NHS
East of England
Clinical Senate

Report of the Independent Clinical Senate Review Panel 6 February 2017

South Essex Partnership University NHS Foundation Trust (SEPT)

and North Essex Partnership University NHS Foundation Trust

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1. FOREWORD BY CLINICAL SENATE CHAIRMAN

The NHS and adult social care face unprecedented challenges in terms of demand, workforce and finances. Sustainability and Transformation Plan (STP) footprints, Clinical Commissioning Groups, local authorities and providers must all need to work together to develop plans to help meet these challenges. The transformation of Mental Health services is an essential component of system wide health and social care future plans.

The impact of mental health on individuals, family members and friends can be profound and in addition there can often be a further impact on physical health, urgent and emergency care use, employment and indeed the wider economy. South Essex Partnership Trust (SEPT) and North Essex Partnership Foundation Trust (NEPFT) are working towards merging to become a single provider of Mental Health services.

We were asked to provide independent clinical advice regarding the key supporting principles and the early stages of the development of transformed patient pathways, services and service delivery for the new proposed single provider. At the time of our independent clinical review panel the two main Trusts delivering Mental Health Services in Essex, SEPT and NEPFT were at an advanced stage of working towards a possible merger. The Essex wide review of mental health services conducted by Essex commissioning bodies in 2015 recommended at the very least more joint working and the consideration of a merger into a single provider. This was reinforced in the 2017/18 commissioning intentions.

We also needed to consider how the proposals were aligned to the requirements of the Five Year Forward View for Mental Health that recommended a major shift of resources from traditional in-patient model to a community and primary care based model. We heard that the two current organisations face many challenges including fall in real term funding, increasing demand, a varied and wide geography, pressures on local primary care and the need to deal with multiple CCGs and STPs.

We thank the team from the two Trusts for the information they provided and their frank and honest response to our panel's questions. I would also like to thank all our panel members for their time, expertise, engagement and energy.

We hope our report with its key findings and recommendations can assist the two Trusts and/or a new merged single Trust to refine and develop its plans to provide high quality services for the Mental Health needs of the population they serve. We would do our best to provide further independent support and advice in the future should they request it.

Dr Bernard Brett
Review Panel Chair and Chair of East of England Clinical Senate

2. BACKGROUND & ADVICE REQUEST

2.1 Mental health services in Essex are provided by two NHS trusts each serving distinct geographical areas, South Essex Partnership University NHS Foundation Trust (SEPT) and North Essex Partnership University NHS Foundation Trust (NEPFT).

2.2 An Essex wide review of mental health services (Essex Mental Health Strategic Review) had been commissioned in May 2015. The review, carried out by Boston Consulting Group, reported (in autumn 2015) that, with ten commissioning bodies across Essex, the mental health commissioning landscape was complex. The report recommended that the commissioning landscape be simplified by way of a pan-Essex mental health commissioning team. The report also recommended that with common challenges in service delivery and funding, the two main providers be encouraged to work closer, with a view to possible merger.

2.3 Since then, a five year forward plan for mental health in Essex has been published by commissioners. The forward plan acknowledged that there needed to be change in the system to deliver equitable, sustainable, high quality mental health services across Essex.

2.4 Following submission to Monitor in 2016 (subsequently NHS Improvement) of the business case for merger, the two trusts were asked to develop a full proposal. The risk rating of the full business case, submitted to NHS Improvement in December 2016, was due to be known late February 2017. Formal official rating for the full business case is expected mid-March 2017. Dependent upon the outcome, this rating will advise whether (or not) full merger of the two trusts to a single trust should proceed.

2.5 In November 2016, the two trusts approached clinical senate to provide an external clinical opinion on the emerging principles that would support a whole system approach. These principles would underpin the development of the future model for mental health provision in Essex.

2.6 Clinical Senate was not being asked to provide opinion on the technical merger of the two trusts.

3. METHODOLOGY & GOVERNANCE

3.1 The scope of the review was discussed with Dr Mel Conway on behalf of SEPT/ NEPFT and Terms of reference for the review were drafted. It was agreed that the purpose of this independent clinical review was to provide a wider clinical debate and opinion on:

- how to deliver different ways of working by Mental Health Trust front line staff and
- how to develop a new relationship with primary care and community organisations

to support the development of proposals for the clinical model for mental health services in Essex in support of trust merger.

3.2 Clinical review panel members (Appendix 2) from within and outside of the East of England Clinical Senate, and experts by experience (patient representatives) were identified. Once the potential panel members had been invited and accepted they made declarations of interest and signed a confidentiality agreement. Panel members were then provided with the background document provided by the SEPT / NEPFT team as information for the panel review.

3.3 A preparatory telephone conference with panel members was held prior to the panel day to identify areas for discussion on panel day consistent with the Terms of Reference for the review. The detail of that discussion was shared with Dr Conway.

3.4 The clinical review panel took place 6 February 2017. Five members of the SEPT/NEPFT team attended, provided further background and context to the proposals and had discussion with the review panel.

3.5 A draft report was submitted to the SEPT/ NEPFT team and panel members for matters of accuracy on 23 February 2017. In response, in addition to some comment around accuracy, which was duly amended, the SEPT / NEPFT team provided further supporting information on the matter of governance – seen at para 4.12 and recommendation 6 at para 5.7 of the report. The team, whilst

acknowledging that the report reflected the discussion on panel day, recognised that it had not responded with the level of detail of the work on that aspect that had been undertaken to date and the level of information available. Exceptionally, the Chair of the clinical review panel agreed that this information was of sufficient importance and an additional paragraph (4.20) has been included. This amended draft was sent to panel members.

3.6 This, final report, was submitted to a specially convened meeting of the East of England clinical senate council on 15 March 2017 for it to ensure that the clinical review panel met and fulfilled the Terms of Reference for the review.

3.6 This report is then provided to the sponsoring organisation on 23 March 2017.

3.7 East of England Clinical Senate will publish this report on its website at the appropriate time as agreed with the sponsoring organisation in the review Terms of Reference.

4. KEY FINDINGS

4.1 The panel welcomed the presentation from the team. It learned that the case for change for the merger of the two trusts was driven by the Essex wide review of mental health services conducted by Boston Consulting Group for the Essex commissioning bodies in 2015. The primary recommendation of the review was a need for SEPT and NEPFT to consider joint working, possibly as a merged single provider. That recommendation was reinforced in the more recent 2017-18 commissioning intentions.

4.2 The panel heard that there was a requirement for the trusts to make savings in the region of £40million over coming five years. Commissioners and providers had agreed that this was an opportunity to review the whole system.

4.3 The SEPT/NEPFT team informed the panel that subject to the outcome of NHS Improvement's rating of the full business case, the Board of Governors and Council of Governors of SEPT and NEPFT would make the final decision on a formal merger, which, if agreed, would establish the new Trust on 1 April 2017. However, Essex commissioners' Commissioning Intentions 2017-18 laid out that a revised model of delivery would still be required irrespective of whether or not the Trusts formally merged.

4.4 The panel supported the proposal by SEPT / NEPFT to align services to the requirements of the national Five Year Forward View for Mental Health[1]; i.e. the recommended major shift of resources from traditional in-patient model to a community and primary care based model. The SEPT/NEPFT team acknowledged that this would require new and different working relationships and the need to dissolve current (working) boundaries and the panel agreed that this would require major transformation with significant cultural change.

1 A report from the independent Mental Health Taskforce to the NHS in England February 2016

4.5 The panel was advised that a high level statement of intent on direction of travel and set of supporting principles had been developed and agreed. As yet there was very little detail beyond that as there was a firm intention that the detail / final model would be co-produced. It had therefore been challenging to describe what the model *per se* would look like, particularly given the diversity of Essex. The likelihood was that the model would look different in different localities. However, the fundamental principles would underpin and be common to all models across Essex.

4.6 There was reference to the 'primary care arena' as a term to describe the primary and community care element of the new model. This was expected to be made up of 24 neighbourhood 'clusters' of GP practices and community services, each with its own bespoke model. The team advised the panel that as the content and detail of the primary / community care model was unknown, it considered the use of 'arena' as a way to describe something which at present was fairly nebulous. The team explained that the term 'arena' had been chosen to depict that it would not be primary care services as currently organised around GP practices but represented a new approach that needed to be developed in co-production. The panel was concerned that both the name and the lack of clarity regarding this term meant that it could dis-engage some key stakeholders, particularly GPs. They may think that the term essentially described a shift of work to primary care as meaning a higher workload and even more pressure on a part of the system that was currently considerably challenged. The panel agreed that primary care particularly needed reassurance as to why and how, that would not be the case.

4.7 The SEPT / NEPFT team advised the panel that there would be wide engagement with stakeholders to develop a model that was affordable and workable and emphasised the intent for co-production of the model, whilst acknowledging that it would be time consuming.

4.8 The panel heard that the multi-disciplinary team (MDT) approach was a well-established culture common to specialist mental health services and this practice underpinned the proposed model. However, this approach was predominantly internal and did not necessarily include other providers that contributed (or should contribute) to the care of patients currently on Trust caseloads. The team recognised that failure to fully develop that MDT approach in partnership with other services, could be a considerable risk to the development and implementation of the model, requiring significant input and resource to get right. In particular, the new model required more patient/clinical risk sharing and holding by clinicians than was current practice. Thresholds for some services would be revised, to enable wider and easier access to services but with an aim to avoid a potential negative impact of increased demand on parts of the system, particularly primary care.

4.9 The panel heard that the commissioning landscape for mental health services across Essex was complex with ten commissioning bodies and three Sustainability and Transformation Plan (STP) areas. The 2017-18 mental health commissioning intentions gave a commitment 'to working with the merged provider to deliver high quality support and transformation plans in line with the Five Year Forward View for Mental Health', and commissioners had committed to two year contract with the new Trust. The panel learned that the 'Post Transaction Implementation Plan' had a five year timescale and included clinical transformation. SEPT & NEPFT had committed to develop and implement new models of care in co-production with commissioners (as well as other stakeholders). Should commissioners choose to tender for mental health service provision beyond the two year contract, this process would need to start at least a year earlier to allow appropriate processes to be followed.

4.10 The team advised the panel that SEPT and NEPFT had agreed that the risk of doing nothing was higher than proceeding with no contractual certainty as, following the Essex mental health review, it was clear that things had to change for patients. Although this work had started prior to the commissioning intentions being issued, as it was based on the Five Year Forward View for Mental Health, the team was confident that it was aligned to commissioning requirements.

4.11 The panel found that working practices in south and north Essex (i.e. the two Trusts) currently varied, considerably in some cases. For example, patient procedures, SEPT had a patient assessment unit (PAU) and no out of area placements; NEPFT had a number of out of area placements, costing circa £3million and no PAU. Length of stays varied across the two Trusts. The two Trusts currently used different IT systems to record and share patient level clinical information.

4.12 In response to questions around governance, the team advised that, as yet, there was no agreement or clarity around clinical responsibility and that it might initially have to be on a "case by case" basis, supported by agreed operational policies that would apply across the board. Overall responsibility for the programme would sit with the new Trust Board (from 1 April 2017). *(NB See para 4.20 below added after the panel).*

4.13 SEPT / NEPFT team advised the panel that it was a Vanguard site for its Health Information Exchange (HIE) system with eight different domains. The HIE was enabling different bodies and individuals registered on the sites to share and question information in a confidential domain. Its potential in patient record sharing was being explored further.

4.14 The panel heard that SEPT / NEPFT had between them a large estate and had built investment in the estate into parts of the model.

4.15 The panel heard that mental health service provision across Essex was complex. For example, both SEPT & NEPFT provided tier 4 (in-patient beds) Child and Adolescent Mental Health Services (CAMHS) but CAMHS community services were commissioned from another mental health services trust. The current complex fragmentation of service provision was one of the key components of the case for change. The panel agreed that reference to this fragmentation of services would be beneficial and suggested that the model include reference to how those services would integrate across the spectrum of mental health provision and how information would be shared in view of the differing information systems. This was a particular issue with young people transferring to adult services.

4.16 The panel was advised that the proposal was to develop a recovery model and heard some examples of co-production that were working well (e.g. the Recovery Café). SEPT / NEPFT team gave examples of some social marketing that identified that most lower cluster[2] patients using services did not want to have a 'mental health' logo or text in services they received. The panel supported the aspiration to identify and treat early and in a primary / community care setting. The panel agreed that this aspiration should be included as part of the narrative to explain how things would be better for patients.

4.17 As an example of how shifting from an in-patient to primary / community care model would benefit patients, SEPT / NEPFT gave illustration of the proposals for personality disorder patients. It was recognised that personality disorder patients currently used health services inappropriately due to lack of direct therapeutic interventional support. The proposal was to pull out the triage assessment of the patient from an in-patient situation into the new 'primary care arena'. The team acknowledged that this would require highly trained experienced staff and that there needed to be good relationships, clear governance arrangements and a structured approach to the assessment.

4.18 The panel agreed that there were some mixed messages around service development with the excellent social marketing / co-production example in contrast to the medicalised pathway for personality disorder. The level of variation made it even more complex to describe.

4.19 The panel agreed that, given the significant transformation required, the timeline for implementation was challenging and a risk to safety and sustainability of the services.

4.20 Ordinarily the report of the clinical review panel refers only to the discussions held on the day, and would not include any further information that may be provided as a follow up. Following receipt of the draft report for matters of accuracy, The SEPT

[2] a cluster is a global description of a group of people with similar characteristics as identified from a holistic assessment and then rated using the Mental Health Clustering Tool (MHCT). NHS England, Mental Health Clustering Booklet 2016/17

NEPFT team, whilst acknowledging that the report reflected the discussion on panel day, recognised that it had not responded fully enough with the level of detail of the work on that aspect that had been undertaken to date and the level of information available. The team provided further supporting information to demonstrate its current level of understanding and proposals for development.

As an exception, the Chair of this clinical review panel has agreed to include the information provided below by the SEPT NEFT team post panel. The Chair considered that the supporting information was sufficiently important to include as it demonstrated that the team had clarified and distinguished between the different aspects of governance and that it had started to address this as part of the development of the model. The team recognised that the comments in para 4.12 above and consequent recommendation (para 5.7 recommendation 6 below), were a reflection of the panel discussion. The team therefore recognised that its response on the day had not provided the level of detail of the work on that aspect that had been undertaken to date and the level of information available. The team had found this a useful reflection and, would in future discussions and presentations on the matter of governance, ensure that that it made clear the requirement of the different aspects .

The inclusion of this information may negate the need for Recommendation 6 (para 5.7 below), but the recommendation is retained in the report with the caveat to refer back to this information. The information below has been provided by the SEPT / NEPFT team and has been included as provided.

> *"i. At the individual patient level, we need to be clear about which agency has primary responsibility for clinical care. The model allows for more flexible and joint assessments than the current rigid, eligibility determined referral procedures. Clinical responsibility for individuals will be decided on a case by case basis as a result of assessment and discussion between relevant clinicians. This will be one of the key service issues addressed by the work-streams charged with developing implementation plans in co-production.*

ii. At the Transformation Programme level, each work stream (for each component of the clinical model) has a Post Transaction Implementation Plan, with agreed timescales, and reports to the Clinical Work-stream Leads Meeting – chaired by Operational and Medical Directors. The Trust governance structures for merger will transfer to mainstream Trust governance structures after the new Trust is formally established and the Board is ratified. Thus ongoing Programme governance is assured.

iii) A third component of governance is around performance management of staff. This is complex and will be driven by the emerging model implementation plans. The implications of closer joint working between front line staff may include organisation to organisation discussions about shared governance, performance management etc. We anticipate that this will be a growing topic as we move closer to implementation of the clinical model, but as yet, we cannot describe issues or potential solutions in detail. "

5. RECOMMENDATIONS

5.1 The panel was asked to identify any additional risks not highlighted in the presentation from the SEPT / NEPFT team. These have been included in the recommendations below.

5.2 Recommendation 1

The panel agreed that the aspiration around the timeline was a high level risk and almost certainly unrealistic. The panel recommended that this be reviewed and assessed to ensure that the pace was balanced with assurance that the right change, and to the right degree, was being undertaken. An appropriately timed, risk assessed sequence of changes should be developed in an implementation plan.

5.3 Recommendation 2

The panel agreed that there was an unquestionable case for change. However, it had not been clearly described in terms of improvement or benefit to patients, their relatives or carers. The panel recommended that a narrative be developed about what would be better for patients, relatives / carers, the public and staff, including a clear description of what would be different and which outcomes would improve and to what degree.

5.4 Recommendation 3

The panel recommended that more clarity be given to the current terminology 'primary care arena' agreeing that perhaps an alternative term should be agreed to capture the vision of multi-disciplinary networked community and primary care locality model.

5.5 Recommendation 4

The panel recommended that there be rigour in the development of locality models to ensure that the offer from each of the respective different localities or neighbourhood clusters did not result in a 'postcode lottery' effect for patients. The approach should also try to ensure that, whilst allowing for local variation, there was

enough consistency and clarity regarding pathways and services so that they could be easily understood and negotiated by patients, relatives, carers and health and social care staff (who might need to relate to several different locality models).

The panel considered that it would be helpful for the team to identify what services were currently available, and how, in these potential neighbourhood clusters / localities, where they were located and what needed to be different under the new model. That would help identify the scale of change required, including the degree of cultural change.

5.6 Recommendation 5

The panel acknowledged that there had been some engagement with stakeholders across Essex to get the model / set of principles to its current position. The panel also acknowledged that SEPT and NEPFT accepted that there needed to be good relationships and that lack of engagement with and / or buy in from stakeholders going forward was the most significant risk to the proposed transformation of services.

The panel agreed that it was reflecting a risk identified by the team in recommending that extensive engagement with a whole range of groups and stakeholders across the system, in particular engagement with primary care colleagues, was crucial to the successful development and implementation of the new model. Failure to have full engagement with, and co-operation of, all stakeholders and colleagues could put patient safety at risk. The panel agreed that this was also central to recommendation 1 above in respect of pace of implementation.

5.7 Recommendation 6

The panel recommended that clear governance arrangements be developed with clarity on where clinical risk was held. This would help inform and reassure stakeholders and should be part of the information shared during the engagement process.

NB – see later additional information provided in para 4.20 above

5.8 Recommendation 7

The panel recommended that the team look to capture and learn from local, regional, national and international good practice. It had identified the success of its Recovery Café for example and should consider how best to learn from this and spread good practice.

5.9 Recommendation 8

The panel recommended that early consideration be given to workforce planning. This should include the development of new roles, where appropriate generic working, a recruitment and retention strategy and a training plan for the range of roles. A particular example would be the upskilling of workforce to take on reliable triage and assessment in community / primary care settings. There should be close liaison with Health Education England to help ensure the development of an appropriate education and training plan.

5.10 Recommendation 9

The panel recommended that a detailed information technology plan be developed as soon as possible. The reliable and secure sharing of information, particularly clinical information, was seen as a vital component to developing a networked multi-provider community and primary care solution. The panel saw the Vanguard status for the Health Information Exchange programme as a potential advantage in achieving this recommendation. The panel felt that careful consideration should be given to how appropriate items / fields of information for sharing were agreed and determined.

5.11 The panel had been asked to comment on whether it considered the model would be an improvement for service users. The panel agreed that based on the information available at this early stage of development, it was unable to answer this question.

End.

APPENDIX 1: Terms of Reference for the review

Note – Terms of Reference front page graphics removed to reduce document size

East of England Clinical Senate Independent clinical review panel for South Essex Partnership University NHS Foundation Trust (SEPT) and North Essex Partnership University NHS Foundation Trust (NEPFT).

6 February 2017

Terms of Reference

CLINICAL REVIEW PANEL TERMS OF REFERENCE

Title: **Early review of proposals of the clinical model for mental health services in Essex in support of trust merger.**

Terms of reference agreed by: **Dr Bernard Brett, Clinical Senate Chairman, chair of the clinical review panel**

on behalf of East of England Clinical Senate and **Dr Mel Conway**

on behalf of Sponsoring bodies: South Essex Partnership University NHS Foundation Trust (SEPT) and North Essex Partnership University NHS Foundation Trust (NEPFT).

Date: 2 February 2017

Clinical review team members

Panel members	
Dr Bernard Brett	Chairman of Review Panel Chairman East of England clinical senate Deputy Responsible Officer and Consultant Gastroenterologist James Paget Hospital NHS Trust
Dr Gillian Bowden	Clinical Senate Council member Psychologist
Joanna Douglas	Clinical Senate Council member CEO Allied Health Professionals Suffolk
Karon Glynn	Head of Mental Health, POC and High Secure Lead Specialised Commissioning (East Midlands Hub)
Dr John Lockley	Clinical Senate Council member GP Bedfordshire
Annemarie Smith	Expert by Experience - Hertfordshire
Dr Catherine Thomas	Consultant Child & Adolescent Psychiatrist Norfolk & Suffolk FT
Lesley Underwood	Consultant Nurse - Suicide Prevention and Serious Incident Investigation, and QIF for SEPT – attendance already discussed
David Walter	Cognitive Behavioural Therapist, Beds Wellbeing Service (IAPT) Beds Wellbeing Service (East London NHS FT)
Dr Imogen Waterston	Retired Consultant Paediatrician, Private School MD, Norfolk
Professor Asif Zia	Clinical Senate Council member Consultant Psychiatrist and Clinical Director for Learning Disability and Forensic services with Hertfordshire NHS University Foundation Trust.

Aims and objectives of the clinical review

The purpose of this independent clinical review is to provide a wider clinical debate and opinion on

- how to deliver different ways of working by Mental Health Trust front line staff and
- how to develop a new relationship with primary care and community organisations

to support the development of proposals for the clinical model for mental health services in Essex in support of trust merger.

Timeline

The review panel will be held on Monday 6th February 2017.

Reporting arrangements

The clinical review team will provide a report to the clinical senate council which will ensure the panel met the agreed terms of reference, agree the report and be accountable for the advice contained in the final report.

Methodology

The review will be undertaken by a review panel meeting to enable presentations and discussions to take place with the SEPT / NEPFT team.

Report

A draft report will be made to the sponsoring organisation for fact checking prior to publication.

Comments/ correction must be received from the sponsoring organisation within **ten working days**.

Final report will be submitted to clinical senate council to ensure it has met the agreed terms of reference and to agree the report.

The final report will be submitted to the sponsoring organisation by no later than 16th March 2017.

Communication and media handling

Communications will be managed by the sponsoring organisation. Clinical Senate will publish the report at a time deemed not to compromise further development of the proposals or any future public consultation. The date of publication will be agreed with the sponsoring body.

Resources

The East of England Clinical Senate will provide administrative support to the review team, including setting up the meetings and other duties as appropriate.

The clinical review team may request any additional existing documentary evidence from the sponsoring organisation. Any requests will be appropriate to the review, reasonable and manageable.

Accountability and Governance

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

The East of 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

i. Provide the clinical review panel with the case for change, options appraisal and relevant background and current information, identifying relevant best practice and guidance.
ii. Respond within the agreed timescale to the draft report on matter of factual inaccuracy.
iii. Undertake not to attempt to unduly influence any members of the clinical review team during the review.
iv. Arrange and bear the cost of suitable accommodation (as advised by clinical senate support team) for the panel and panel members.

Clinical Senate Council and the sponsoring organisation will

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

Clinical Senate Council will

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

v. submit the final report to the sponsoring organisation

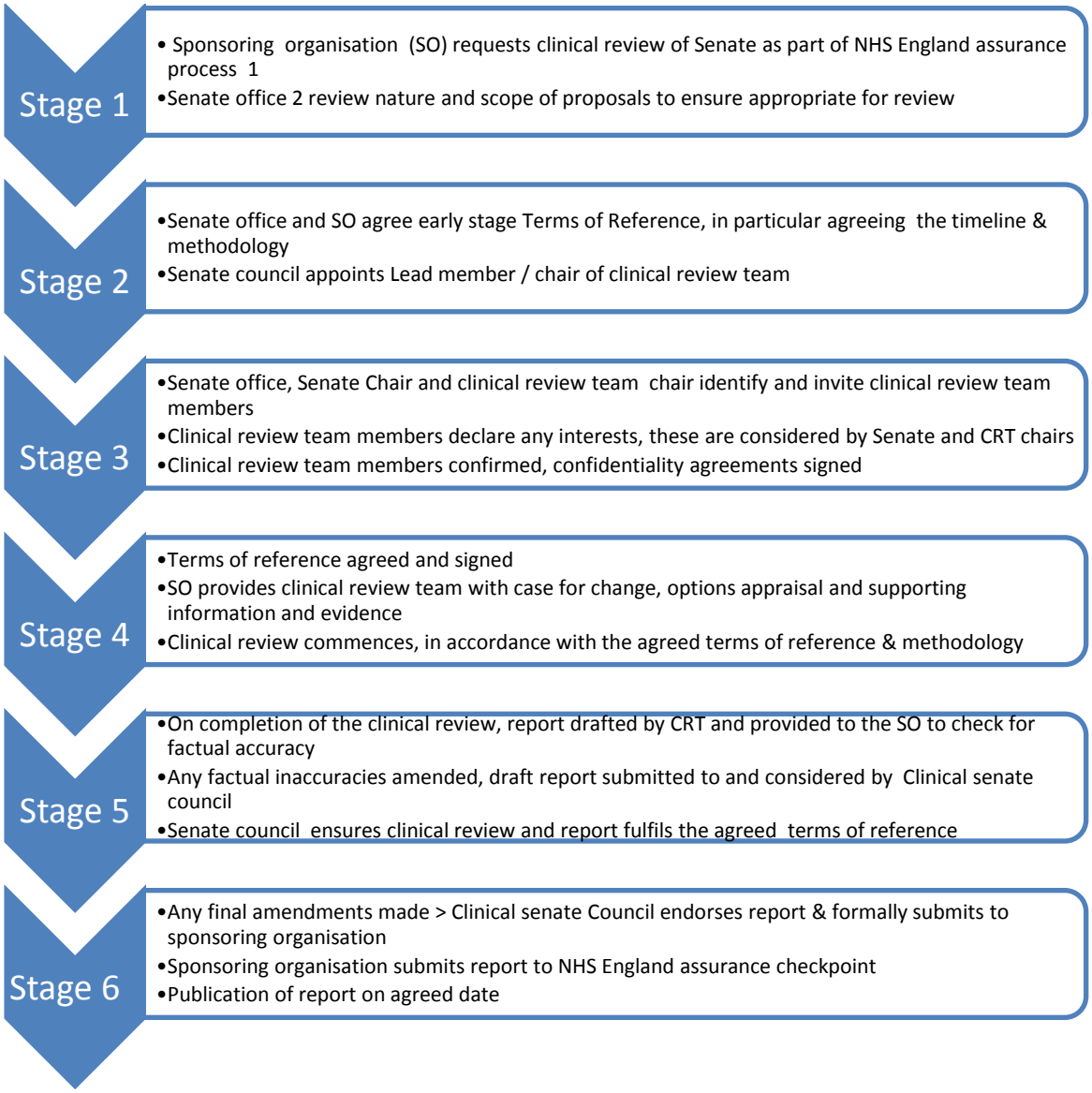
Clinical review team will

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

Clinical review team members will undertake to

i. Declare any conflicts of interest and sign a confidentiality agreement prior to having sight of the full evidence and information
ii. commit fully to the review and attend all briefings, meetings, interviews, panels etc. that are part of the review (as defined in methodology).
iii. contribute fully to the process and review report
iv. ensure that the report accurately represents the consensus of opinion of the clinical review team
v. 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 Head of Clinical Senate, any conflict of interest that may materialise during the review.

Summary of process


Stage 1
• Sponsoring organisation (SO) requests clinical review of Senate as part of NHS England assurance process 1
•Senate office 2 review nature and scope of proposals to ensure appropriate for review
Stage 2
•Senate office and SO agree early stage Terms of Reference, in particular agreeing the timeline & methodology
•Senate council appoints Lead member / chair of clinical review team
Stage 3
•Senate office, Senate Chair and clinical review team chair identify and invite clinical review team members
•Clinical review team members declare any interests, these are considered by Senate and CRT chairs
•Clinical review team members confirmed, confidentiality agreements signed
Stage 4
•Terms of reference agreed and signed
•SO provides clinical review team with case for change, options appraisal and supporting information and evidence
•Clinical review commences, in accordance with the agreed terms of reference & methodology
Stage 5
•On completion of the clinical review, report drafted by CRT and provided to the SO to check for factual accuracy
•Any factual inaccuracies amended, draft report submitted to and considered by Clinical senate council
•Senate council ensures clinical review and report fulfils the agreed terms of reference
Stage 6
•Any final amendments made > Clinical senate Council endorses report & formally submits to sponsoring organisation
•Sponsoring organisation submits report to NHS England assurance checkpoint
•Publication of report on agreed date

APPENDIX 2: Membership of the review panel

Chairman of review panel: Dr Bernard Brett
Deputy Responsible Officer and Consultant Gastroenterologist
James Paget University Hospitals NHS Foundation Trust
Dr Bernard Brett MB, BS, BSc, FRCP, Advanced Medical Manager (BAMM) is a consultant in Gastroenterology and General Internal Medicine based at the James Paget University Hospitals NHS Foundation Trust, and also works at the Norfolk and Norwich University Hospital NHS Foundation Trust. He has a strong interest in Management and Leadership.

Panel Members:

Dr Gillian Bowden MBE
A Clinical Senate Council member, Gillian is Consultant Clinical Psychologist with Norfolk and Suffolk NHS Trust, Gillian is an Honorary Senior Lecturer with the University of East Anglia and the current East of England branch chair of the Division of Clinical Psychology, British Psychological Society. Gillian has worked in various mental health and learning disability services since 1984 and was awarded an MBE for services to mental health in Norfolk in 2009.

Joanna Douglas
Chief Executive Officer of Allied Health Professionals Suffolk CIC, and has led the service throughout its journey to form a social enterprise. Jo is a Chartered physiotherapist and continued with an element of clinical practice until recently. She has 35 years of NHS experience and has senior management level experience within the NHS for the past 15 years, working in a variety of clinical and organisational settings. Jo has been a Clinical Senate Council member since 2013.

Karon Glynn
Karon is Head of Mental Health for East Midlands Specialised Commissioning, NHS England. The role includes all mental health and learning disability provision across the area including High Secure Care and requires close liaison with colleagues across the country. Previous to this she has significant experience of commissioning mental health and learning disability services across local NHS communities.

Karon has a background in mental health and learning disabilities nursing with experience and knowledge of managing change and is currently undertaking a doctorate study which is focused on patient experiences of services.

Dr John Lockley
A part-time GP in Ampthill, Bedfordshire; clinical lead for informatics at Bedfordshire CCG; a member of the Bedfordshire and Hertfordshire LMCs (and on their board); Vice-Chair of the SystmOne National User Group (SNUG); a member of the National Clinical Reference Panel for Choose and Book; on the re-design panel for the electronic Reference Service (eRS), a a member of the National Programme Board for eRS; a University of Cambridge Senior Clinical Tutor; and a writer and broadcaster.
Annemarie Smith

Annemarie is a member and past Acting Chair of HPFT MH Trust Carers Council and also sits on the Patients Care and Environment Committee for Lister Hospital, N and E Herts Acute Hospital. She also sits on a committee for NHS England and trains the new Leadership on patient and carer issues in the Nye Bevan initiative. Also a member of the Citizens' Senate for East Anglia.

Annemarie an interest in Research and involved in joint projects with Cambridge University and Anglia Ruskin and Hertfordshire University where she teaches as an expert by experience. Sits on the validation committee for the new nursing degree and on the NHS Health Committee for smoking cessation for Britain. A stakeholder member of Healthwatch Hertfordshire and also undertakes other voluntary work.

Dr Catherine Thomas

Catherine has been working as a child psychiatrist in the Trust CAMHS service for ten years. During this time she has specialised in the clinical application of attachment theory particularly in relation to parents and babies. In 2014, she initiated a small interagency parent –infant attachment project for high risk families in the Lowestoft and Waveney area. She is now clinical lead along with her colleague Richard Pratt, for the Norfolk PIMH Attachment Team, which is modelled along similar lines. She continues to work in the under 14's Children and Family Service, offering direct work with children with families, as well as training, consultation and supervision to clinicians within the Trust and with other agencies.

Lesley Underwood

Lesley qualified as a General Nurse in 1985 and acquired a Dip HE in Mental Health Nursing in 2000, whilst working in Assertive Outreach undertook an Independent Prescribing Course to improve the physical and mental health of the patients. Undertaking further qualifications to obtain a BA (Hons) in mental health nursing and later an MSc in Public Health which were both used to support the physical health care agenda within mental health services both in Bedfordshire and Luton and later in South Essex.

Lesley is currently working as the Consultant Nurse for Suicide Prevention and Serious Incident investigations, within the Governance team at South Essex University Partnership NHS Foundation Trust. With a remit to provide Suicide Prevention Training, attend and give evidence at Coroners Inquests, provide support to bereaved families, provide support and expert advice to staff who are supporting particularly vulnerable suicidal patients and undertake Serious Incident investigations.

Dr Imogen Waterstone

Currently teaching 4th and 5th year medical students for consultation skills training at University of East Anglia, Imogen has been Consultant Community Paediatrician in King's Lynn, West Norfolk and Wisbech for 18 years until August 2008 and the Bethel Hospital in Norwich. Imogen also had regular sessions with the CAMH unit in King's Lynn, working jointly with many different clinicians Child and Adolescent mental health and Learning Disabilities . As an executive member of the West Norfolk PCT, Imogen was involved with decisions around the future of Mental Health services in West Norfolk.

David Walter

David has worked within IAPT services for 11 years; two years as a Primary Care Mental Health Worker and noneyears as a Cognitive Behavioural Therapist. David delivers one to one therapy, design and run group interventions and provide and receive supervision, he is also a Visiting Lecturer on the University of Hertfordshire's CBT PGDip course.

Professor Asif Zia
Professor Asif Zia is a Clinical Senate Council member and consultant Psychiatrist and Clinical Director for Learning Disability and Forensic services with Hertfordshire NHS University Foundation Trust. He was the chair of the Managed Clinical Network for Learning Disability and Autism work stream for NHS England Midlands and East. His areas of interest include autism, epilepsy and improving health care for people with intellectual disability.

IN ATTENDANCE AT PANEL

SEPT / NEPFT team

Dr Mel Conway, Consultant in Public Health
Declan Jacob, Clinical Project Lead – Former Director of Mental Health
Dr Llew Lewis, Deputy Medical Director (SEP)
Amba Murdamootoo, Service Development Manager
Thomas Way, Expert by Experience.

Clinical Senate Support Team:

Sue Edwards, East of England Head of Clinical Senate, NHS England.
Brenda Allen, Clinical Senate Senior Project Support

APPENDIX 3: Declarations of Interest

Name	Personal pecuniary interest	Personal family interest	Non-personal pecuniary interest	Personal non-pecuniary interest
Dr Bernard Brett	None	None	None	None
Dr Gillian Bowden	None	None	None	None
Joanna Douglas	None	None	None	None
Dierdre Fowler *(unable to attend panel day)*	None	None	None	None
Dr David Gaunt *(unable to attend panel day)*	None	None	None	None
Karon Glynn	None	None	None	None
Dr John Lockley	None	None	None	None
Annemarie Smith	None	None	None	None
Dr Catherine Thomas	None	None	None	None
Lesley Underwood	None	None	Declared*	None
David Walter	None	None	None	None
Dr Imogen Waterston	None	None	None	None
Professor Asif Zia	None	None	Declared**	None

*Lesley Underwood is employed by South Essex Partnership Trust, as a Consultant Nurse – Suicide Prevention and Serious Incident Investigation. Her membership of the panel was agreed by Dr Mel Conway on behalf of SEPT, on the basis that there was no direct conflict of interest.

** Professor Asif Zia is employed by Hertfordshire NHS University Foundation Trust who provide Learning Disability and IAPT services for NEPFT. His membership of the panel was agreed by Dr Mel Conway on behalf of SEPT, on the basis that there was no direct conflict of interest.

KEY

CCG	Clinical Commissioning Group
CAMHS	Child and Adolescent Mental Health Services
GP	General Practitioner
HIE	Health Information Exchange
IAPT	Improving access to psychological therapies
PAU	Patient Assessment Unit
NEPFT	North Essex Partnership University NHS Foundation Trust
SEPT	South Essex Partnership University NHS Foundation Trust
STP	Sustainability and Transformation Plan