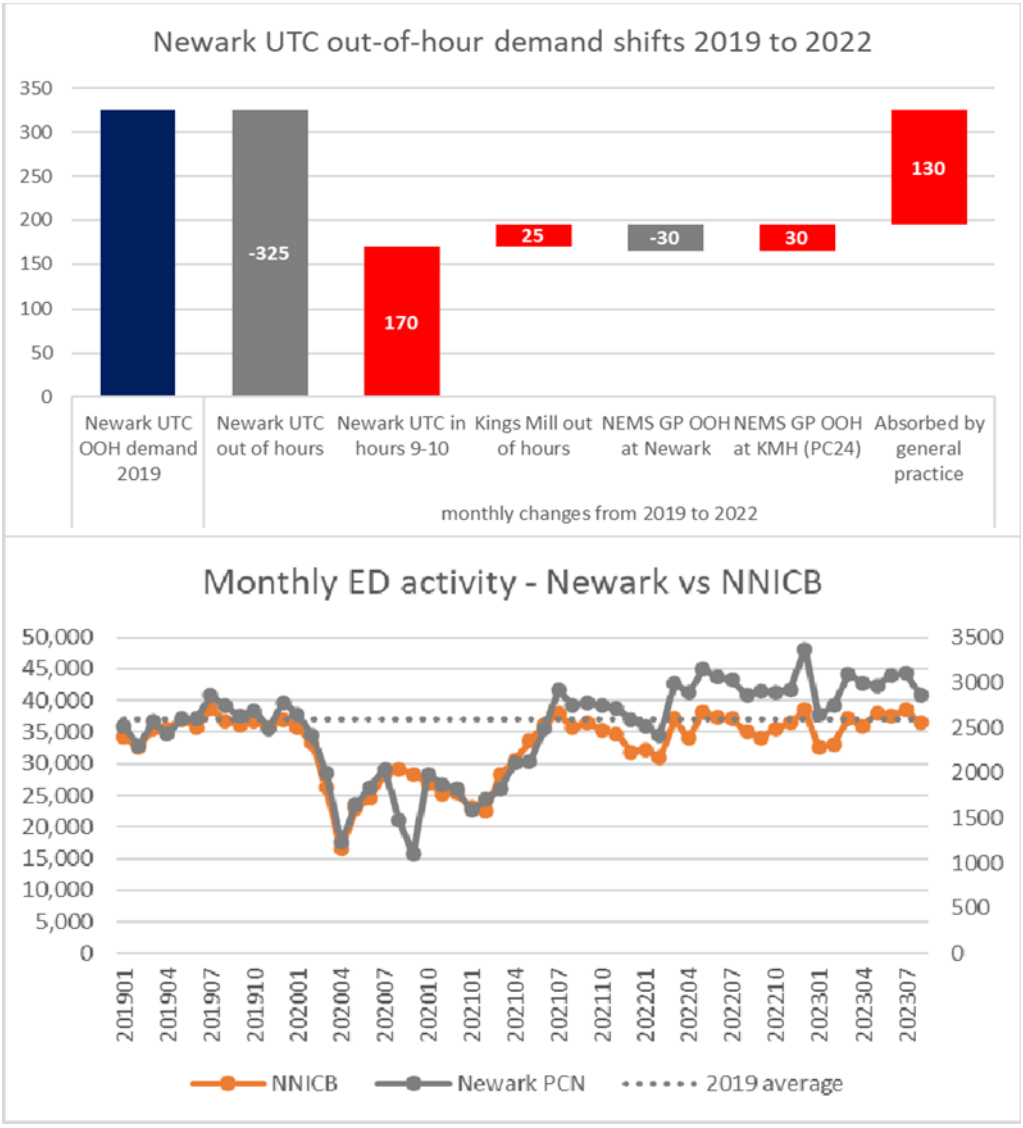


The urgent community response service is a local team who have proved extremely valuable working closely with the ambulance service and out of hours provider to reduce conveyances to hospital and manage the care of patients at home where appropriate. Improved access to primary care services is needed, which is not an issue unique to Newark, and work is ongoing around this, with plans to incorporate all the components which will augment the service provided by the UTC.

The presentation continued with the Clinical Director of Urgent and Emergency Care from Sherwood Forest Hospitals NHS Trust. They described the journey from Newark Hospital originally termed as an Emergency Department, which was inappropriate as it did not have the requisite support from specialist services to comply with the Emergency Department designation. The designation subsequently changed to a Minor Injuries Unit although there were no changes to the staffing model or services provided simply cessation of ambulance service patient delivery. The final iteration was the classification as an Urgent Treatment Centre that more appropriately reflects the work of the unit, which presently sees minor injuries and minor illnesses. The hospital does not have medical wards available to admit patients seen in the unit and x-ray facilities are only available until 10pm. Prior to 2020 when the unit operated 24 hours a day, the average attendances between the hours of

midnight to 8am was 2, and between 1am and 7am was 1. It has become increasingly challenging to staff these overnight shifts largely for this reason as staff like to be active and engaged.

The unit has always been busy and fully utilised outside of the overnight period, and there have been more than 100,000 visits to the UTC during the past four years (April 2019 – May 2023), with on average 500 more people per month choosing to use the UTC during daytime hours, and especially in the first hour of the unit opening.



The service is nurse led (although there is the presence of a locum doctor in the daily staffing) with a staffing complement of 31.69 WTE, and the skill mix of staff varies

throughout the week to best meet the needs of patients and the predicted attendance rates. Alternative staffing models have been put into place including:

- Staggered shifts for nursing staff to cover the service opening hours and the busiest periods.
- ENP role introduced to support with minor injuries (with additional cover on Mondays and weekends to meet demand).
- ACP role introduced to treat minor medical issues.

Recruitment and retention challenges remain, but the panel heard that staff continue to be engaged. Staff can be drawn from King's Mill Hospital ED if required at short notice due to sickness and there is also a long-term locum doctor within the establishment reflecting the challenges affecting staffing the unit.

Day	Staffing	Shift Pattern
WEEKDAY MEDICS (Mon)	X1 Speciality Doctor (MG) X2 Emergency Nurse Practitioner (ENP)	Monday – Sunday: 09:00-22:00
WEEKDAY MEDICS (Tue-Fri)	X1 MG X2 ENP X1 Advanced Clinical Practitioner (ACP)	
WEEKDAY NURSING (Mon)	X2 LD Nurses	Monday: • 08:45-21:45 • 09:00-22:00 • 09:15-22:15
WEEKDAY NURSING (Tue-Fri)	X2 LD Nurses X1 Twilight Nurse X1 Health Care Support Workers (HCSW) X1 HCSW to meet increased demand at peak times – covered utilising existing hours or bank AfC Band 2	Tuesday – Sunday: • 08:45-21:45 • 09:15-22:15 • 10:00-22:00 Monday – Sunday 09:00 – 22:00 Saturday – Tuesday • 09.00-22.00 Wednesday – Friday • 16:00 – 22:00
WEEKEND MEDICS	X1 MG X2 ENP X1 ACP	
WEEKEND NURSING	X2 LD Nurses X1 Twilight Nurse X1 HCSW	
RECEPTION	X2 Receptionist	Monday – Sunday: • 08:45-18:00 • 14:00-22:15

The panel heard that General Practice colleagues have been engaged previously during discussions around the staffing of the unit, but there has historically been no appetite from them to be involved in the service.

As a result of the changes in 2020 the hospital team reviewed data from multiple areas with the following noted:

- No ambulance journey changes overnight.
- No serious incidents being raised due to not being recorded.
- King's Mill Hospital admission rate has not increased.
- Grantham Hospital had raised concerns over increased activity. This has been measured at an average of 1 patient per day. It was also noted during the afternoon session of the clinical review that patients travel from out of area to visit the Newark UTC because of its excellent reputation particularly in respect of waiting times.
- No increase in transfers out of Newark UTC.

The panel then heard again from the Locality Director and the Director of Communications and Engagement at the ICB who described how the engagement with patients and the public was being undertaken and how it is planned to use the feedback to ensure a safe and sustainable option can be realised. The sixty-day engagement exercise concluded the day before the review (October 17th 2023) so information was 'hot off the press' and as a consequence the headlines were mainly in quantitative form (as qualitative analysis will take considerably longer):

- Almost 1,000 (n = 962) people had completed the survey online, with a further 56 paper copies to be added to the dataset. 692 people participated through other methods. In total 1710 individuals participated in the listening exercise.
- Six public events had been undertaken, an increase from the 5 originally planned.
- Meetings with elected members, community groups and further targeted groups.
- Engagement included speaking to children and young people at the annual Nottinghamshire "Shadow" event.

One output of the survey was:

- Seventy-one per cent disagree/strongly disagree that the current opening hours of Newark Hospital's UTC are suitable (n = 953).

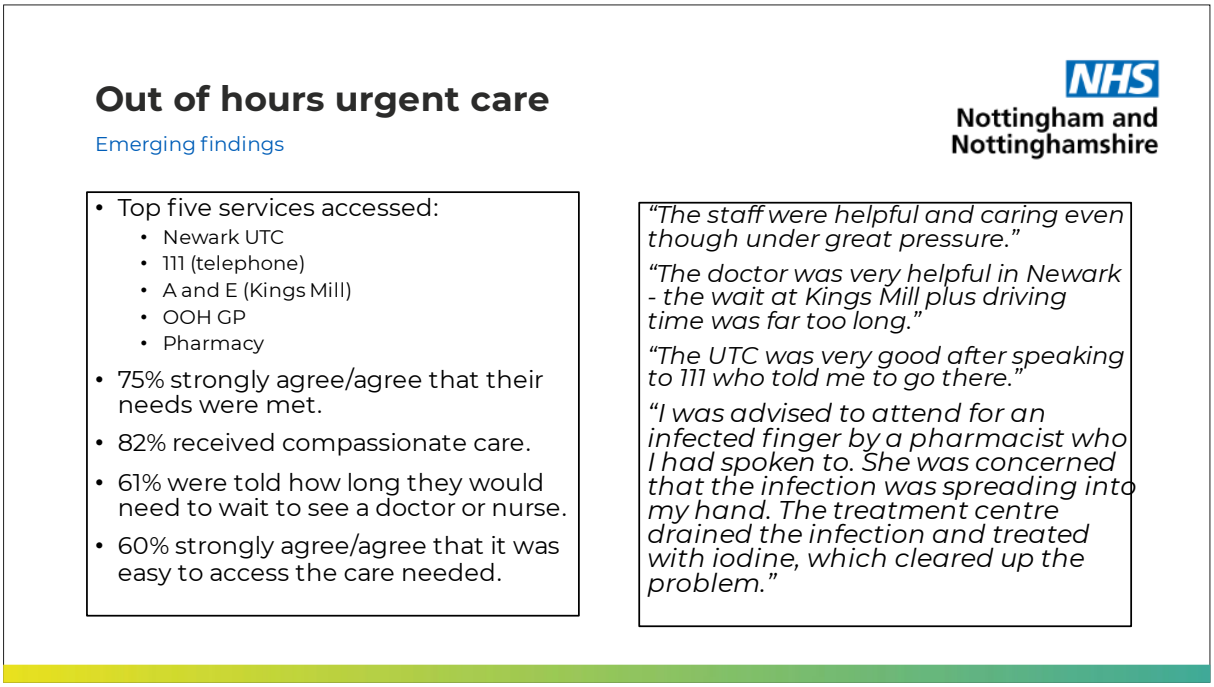
Some comments received to date have been:

"For a town of this size, and one which is growing exponentially due to the growth point, I feel we should have a 24-hour service in Newark, like we used to do…. by forcing Newark and Sherwood residents to use other areas' services, we are adding to the pressure of other hospitals in areas where they already have large populations to care for." [sic].

"*If something has happened during the night 9am is a long time to wait. Also opening earlier, say 8am, would avoid the 'rush hour' and school run."*

"*As a parent of young children, it seems to always be the case that children start deteriorating as the day goes on - and then by the time we've gone through GP/111/had a call back/etc. it's very late."*

When considering the wider access to urgent care out of hours the following was presented to the panel:



The full feedback will take some time to bring together and will be used, together with the Clinical Senate's review and other strategic context to decide on the most appropriate, safe and sustainable way forward.

The Clinical Senate Chair thanked the sponsoring organisations for their presentation and further supporting information, the session then continued with key clarifying questions from panel members, before splitting into two groups for the afternoon. Panel members were able to meet with staff who work within the UTC and walk around the physical site to better understand the layout and protocols.
Following the afternoon sessions, the review panel were able to assimilate all that they had seen, heard, and read in the submitted evidence to form areas of feedback for the sponsoring organisations. This is set out below under the panel's conclusions.

Opening hours and model of care

The panel heard throughout the review process that the changes to how the Newark Urgent Treatment Centre was named and has been known locally had taken place over a number of years, but the change to the opening hours was made as a temporary service change in March 2020 at the outset of the Covid-19 pandemic. The panel also heard how prior to this there had been occasions when at short notice the unit would close, due to staffing shortages, particularly in that overnight period, and that the attendances during the midnight to 8am period were also particularly low at an average of two attendances per night over the 8-hour period.

In reviewing the feedback received from the engagement events undertaken with the public it is clear that the population of Newark would like a service which can deal effectively with any emergency situation - an Emergency Department in Newark 24 hours each day - as they consider that as this was what was previously in place any reduction is undesirable. There are also implications with additional travelling times for emergency care.

The panel did however note that whilst the unit is designated as an Urgent Treatment Centre, it appears that it provides services that are significantly beyond those which would be expected of a UTC as defined by the national specification. Examples of this are, access to CT scanning with contrast, measurement of amylase and blood gas analysis.

The unit is certainly well attended, and the signposting to the service appears to work well from routes such as NHS 111. It was however clear that some of the work being

undertaken by the UTC is overspill from General Practice and could be better managed by a GP or other suitably trained clinicians such as Allied Health Professionals, either outside of the unit within core general practice hours, or potentially within the UTC. It was noted that an increase in GP capacity locally had been achieved (a 3% increase in GP appointments and a 7% on the day increase) but there was still work to be done in this area particularly to support the management of long-term health conditions. In addition, patients appear to travel from areas such as Grantham in Lincolnshire and Nottingham to use this unit as it has a reputation of providing high quality care with waiting times which are significantly shorter than other urgent care providers in the region. This does however place additional strain on the unit during busy periods. These busy periods coupled with the team working above and beyond the expectation of a UTC does mean they regularly work over their shift finish time to ensure all patients are seen and managed prior to them leaving (anecdotally the panel heard this is as much as 50% of the time). This commitment of staff was commended by the panel, but it should be noted this has the potential to have a negative impact on staff morale and if it becomes a regular unmitigated occurrence it would clearly cause further issues with recruitment and retention of staff.

Staffing

The panel received information which highlighted that the staffing model at the unit has not changed significantly since the original designation as an Emergency Department. It was however noted that while the compliment of staff is considered complete this includes the utilisation of a long-term locum doctor which is not an ideal situation and permanent suitably trained staff would be preferrable.

Staff feel well supported both managerially and by their peer group and they have access to senior clinical decision makers within the King’s Mill Hospital Emergency Department and on-call rotas to discuss specific cases and agree appropriate treatment plans.

The panel heard how staff work 13 hour shifts to cover the opening hours of the service, but due to demand and sometimes the need for transfer to an Emergency Department for example, there are occasions when staff work beyond this time,

sometimes for more than an hour, to ensure the safety of the patients. This is laudable but is not considered a sustainable or effective use of resource and the panel concluded that this needs to be investigated and addressed to prevent a negative impact on staff morale and further recruitment and retention issues. Additionally, this way of working is likely *per se* to have patient safety implications. Even with the clear dedication and passion displayed by all the staff they will not be able to consistently deliver the highest standard of care if by necessity they work a 14 hour shift and are also needed to staff the rota on the following day. Depending on the final decision regarding the opening hours of the service, the management team may wish to consider offering staff different shift options, particularly in the earlier and later parts of the day. The use of demand and capacity modelling and frequency of occurrence data will help with the planning of this.

The panel felt staff were well engaged in the department and observed their evident passion, empathy, professionalism, and work ethic with a can-do attitude, which is laudable and presently certainly not ubiquitous in the wider NHS. Staff told the panel they were generally happy and felt supported within the unit, although one area of frustration appeared to be around not having the ability to ‘stream’ patients appropriately on their arrival to the department, and the panel felt this could be an area of joint working between staff and management to look for ways to address this issue.

Governance

The panel received information relating to how the operational and clinical governance is overseen for the unit, broadly this was felt to be adequate with suitable mechanisms for escalation in place and management available to deal with issues as they arise. The panel did note the use of Standard Operating Procedures (SOPs) was slightly more variable, and the panel were left feeling that this area of governance would benefit from some scrutiny by the Trust. The panel did not identify any specific clinical risks but there appeared to be the potential for the application of SOPs to be flexible across staffing groups, and the scope of practice of clinicians could be stretched with the type of presentations the unit receives. Staff have access to, and frequently use the support mechanisms at King’s Mill Hospital Emergency Department, which is clearly appreciated, a significant clinical safety net and provides

additional decision-making support when treating and managing the more complex patients. The unit ensures all staff are trained and their knowledge is regularly updated, utilising both real life and simulated modules which gives the staff in the unit the confidence and ability to deal with the range of patients who present to the UTC. The wait for a blue light ambulance and the travel times to the local Emergency Department for conveyancing can be significant.

Engagement

The panel received information on the engagement plans that were in place with the general public as well as elected members of the local community and other key individuals who could be affected by any changes to the service provision at the UTC. The engagement appeared to be reasonably wide reaching, although the panel did feel that there was an opportunity to increase co-production of service options with the potential service users, through the future options appraisal and future service design process. The panel did recognise that this can be difficult to achieve but would recommend consideration be made to this moving forward. The panel were grateful to be shown the headline results of the recently completed surveys and face to face sessions and noted the positive feedback around quality of care and access to urgent care. There is clearly an underlying feeling within the area that the local population are '*missing out'* on not having an emergency department within the town. The panel felt that some careful and well-placed communication around the services presently available and how to access them appropriately, should ameliorate this issue. It is understandable that patients want to know that if they suffer a severe illness or injury that they can access timely treatment and care, however this area was out of scope of the review and is also not within the remit of an Urgent Treatment Centre.

Wider system integration and co-operation

The panel heard during the review how integration within the local system has challenges and similar to GP engagement and provision of service this is not unique. There are clearly some areas of good practice in place such as the urgent community response service, and the East Midlands Ambulance Service (EMAS) Hear and Treat and See and Treat models, rather than conveyance to ED facilities patients are treated for their health problems at home. This does need further work to align with

and engage the local GP workforce and third sector to understand the population health needs to ensure it is both fit for purpose and sustainable. The panel were disappointed that the local Primary Care Network was not formally represented on the day of the review, however, they did hear from a GP and Mid-Nottinghamshire Place Based Partnership Clinical Lead engaged with the local GP population and who was in attendance for the morning presentation to represent GP views, as the GP service within Newark was described as fragile. The panel's view was that by bringing together the differing organisations and workforces they could both complement one another and provide additional capacity and high-quality care to the population of Newark.

The day concluded with high level feedback from the panel Chair which is detailed in section 6 below.

6. Conclusions and advice

The Chair invited the sponsoring organisations back to draw the day to a conclusion, consolidating the panel's opinions from the written evidence and information gathered on the day.

The Chair explained how the panel had unanimously agreed that the documentation and evidence supplied prior to the review was of a very high standard and quality which had aided a sufficient understanding of the service. The Chair continued by recognising the excellent service presently being provided by the Urgent Treatment Centre and how staff were open, honest, and happy to work at the centre and proud to be a part of the Newark UTC. The Chair then thanked staff for their time and contributions.

It is usual for the panel to look to answer the questions posed in the Terms of Reference that had been agreed with the sponsoring organisations in advance, however, the Chair explained how the panel had found this more difficult to achieve with this review. In part this was due to the UTC changing over time from an Emergency Department (ED), to a Minor Injuries Unit (MIU) and then to an Urgent Treatment Centre (UTC), but also because of how the UTC fits within the wider urgent and emergency care offer, the local primary care offer in Newark and beyond and how there is significant potential for the UTC to have an increased role in the future health and wellbeing of the population it serves.

The aim of the conversations throughout the day had been to provide the clarity and detail necessary to allow the panel to consider the proposals to ensure they are the correct way forward for the system. The questions posed in the Terms of Reference and challenges faced are multifaceted. Thus, the panel's conclusions below are split into the key areas. The passion and desire to drive change was clear across all members present from the system which was both welcomed and appreciated by the panel.

Are the proposed operating hours of 9am to 10pm (which have been in place since March 2020) for the Urgent Treatment Centre appropriate?

The panel concluded after reviewing both the written evidence supplied and the data available on use of the service during hours of opening from both pre and post Covid-19 pandemic periods and through conversations on the day, that it would not be appropriate for the Urgent Treatment Centre at Newark Hospital to be open through the night. The activity levels seen and the acuity of those patients attending during the night-time hours are not sufficient to warrant the staffing that would need to be available, thus making it a highly inefficient use of staffing. In addition, staff would by necessity have to be moved or rotated from the daytime rota which would likely adversely affect the quality of patient care, staff morale and recruitment. To meet the specification of a UTC the unit must be open for at least 12 hours a day, however, the panel concluded that the actual times of opening should be decided by the Trust based on activity levels, staff availability and the requirement for safe staffing levels. Staff working in the UTC should also be involved in the decision-making process with regards to opening hours.

Does the Urgent Care Centre at Newark Hospital meet the National Specification for an Urgent Treatment Centre?

The panel concluded after reviewing the current service provision at the UTC and compared with the "Urgent Treatment Centres – Principles and Standards July 2017"[2] that the Urgent Treatment Centre operates above the level expected, offering services that would not normally be undertaken in a traditional UTC. These include but are not limited to, Computerised Tomography scanning with Contrast (cCT), amylase measurement in patients with abdominal pain and blood gas analysis. However, it was noted that the service appears to operate more as a satellite service for the Sherwood Forest Hospitals Trust Emergency Department and not as part of the urgent care offer within the Newark area. Any future strategy should aim to develop an independent Newark UTC working more closely with primary care providers, General Practice and third sector organisations. Another key consideration is that the national specification states that 'The urgent treatment centre will "*usually*

[2] The new standards were published on 20th October 2023 and last updated on 23rd October 2023. This is the link to the standards but this version was not available at the time of the Clinical Senate Review on 18th October 2023: https://www.england.nhs.uk/long-read/urgent-treatment-centres-principles-and-standards/

be a GP-led service", which is under the clinical leadership of a GP' and the clinical review panel understand that this is not necessarily a mandatory requirement (the National Specification is unclear and somewhat ambiguous) but feel strongly that a good way of engaging the local GPs would be to involve them in the leadership of the unit. The panel concluded that the sponsoring organisations should undertake an in-depth assessment of how they fit the national criteria and develop their plans based on the outcome from that assessment.

The panel felt that based on what it heard from the sponsoring organisations representatives and from the frontline staff within the unit, coupled with the availability of equipment such as a CT scanner, that Newark Hospital Urgent Treatment Centre could become the focal point of an excellent, wider urgent care system offering an extended service to better support the local population, with access to diagnostics locally and expert advice available remotely when necessary. CT Scanners in particular are such valuable assets for a local population their use should be increased to offer additional capacity for routine imaging and ensure the efficient utilisation of expensive equipment.

Is the current model of provision sustainable and able to meet the demands for urgent care services with appropriate resources in the context of current workforce challenges?

The panel concluded that with the current service model, which is operating above and beyond what is expected of a UTC, that the sponsoring organisations should review their staffing model with particular attention to the reliance on locum staff. Furthermore, because the UTC frequently treats patients with more complex or significant health needs, staff invariably work over their shift times, sometimes for a number of hours until the patient's treatment is completed or they can be safely transferred. This has a detrimental impact on the quality of life of staff and could potentially lead to shortages should staff become unwell because of overwork or dissatisfied if a resolution or mitigation cannot be identified. It is recognised that there is a shortage of appropriately skilled and trained staff to work in UTCs and the panel heard how Newark hospital has training in place to upskill staff already within the unit. This was welcomed, however, the Clinical Senate would urge the sponsoring

organisations to consider the wider use of GPs and other suitably qualified practitioners within the Additional Roles and Responsibilities Scheme (ARRS). Physiotherapists, pharmacists, and paramedics would add great value to the UTC and improve the offer to patients and the public. It was clear to the panel that workload will inevitably and inexorably increase, particularly if GP capacity does not meet its demand, which could jeopardise the sustainably of the service in the future by overloading, leading to staff burn out or poor patient experience.

Additional areas for consideration

Training and Governance

The panel concluded that staff are generally well trained and have access to additional training opportunities if they wish to progress. The panel heard that there is a range of Standard Operating Procedures in place, but application of these was not as robust or as consistent as it could be and this is an area they felt would benefit from some focus. In addition, ensuring that once trained staff are regularly refreshed and updated on new ways of working and changes to best practice guidelines, it is essential that all staff are working to the same processes and protocols, particularly in urgent and stressful situations.

Communication and engagement with Patients and the Public

The panel concluded that the sponsoring organisations had sought to undertake a wide-ranging exercise in communication and engagement with key individuals in the area, including patients and carers, elected members and other identified groups of people who may use the service available at Newark UTC. Engagement with the exercise had been good with over 1500 responses received, and the panel heard how the depth of feeling was palpable at some of these 6 public events. It was clear to the panel that the urgent, emergency, and primary care services offered to the public within the area are complex and may confuse patients. This is not unique and an almost inevitable consequence of the introduction of units providing different levels of urgent care and the redesignation of some existing units. The ability to communicate effectively with the public concerning the available options and how and when to access them is essential to ensure they access the appropriate service at the right time and are able to do so. The panel would recommend communication

work takes place to address this, particularly targeting those in need and in areas of deprivation to prevent health inequalities being further exacerbated.

7. Recommendations

7.1.1 Recommendation 1

The panel recommends that the Urgent Care Centre at Newark Hospital should not operate 24 hours per day, and that NHS Nottingham and Nottinghamshire ICB and Sherwood Forest Hospitals NHS Foundation Trust should decide what times they must be available based on activity levels and available staffing to ensure good use of resources. This should include consideration of an appropriate amount of time for staff at the end of their shift after the UTC has closed. It is suggested that half an hour is not sufficient due to the complexity of patients being managed and 90 minutes is more appropriate.

7.1.2 Recommendation 2

The panel recommends a review of the use of Standard Operating Procedures at Newark Urgent Treatment Centre to ensure robust and consistent application to reduce any variance that may be occurring.

7.1.3 Recommendation 3

The panel recommends that the NHS Nottingham and Nottinghamshire ICB and Sherwood Forest Hospitals NHS Foundation Trust utilise a collaborative approach with partner organisations, including General Practice, local pharmacy and third sector organisations to enhance the urgent care model within the area and promote Newark Urgent Treatment Centre as a central hub to support this. It is suggested that negotiation with General Practice specifically around the creative use of ARRS roles could both support and expand the UTC capacity and skills set whilst alleviating pressures on primary care appointments.

7.1.4 Recommendation 4

The panel recommends further engagement and communication work with the local population to both understand their views regarding the wider services they need and also to provide information on the services available to them across the local health system. The local public and patient leaders should ideally be engaged in a co-production exercise for urgent care services for Newark.

Appendix A: Clinical Review Panel Terms of Reference

NHS East Midlands Clinical Senate

CLINICAL REVIEW TERMS OF REFERENCE

Title: Newark Hospital - Urgent Treatment Centre

Sponsoring Organisation(s):

NHS Nottingham and Nottinghamshire ICB and Sherwood Forest Hospitals NHS Foundation Trust

Clinical Senate: East Midlands Clinical Senate

NHS England region: Midlands

Terms of reference agreed by:

Name: Emma Orrock / Ashley Dennison **on behalf of clinical senate and**

Name: Lucy Dadge / David Ainsworth **on behalf of sponsoring organisation(s)***

Date: 18th August 2023

Clinical review team members

Chair: Professor Ashley Dennison, Consultant Hepatobiliary and Pancreatic Surgeon, University Hospitals of Leicester NHS Trust and Clinical Senate Chair

Panel members:

Name	Role	Organisation
Bernadette Armstrong	Advanced Physiotherapy Practitioner	Northamptonshire Healthcare NHS Foundation Trust

* Written email confirmation approving these TORs must be received by the Head of Clinical Senates from each sponsoring organisation by the named person in these TORs or their nominated deputy/deputies.

Iain Lennon	Consultant in Emergency Medicine	University Hospitals of Derby and Burton NHS Foundation Trust
Ian Mursell	Consultant Paramedic	East Midlands Ambulance Service NHS Trust
Julia Emery	Consultant in Public Health - Strategic Healthcare	NHS England - Midlands
Kerry Webb	Nurse Consultant	Birmingham and Solihull Mental Health NHS Foundation Trust
Lesley Roberts	Older People Speciality Advanced Clinical Practitioner	Derbyshire Community Health Services NHS Foundation Trust
Liz Miller	Trust Pharmacist	East Midlands Ambulance Service NHS Trust
Lynsey Havill	Ophthalmology Advanced Clinical Practitioner	University Hospitals of Derby and Burton NHS Foundation Trust
Mangesh Marudkar	Consultant Psychiatrist for Older Adult Mental Health Liaison Services	Leicestershire Partnership NHS Trust
Miles Langdon	GP	North West Anglia Foundation Trust (NWAFT) at Peterborough City Hospital Emergency Department in the UTC
Paul Midgley	Patient Representative	East Midlands Clinical Senate

Roger Kunkler	Associate Postgraduate Dean Urological Surgeon	NHS England – Workforce, Training and Education Directorate
Saul Hill	Integrated Community Manager - DCHS Wound Clinic Service	Derbyshire Community Health Services NHS Foundation Trust
Shaun McGill	Specialty Trainee in Public Health Medicine (ST4)	NHS England - Midlands
Steve Lloyd	GP Board Director DHU CIC (111 and UEC provider) NICE Technology Appraisal Committee C Clinical Director Conclusio	Eyam Surgery Derbyshire DHU CIC NICE Conclusio Consultancy
Susan Edge	Patient Representative	East Midlands Clinical Senate
Tareq Al Saoudi	Senior Clinical Fellow in HPB Surgery	University Hospitals of Leicester NHS Trust
Umar Khan	Consultant in Emergency Medicine	Nottingham University Hospitals NHS Trust

Background

The Newark Urgent Treatment Centre (UTC) is a key element of the urgent and emergency care available to the local population alongside NHS 111, GP out of hours and ‘same day’ appointments in hours, community pharmacies, 999 and A&E. It currently delivers everything that the national NHS specification for UTCs requires.

The Urgent Treatment Centre within Newark Hospital is currently open between 9.00am and 10.00pm. These opening hours have been in place on a temporary basis

since March 2020, when the impact of the Covid-19 pandemic made issues with safely and sustainably staffing the UTC worse than they had previously been. It is recognised that continued temporary arrangements do not provide the certainty that Newark residents expect and the ICB are now considering what the future permanent arrangements should be.

Aims and objectives of the clinical review

The clinical review team is asked to consider the current model of delivery which has been in place on a temporary basis since March 2020, and the permanent change to the opening hours of the Urgent Treatment Centre at Newark Hospital.

The clinical review team will provide a clinical opinion based on the written evidence and data submitted and supported by clinical and professional conversations and any observations made during the site visit and clinical review day itself, including feedback from presentations, conversations with frontline staff working in the services and broader senior and executive discussions.

The clinical review team is asked to consider some key areas when making its assessment of the plans proposed:

1. To assess the appropriateness of the clinical evidence base and national guidance used to develop the proposals.

2. To give an independent view on whether the proposals are:
    - in line with the national specification for urgent treatment centres
    - an appropriate interpretation of the national specification for the Newark population

3. To give an independent view on the extent to which the proposals are likely to be:
    - sustainable
    - in line with drivers for change
    - able to meet demand for urgent care services
    - appropriately resourced in the context of current workforce challenges

4. To provide any additional information or suggestions that the programme may find helpful in improving the quality of the proposed models or would aid effective implementation

Scope of the review

When reviewing the case for change and options appraisal the Clinical Review Panel should consider (but is not limited to) the following questions:

- Will these proposals deliver real benefits to patients (access/clinical outcomes/quality[3])? For example, do the proposals reflect:
    - The rights and pledges in the NHS Constitution?
    - The goals of the NHS Outcomes Framework?
    - Up to date clinical guidelines and national and international best practice e.g. Royal College reports?
- Is there evidence that the proposals will improve the quality, safety and sustainability of care? For example:
    - Do the proposals align with local joint strategic needs assessments, commissioning/ICB plans and joint health and wellbeing strategies?
    - Does the options appraisal consider a networked approach - cooperation and collaboration with other sites and/or organisations?
    - Is there a clinical risk analysis of the proposals, and is there a plan to mitigate identified risks?
- Do the proposals meet the current and future healthcare needs of their patients?
- Do the proposals demonstrate good alignment with the development of other health and care services?
- Do the proposals support better integration of services?

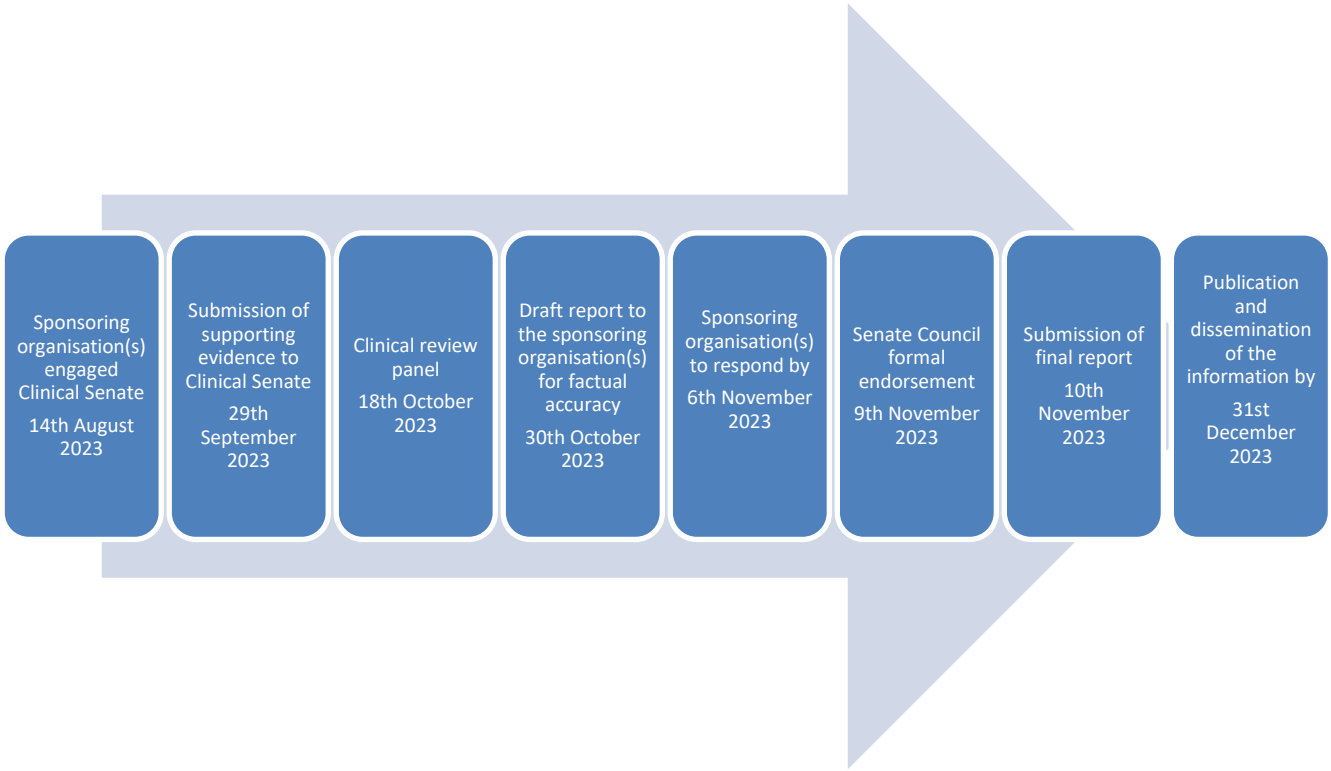
[3] Quality (safety, clinical effectiveness and patient experience)

- Do the proposals consider issues of patient access and transport? Is a potential increase in travel times for patients outweighed by the clinical benefits?
- Will the proposals help to reduce health inequalities?
- Do the proposals consider the workforce requirements and transformation required to deliver this new model?

The Clinical Review Panel should assess the strength of the evidence base of the clinical case for change and proposed models. Where the evidence base is weak then clinical consensus, using a voting system if required, will be used to reach agreement. The Clinical Senate Review should indicate whether recommendations are based on high quality clinical evidence e.g. meta-analysis of randomised controlled clinical trials or clinical consensus e.g. Royal College guidance, expert opinion.

Timeline

The lead in time for clinical reviews is a minimum of 8-10 weeks' notice due to Senate members working in a voluntary capacity (which allows sufficient time for clinical commitments to be covered and the appropriate notice to be given if required) and also due to the preparation and planning requirements in the lead up to the review. It is highly unusual that a system/provider would make a unilateral decision to stand down a Senate review and this should be considered as exceptional circumstances only and certainly not within 6 weeks before the planned review day itself given the commitment that will already have been made by Senate panel members. It is essential that the sponsoring organisation(s) is committed to the review timeline and process before formally engaging the Clinical Senate and agreeing a clinical review date. Any concerns should be discussed with the Head of Clinical Senates at the earliest opportunity.



A full Senate review and site visit will include time during the day spent with both senior and frontline staff working in the services and sometimes walking around a department/pathway(s). The clinical review team may wish to determine which professional staffing groups and roles it would like to have access to as part of the review process. On occasion, it may be helpful for a smaller number of panel members to visit a site/organisation before the review day itself if not all areas can be covered in a day and this is deemed essential by the clinical review team.

Reporting arrangements

The clinical review team will report to the Clinical Senate Council which will agree the report and be accountable for the advice contained in the final report.

Clinical Senate Council will report to the sponsoring organisation(s) and this clinical advice will be considered as part of the NHS England assurance process for service change proposals (if appropriate).

Methodology

The sponsoring organisation(s) has agreed to collate and provide the following supporting evidence to the Clinical Review Panel, and to reference the evidence base wherever possible when drawing on clinical guidelines and national best

practice. The evidence submitted will be meaningful and credible. To support the development of the evidence submission, the sponsoring organisation(s) will have consulted the Suggested Minimum Evidence Requirements document provided by the Senates team as part of the review process. *The duty is on the sponsoring organisation(s) to make sure the supplied material is only relevant to the review.*

- **Clinical case for change and a summary of the current position and proposed alternative service/care model**
- **Data on patient numbers across 24 hours of the service as provided pre-Covid-19 and the comparable data since the reduction of the opening hours at the Urgent Treatment Centre at Newark Hospital.**
- **Copies of Quality Impact Assessments**
- **Information pertaining to/copies of any evaluation criteria used to shape the proposals/options appraisal required for the Pre-Consultation Business Case such as the hurdle criteria (please see document provided entitled "Suggested Minimum Evidence Requirements" where relevant)**
- **Impact of withdrawing/reconfiguring services, including risk register and mitigations**
- **How proposals reflect clinical guidelines and best practice, the goals of the NHS Outcomes Framework and Constitution**
- **Alignment with local authority joint strategic needs assessments and a narrative around health inequalities and demographics e.g., HEAT Tool (Health Equity Assessment Tool) and Equality Impact Assessment (EIA)**
- **Evidence of alignment with organisational/system plans**
- **Evidence of how any proposals meet future healthcare needs, including activity modelling, pathways, and patient flows.**
- **Demonstrate how patient access and transport will be addressed.**
- **Demonstrate how any implications on the Ambulance Service will be addressed.**
- Consideration to a networked approach
- **Education and training requirements**

- **Implications on workforce (to be able to demonstrate alignment to new ways of working, and to describe how the future workforce will look to support any new models of care/reconfiguration proposed)**
- **Implications for the workforce (to describe how the workforce will be engaged, supported and motivated to work in new ways and in new places that support any new models of care/reconfiguration proposed)**
- **Implications for the clinical support services and those staff (e.g. clinical engineering, radiology, pharmacy)**
- SHAPE (Strategic Health Asset Planning and Evaluation) Place Atlas, which helps organisations to consider the evaluation of the impact of service configuration on proposals and assess the optimum location of services.
- Core service inspection reports (i.e. CQC)
- **Public, patient and staff engagement plans and particularly, evidence of patients' experiences of services (including any engagement with or involvement by patients and public at the earliest developmental design stages of any proposed services changes)**
- **Evidence of consideration to the sustainability and environmental impact of these proposals**
- Clinical framework for presenting evidence and considering multiple site single service models of care (recommended clinical framework can be found here: Midlands Clinical Senates - Proactive Projects (midlandssenates.nhs.uk))

Additional information to support this review has been identified by the clinical review team:

- Population demographics and catchment it serves
- Narrative on access
- Distribution of other UTCs and ED facilities in Nottinghamshire and Lincolnshire
- Data sharing with primary and community care
- Any other stakeholder engagement

All evidence should be submitted three weeks prior to the review date as specified in the TORs. Any allowances to this should be agreed with the Head of Clinical Senates

(or one of their deputies) and only in exceptional circumstances can we consider a late submission. Any evidence received within 48 hours of the review will likely not be shared with panel members and may not be considered within the review process unless prior agreement with the Head of Clinical Senates (or one of their deputies).

Report

Timelines have been compressed to accommodate the overall timescales the sponsoring organisations are working to.

A draft clinical senate report will be circulated within 5 working days of the final meeting - to team members for comments, and to the sponsoring organisation(s) for fact checking thereafter.

Comments/corrections must be received within a further 5 working days.

The final report will be submitted to the sponsoring organisation(s) by 10th November 2023.

Communication and media handling

The clinical senate will publish the final report on its website once it has been agreed with the sponsoring organisation(s). The sponsoring organisation(s) is responsible for responding to media interest once in the public domain.

Disclosure under the Freedom of Information Act 2000

The East Midlands Clinical Senate is hosted by NHS England and operates under its policies, procedures and legislative framework as a public authority. All the written material held by the clinical senate, including any correspondence you send to us, may be considered for release following a request to us under the Freedom of Information Act 2000 unless the information is exempt.

Resources

The senate(s) office will provide administrative support to the review team, including setting up the meetings, taking minutes 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(s).

Accountability and Governance

The clinical review team is part of the East Midlands Clinical Senate's accountability and governance structure.

The East Midlands Clinical Senate is a non-statutory advisory body and will submit the report to the sponsoring organisation(s).

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

Functions, responsibilities and roles

The **sponsoring organisation(s)** will

- provide the clinical review panel with all relevant background and current information, identifying relevant best practice and guidance. Background information may include, among other things, relevant data and activity, internal and external reviews and audits, impact assessments, relevant workforce information and projections, evidence of alignment with national, regional and local strategies and guidance
- respond within the agreed timescale to the draft report on matters of factual inaccuracy
- undertake not to attempt to unduly influence any members of the clinical review team during the review. Additionally, all communication (verbal and written) throughout the whole process should be addressed to the Head of Clinical Senates or an appropriate identified deputy
- submit the final report to NHS England for inclusion in its formal service change assurance process (if appropriate)
- arrange and bear the cost of a suitable venue and light refreshments (as advised by the senate(s) office) for the panel

Clinical senate council and the sponsoring organisation(s) will

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

Clinical senate council will

- appoint a clinical review team; this may be formed by members of the senate, external experts, or others with relevant expertise. It will appoint a chair or lead member
- endorse the terms of reference, timetable and methodology for the review
- endorse the review recommendations and final report
- provide suitable support to the clinical review team

Clinical review team will

- undertake its review in line with the methodology agreed in the terms of reference
- follow the report template and provide the sponsoring organisation(s) with a draft report to check for factual inaccuracies
- 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
- 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 or 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 Head of Clinical Senates, any conflict of interest prior to the start of the review and /or which may materialise during the review

Appendix B: Summary of documents provided by the sponsoring organisations as evidence to the panel

The following evidence was submitted by the sponsoring organisations for this review on 29th September 2023 and disseminated to the panel on the same day:

1. Newark UTC Clinical Senate Evidence Pack 18.10.23 FINAL V3.pptx

In addition, the Clinical Senate received further documents on 12th October 2023:

2. Clinical Senate – Newark UTC 18.10.2023 V1.pptx
3. Newark Staffing Model.docx

Additionally, the Clinical Senate support team provided the following documents to the panel:

- UTC Standards Brief Summary
- access-to-unplanned-or-urgent-care.pdf
- urgent-treatment-centres-faqs-v2.0.pdf
- quick-guide-improving-access-to-utc-using-dos.pdf
- urgent-treatment-centres-principles-standards.pdf
- References to UTCs in the Long Term Plan.doc
- media monitoring.docx

Appendix C: Additional Considerations

The new urgent treatment centres – principles and standards were published on 20th October 2023 and last updated on 23rd October 2023. This is the link to the standards but this version was not available at the time of the Clinical Senate Review on 18th October 2023: https://www.england.nhs.uk/long-read/urgent-treatment-centres-principles-and-standards/

As these standards were updated and published whilst the Clinical Senate process was still in progress, the panel has listed here some areas where the guidelines will likely have an impact. This is not an exhaustive list as this is for the ICB and Trust to work through and consider however, the panel felt it would be remiss to not make reference to the changes as the Senate report was still being drafted.

The name 'urgent treatment centre' must be adopted, including both road signage and onsite signage. Localities must also ensure that names are updated on relevant websites, the directory of services (DoS) and all other communications (both for internal and external stakeholders) about the service.

An essential requirement is that all UTCs accept all ages and both minor injury and illness. Clear protocols must therefore be in place to manage critically ill and injured adults and children who arrive at a UTC unexpectedly.

The UTC must be led and governed by an appropriate named senior clinical lead who will take responsibility for general oversight, governance, audit, staff training and the strategic development of the service. This leadership and governance may be on site, remote or a mixed model. While GPs have often been the default, this leadership can be provided by a GP, ED consultant or other appropriate senior clinical lead.

The panel acknowledged that the UTC currently has an ED consultant lead. This does not detract from the panel's view on further engagement and utilisation of GP and primary care assets.

Appendix D: Clinical review team members and their biographies and any conflicts of interest

Name	Role	Organisation	Conflict of interest
Bernadette Armstrong	Advanced Physiotherapy Practitioner	Northamptonshire Healthcare NHS Foundation Trust	None
Iain Lennon	Consultant in Emergency Medicine	University Hospitals of Derby and Burton NHS Foundation Trust	None
Ian Mursell	Consultant Paramedic	East Midlands Ambulance Service NHS Trust	Pan East Midlands coverage but no involvement in planning for this change
Julia Emery	Consultant in Public Health - Strategic Healthcare	NHS England - Midlands	None
Kerry Webb	Nurse Consultant	Birmingham and Solihull Mental Health NHS Foundation Trust	None
Lesley Roberts	Older People Speciality Advanced Clinical Practitioner	Derbyshire Community Health Services NHS Foundation Trust	None
Liz Miller	Trust Pharmacist	East Midlands Ambulance Service NHS Trust	None
Lynsey Havill	Ophthalmology Advanced Clinical Practitioner	University Hospitals of Derby and Burton	None

		NHS Foundation Trust	
Mangesh Marudkar	Consultant Psychiatrist for Older Adult Mental Health Liaison Services	Leicestershire Partnership NHS Trust	None
Miles Langdon	GP	North West Anglia Foundation Trust (NWAFT) at Peterborough City Hospital Emergency Department in the UTC	None
Paul Midgley	Patient Representative	East Midlands Clinical Senate	Not conflicted as this is mid Notts rather than South Notts which is my area/Place and the various committees I'm on are all S Notts based
Roger Kunkler	Associate Postgraduate Dean Urological Surgeon	NHS England – Workforce, Training and Education Directorate	None
Saul Hill	Integrated Community Manager - DCHS Wound Clinic Service	Derbyshire Community Health Services NHS Foundation Trust	None
Shaun McGill	Specialty Trainee in Public Health Medicine (ST4)	NHS England - Midlands	None
Steve Lloyd	GP	Eyam Surgery	Board director at DHU CIC which is a 111 and

	Board Director DHU CIC (111 and UEC provider) NICE Technology Appraisal Committee C Clinical Director Conclusio	Derbyshire DHU CIC NICE Conclusio Consultancy	UEC provider – not a conflict as agreed with the sponsoring organisations
Susan Edge	Patient Representative	East Midlands Clinical Senate	Been to clinics & radiology at Newark hospital as a patient, but not to the UTC or MIU
Tareq Al Saoudi	Senior Clinical Fellow in HPB Surgery	University Hospitals of Leicester NHS Trust	None
Umar Khan	Consultant in Emergency Medicine	Nottingham University Hospitals NHS Trust	None

Clinical Senate Support Team

Emma Orrock – Head of Clinical Senates, NHS England

Chris Harris – Senior Programme Manager, East Midlands and West Midlands Clinical Senates, NHS England

Biographies

Ashley Robert Dennison

MB, ChB, MD, FRCS

Consultant Hepatobiliary and Pancreatic Surgeon and Professor of Hepatobiliary and Pancreatic Surgery

Ashley graduated with MB, ChB from Sheffield University in 1977, obtained his FRCS in 1982 and his MD (Sheffield) in 1985. He was a Wellcome Research Fellow in Oxford from 1983-85, and from 1990-92 worked in Switzerland with Professor Blumgart, Paris with Professor Bismuth and Hannover with Professor Pichlmayer.

Since 1994 he has been a consultant hepatobiliary and pancreatic surgeon at the University Hospitals of Leicester NHS Trust. He is the chief investigator and responsible for all research supervision and collaboration with external centres (national and international). He is also the lead clinician responsible for “sense checking” initiatives for service improvement and delivery.

His main clinical and research interests relate to the metabolism and anti-cancer properties of intravenous lipid emulsions, the treatment of colorectal metastases and pancreatic adenocarcinoma and islet cell autotransplantation following total pancreatectomy for chronic pancreatitis. He has investigated ablative techniques for the treatment of colorectal metastases and the anti-inflammatory and anti-cancer effect of infusions of lipid emulsions containing omega-3 fatty acids. He has the largest European experience of pancreatectomy followed by islet cell auto-transplantation for chronic pancreatitis and is at present investigating the potential clinical applications of pancreatic ductal cells (intermediate cells). His interest in lipids has recently resulted in trials in acute pancreatitis, sepsis in the intensive care setting, colorectal liver metastases and pancreatic cancer. He is also the Chair of the East Midlands Clinical Senate.

Bernadette Armstrong

Advanced Physiotherapy Practitioner

Bernadette is an Advanced Physiotherapy Practitioner practicing as a musculoskeletal specialist, working for Northamptonshire

Healthcare NHS Foundation Trust (NHFT) in the Integrated Musculoskeletal service (IMSK). She has worked for the NHS for 27 years and has her own private practice. She is a clinical lead for IMSK NHS physiotherapists in Northamptonshire, specialising in spinal and lower limb problems with a particular interest in the knee. She works across trusts in Primary and Secondary care and has been involved in GP and registrar teaching and mentoring. She played a key role as an Extended Scope Practitioner in the locally commissioned spinal service, which has now evolved into an AQP (Any Qualified Provider) service. As a Physiotherapy representative, she has been involved in the set-up of the Total Hip and Knee pathway across primary and secondary care and is currently auditing the physiotherapy outcomes. She is an active member of the NHFT's Leadership forum and the East Midlands Clinical Senate.

She completed an MSc in Physiotherapy with Nottingham University in 2010 and her dissertation on Patellar Dislocation Primary Management was published in 2012 in the respected journal "The Knee". This was a collaborative project between Orthopaedics, A&E and Physiotherapy departments, and has led to international interest in her work. She served on the committee of ACPOMIT (Association of Physiotherapy Orthopaedic Medicine and Injection Therapy) as a CPD and PR officers and has also taught at Coventry University on the Injection Therapy masters module for Physiotherapists.

Iain Lennon

Consultant in Emergency Medicine

Iain has been an Emergency Medicine Consultant at UHDB since 2006. He has interests in trauma care, healthcare systems and technology, and humanitarian aid. He has previously been the chief clinical informatics officer for UHDB, and co-chair of the East Midlands Regional Trauma network Clinical Governance group. He has been involved with Clinical Senate reviews since 2015.

Ian Mursell

Consultant Paramedic

Ian is a Consultant Paramedic with East Midlands Ambulance Service NHS Trust. As a senior clinician and Lead AHP, Ian is responsible for clinical leadership across the East Midlands and for the development of strategy and care across a range of areas

of prehospital emergency care. Ian has a background as an advanced practitioner and academic teaching on a range of Paramedic and Nursing related programmes related to his specialist fields. As a proactive member of his profession, Ian is a published author and contributes to wider healthcare issues through the East Midlands Clinical Senate, guideline development for the Joint Royal Colleges Ambulance Liaison Committee and membership of national ambulance leadership groups. As a practicing Paramedic, Ian works alongside multidisciplinary teams to provide clinical care across the spectrum of acuity. This is complimented by his role as an examiner for the Royal College of Surgeons of Edinburgh Diploma in Immediate Care and active role in research and development.

Julia Emery

Consultant in Public Health - Strategic Healthcare

Julia is a Consultant in Public Health specialising in Health Care Public Health (HCPH). She started an NIHR doctoral fellowship in September 2022 and her focus is on optimising the adoption, uptake and impact of symptomatic FIT in the primary care pathway for patients with signs or symptoms of suspected colorectal cancer.

Kerry Webb

Nurse Consultant

Kerry is a mental health nurse who has worked in the field of mental health and substance misuse since 1990, across the UK, in New Zealand and the Middle East. For 23 years he has led the addiction psychiatry service at the Birmingham liver unit working predominantly with transplant candidates as a consequence of their alcohol or drug use or due to wider issues such as paracetamol overdose and poor treatment adherence. Nationally, he has previously served as the journal editor for the Association of Nurses in Substance Abuse (ANSA), as a member of the National Treatment Agency clinical team and was also deputy lead for the Addiction Psychiatry MSc at the University of Birmingham. In 2008 he joined the project team tasked with reviewing liaison psychiatry services and devising a model for acute hospitals for the effective assessment, management and discharge of patients with broad spectrum mental health issues. As a result, the Rapid Assessment, Interface and Discharge liaison service was developed for which he jointly received the HSJ award for innovation. In 2015 he was appointed as a nurse consultant, continuing in

a part-time capacity to provide a clinical service to the liver unit in Birmingham and has published widely in this area. He is also the suicide prevention lead for Birmingham and Solihull Mental Health Trust and sits on the patient safety group for the Trust. In December 2017 he was also appointed as a clinical director acute mental health services within Birmingham and Solihull Mental Health Trust, responsible for patient care in the acute inpatient wards and the home treatment teams.

Lesley Roberts

Older People Speciality Advanced Clinical Practitioner

Lesley started her career in nursing as a mature student aged 28. She has worked her way up from joining as a phlebotomist in her hometown of Hull in 2001 and progressed through to being seconded to complete her degree in adult nursing, qualifying in 2007. Her passion has always been the elderly and her nursing career has always been driven to improve and provide the best care for this patient populus. Lesley moved to the East Midlands in 2011 and worked for Nottingham CityCare CIC, within the Community Falls and Rehabilitation team, this role developed and evolved, and she branched into Bone Health and Osteoporosis and completed her MSc Advanced Practice in 2021 as a specialist in the field. Lesley, and a Secondary Care Consultant led and developed an innovative integrated community bone health service, which led to an invitation to NHSE head office for consideration of wider distribution and a pilot to deliver long term condition care and management within the community and reduce secondary care burden. Unfortunately, this was February 2020 and Covid-19 halted all progression and discussion. During Covid-19, Lesley was redeployed to Community Nursing, and this led to reflection of career direction. Lesley decided to change her pathway and joined Derbyshire Community Health Services (DCHS) as a Trainee ACP within the inpatient rehabilitation wards, although holding MSc Advanced Practice she was required to produce a portfolio of evidence and has continued to collate her evidence and will be submitting in November 2023. During a rotation Lesley joined the community Frailty team and found this to be her niche and successfully transferred to the team where she currently works providing the medical support for housebound and care home residents.

Lesley also offers shifts to the DCHS bank and regularly works within two of their UTC facilities providing support for minor illness.

Liz Miller

Trust Pharmacist

Liz is a pharmacist at the East Midlands Ambulance Service NHS Trust. Originally trained and qualified in New Zealand Liz has more than 25 years' experience as a registered pharmacist in the UK working across NHS hospitals, primary care and ambulance services as well as in private hospitals, community pharmacy and hospice charitable sectors. She completed a professional doctorate in pharmacy looking into timely access to palliative medicines in the community and the community pharmacists' role in 2017 and qualified as a pharmacist independent prescriber in 2019. Liz holds the position of honorary lecturer at the University of Sheffield and is actively involved in research and evaluation within palliative care and emergency services.

Lynsey Havill

Ophthalmology Advanced Clinical Practitioner

Lynsey completed her MSc at the University of Derby in Advanced Clinical Practice in specialist medicine with a particular interest in Diabetes and Endocrinology. During Her role as a specialist medical Advanced clinical practitioner, Lynsey has worked within all medical specialities and Acute medicine.

Lynsey is now based in the Eye department, in her Role as an Ophthalmic Advanced Practitioner, the role is a generalist one within the department which includes inpatient management, theatre, inpatient and emergency care.

Mangesh Marudkar

MBBS, MD, MRCPsych, PhD

Consultant Psychiatrist for Older Adult Mental Health Liaison Services

Mangesh is Consultant Liaison Psychiatrist at Leicestershire Partnership NHS Trust (LPT) and a member of the Clinical Senate Assembly. Mangesh was previously Associate Medical Director at LPT, MRCPsych course organiser, Executive member of the Trent Division of Royal College of Psychiatrists (RCPsych) and of the Faculty of Old Age Psychiatry of the RCPsych.

Miles Langdon

GP

Miles has been a GP partner since 1993, after VTS training in Hillingdon, Greater London, then worked in rural practice in Newfoundland, Canada. He returned to the UK and became a GP partner in Ilkeston, Derbyshire. He also worked in a local community hospital and MIU and he was a Director at East Derbyshire OOH cooperative.

He left the NHS again to become a Salaried GP on Guernsey for 2 years, enjoying the lifestyle and beaches!

He came back to the UK to join St Mary's Medical Centre as a partner in Stamford, Lincolnshire in 2008. He was elected Chair of NHS South Lincolnshire CCG 2011-14 and then became part time Clinical Director for Emergency Medicine Peterborough and Stamford Foundation Trust in 2015 (now North West Anglia Foundation Trust), while still a part time GP partner. Miles helped to merge three practices in the same town together and with other practices merged with Lakeside Healthcare, which was a fully merged single GP partnership over multiple sites in Lincolnshire, Cambridgeshire and Northamptonshire. He became Executive GP Lead Stamford Primary Care Home as part of the NAPC second wave programme (which was the precursor to Primary Care Networks) and also worked with the Acute Frailty Network. He was also Responsible Officer for Lakeside Healthcare Group Designated Body for non-connected research doctors employed by the partnership.

Miles started working for East Midlands Academic Health Science Network four years ago to implement a primary care based liver fibroscan service in collaboration with NUH, NWAFT and Cambridge University Hospitals. He became Clinical Advisor to the EMAHSN in 2021 to help implement the UCL Partners AHSN Proactive Care Frameworks and at the start of 2022 became the Cardiovascular and Lipid lead to help implementation of the NICE/AAC Lipid Management Pathway in the region. He is also working with a Swedish company called Doctrin to implement a new digital platform into NHS Primary care over multiple sites with excellent patient and staff satisfaction.

Finally, Miles left GP partnership after almost 30 years and has commenced his latest challenge - working as a GP in an Urgent Treatment Centre back in Peterborough.

Paul Midgley

Patient and Public Involvement representative

Paul has been involved in patient leadership since 2006 when he was appointed to the board of Principia CIC (Practice Based Commissioning Group for Rushcliffe, Notts).

Paul is a patient member on the Nottingham & Nottinghamshire ICS Digital Notts and Greener Notts boards, East Midlands Clinical Senate Council, Rushcliffe Primary Care Network (PCN) Board, chair of Rushcliffe PCN PPG Chairs Group, and chair of Musters Medical Practice PPG.

Previous voluntary roles have included Notts CCG PPEC member, prioritisation panel at Nottinghamshire Healthwatch and various committees at Principia and NHS Rushcliffe CCG including the Clinical Reference Group and Finance and Performance committee.

In working life, Paul has recently set up his own business providing NHS insight services. Prior to this, Paul was a Principal Consultant within Wilmington Healthcare's Thought Leadership Group, where he chaired joint NHS and industry events around service transformation and supported partnership-based improvement projects.

Paul spent over 15 years after graduating from Leeds University with a BSc in Biotechnology working in various commercial roles with the Pharmaceutical Industry prior to leaving in 2000 to set up his own training consultancy, which was acquired by Wilmington plc in 2013.

Roger Kunkler

Associate Postgraduate Dean and Urological Surgeon

Roger is a Urological surgeon from Northampton and an Associate Postgraduate Dean for NHS England.

Amongst his responsibilities for NHS England, he has extensive experience of medical training assessments, is the lead for the Professional Support and wellbeing service and chairs medical training appeal panels.

Saul Hill

Integrated Community Manager

Saul is an Integrated Community Manager and Wound Clinic Service Manager for Derbyshire Community Healthcare Services NHS Foundation Trust. A major provider of complex wound care services to the people of Derbyshire with 65,000 service user contacts per year, the service is an integral part of the Trust's Integrated Community Services.

After serving in the British Armed Forces, Saul began his career as a Registered Podiatrist, and has since worked as a clinician and senior manager within Community Health Services focusing on clinical research, multidisciplinary team working, and integrated care systems. Between these appointments Saul has published widely, lectured at the University of Salford, and holds a position on the Medicines and Medical Devices Committee for the Royal College of Podiatry.

Shaun McGill

Specialty Trainee in Public Health Medicine (ST4)

Shaun is a doctor on the public health medicine specialty training programme in the East Midlands. He is currently with the NHS England Midlands healthcare public health team where he has worked with dental, health and justice, and specially commissioned services. Prior to beginning specialty training, Shaun worked clinically in Birmingham.

Steve Lloyd

GP and Board Director

Steve is a board director at Derbyshire Health United urgent care and 111 provider. He is part of the NICE Technology Appraisal Committee. He is also an associate at Optum and associate medical director at Conclusio.

He has a broad background in medicine and dental surgery, being originally a maxillofacial surgeon, and has been a GP partner in Derbyshire for over 20 years. Steve was previously the chair of NHS Hardwick CCG and commissioning Executive

Medical Director. He has also led major scientific expeditions and was previously a reserve RAF officer.

Susan Edge

Patient and Public Involvement representative

Susan was involved in the further, adult and work-based learning sector for over 30 years and gained significant experience of quality assurance and quality improvement. Subsequently she was the Patient and Public Involvement member of her local clinical commissioning group's governing body for 8 years and was also a public contributor for the National Institute for Health Research.

Currently co-chair of the East Midlands Patient and Public Involvement Senate, hosted by the East Midlands Academic Heath Science Network, Susan is also a lay partner for Health Education England in the East Midlands. She is a member of the Education, Training and Practice Committee of the UK Council for Psychotherapy.

Tareq Al Saoudi

Senior Clinical Fellow in HPB Surgery

Tareq finished medical school and general surgery training in Jordan. He is currently a senior clinical fellow in HPB surgery at the University Hospitals of Leicester NHS Trust.

He is also undergoing an MD degree with the University of Leicester. He is interested in medical education and quality improvement.

Umar Khan

Consultant in Emergency Medicine

Umar is an Emergency Medicine consultant and currently working at Nottingham University Hospitals NHS Trust. Umar qualified as a doctor more than 15 years ago from Pakistan. Since then, he has been working in multiple specialties. After completion of his postgraduate qualification in Public Health, he undertook Emergency Medicine training in the East Midlands. During this period, he was involved in multiple roles such as East Midlands regional Trainee Rep, Chief Registrar at Nottingham University Hospitals NHS Trust and then Chief Registrar at Sherwood Forest Hospitals NHS Trust.

He has been working on regional and Trust wide projects mainly focusing on patient flow management across the hospital, workforce management, training and development – especially leadership and management training. His Leadership Training programme has gained accolades such as Medical Director's commendation award. His East Midlands Emergency Medicine Forum has brought together all training clinicians (trainees and Advanced Care Practitioners) across the region in order to share learning and best practice.