



## Mid & South Essex Sustainability and Transformation Partnership

### Supplementary report of the follow up clinical review panel held on 17 October 2017

*(NB: to be read in conjunction with the report of the clinical review panel of 18 September 2017)*

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## Glossary of abbreviations used in the report

A&E	Accident and Emergency
ED	Emergency Department
EEAST	The East of England Ambulance Service Trust
HASU	Hyper Acute Stroke Unit
MSE STP	Mid and South Essex Sustainability and Transformation Partnership
(S)SNAP	Sentinel Stroke National Audit Programme (data collected on all stroke patients)
STP	Sustainability and Transformation Partnership
24/7	24 hours a day, seven days a week.

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# 1. ADVICE REQUEST AND SCOPE OF THE REVIEW

- 1.1 The East of England Clinical Senate has to date reviewed emerging proposals for the Mid and South Essex STP (formerly Success Regime) on three separate occasions:
- In June 2016, which focused on the early emerging thinking,
  - In October 2016, which considered in more detail the five potential configuration options that subsequently fed into the STP's formal options appraisal process, and
  - In September 2017, when the panel conducted a preliminary review of the STP's final pre-consultation proposals.
- 1.2 The clinical review panel that met in September 2017 broadly supported the STP's revised proposals across a range of pathways. However, some concerns were expressed over the STP's proposals for stroke services; specifically, the panel concluded that although it supported the proposal to establish a single Hyper Acute Stroke Unit (HASU) for the 1.2m population of the STP, it noted that, based on the evidence presented to the panel, *"there was insufficient evidence to include stroke services in the... treat and transfer model"*.
- 1.3 The panel's recommendation that *"thrombolysis be delivered either at or in close proximity to the proposed HASU"* was a departure from the STP's proposal that all patients that have a suspected stroke should be seen at their local A&E, diagnosed, thrombolysed, and then transferred to the HASU for the first 48-72 hours of care.
- 1.4 Following Clinical Senate's review in September 2017, the STP advised Clinical Senate that, prior to moving to public consultation; it would gather more evidence to demonstrate the benefits of its proposed model for stroke services. The STP requested Clinical Senate to undertake a further review to look at that evidence. It was intended that it would include a review of published national and international clinical evidence, the views of national experts such as NHS England's National Clinical Director and identifying other

areas of the country that had developed a similar model. Clinical Senate agreed to convene a new panel to review that additional evidence.

- 1.5 However, at the time of the review panel (17 October 2017) the review of national and international published evidence had not been completed and was therefore not available for consideration by the panel. The panel therefore relied upon the evidence brought together by the STP itself and the discussion on the (teleconference) panel.
- 1.6 The scope and focus of this clinical review panel was to consider the evidence provided by the STP team to support its proposed model for stroke services. This was not a review to look again at the proposals considered on 18 September or to look at any other services or inter-dependencies of the stroke service.

## **2. METHODOLOGY & GOVERNANCE**

- 2.1 Clinical Senate Chair and the MSE STP Programme Director agreed that given the short notice, and the need to meet other external assurance deadlines, the clinical review panel would take place as a teleconference.
- 2.2 Clinical review panel members (Appendix 2) from within and outside of the East of England Clinical Senate were identified and signed conflict of interest and confidentiality agreements. East of England Clinical Senate would like to acknowledge the support of the Clinical Senates across England in securing senior credible physicians to be members of this panel. The Chair of Clinical Senate would also like to express his sincere gratitude to all panel members for their valuable input to this review, either on the panel or with written comments, and for arranging to support this at such notice.
- 2.3 Terms of reference for the review were drafted by the Programme Director and agreed by Dr Bernard Brett, Chair of East of England Clinical Senate and Joanna Douglas, appointed Chair of clinical review panel.

- 2.4 There was insufficient time between receipt of the evidence and the panel day to hold the usual pre panel teleconference to prepare members and discuss potential key lines of enquiry. Additional time was therefore built into the agenda for the panel day (Appendix 3) to include this.
- 2.5 The clinical review panel took place on Tuesday 17 October 2017 by teleconference. A draft report was sent to the members of the panel for review and confirmation of accuracy. The MSE STP team received a draft report on 19 October and requested minor changes around points of accuracy which were made. The final draft report was approved by the Chair of the clinical review panel and chair of Clinical Senate.
- 2.6 The final report is normally submitted to the East of England Clinical Senate Council for it to ensure that the clinical review panel met and fulfilled the Terms of Reference for the review and is then submitted to the commissioning body. In this instance due to the short turnaround time, Senate Council agreed Chairman's action for the Chair of Clinical Senate to approve the report. The report will be submitted to Senate Council at its next meeting on 13 December 2017.
- 2.7 East of England Clinical Senate will publish this report, as a supplementary report incorporated into the report from the Clinical Review panel of 18 September 2017 on its website as agreed with the sponsoring organisation, the Mid and South Essex STP.

### 3. SUMMARY OF KEY FINDINGS & RECOMMENDATIONS

#### Key findings:

- 3.1 The panel agreed that it was clear there had been a lot of work across Mid and South Essex developing the model and that it had been clinically led. The panel recognised that there had been an acknowledgement that change needed to happen in order to meet future demands and needs and incorporating new technologies; having that clinical ownership and recognition would enable a much greater chance of success.
- 3.2 The panel acknowledged that current arrangements and SSNAP data showed that the existing model worked reasonably well with no major concerns.
- 3.3 **Three point access ('drip and ship') model:** The panel heard that patients assessed by the Ambulance Service as suspected stroke patients would be taken by ambulance direct to their local Emergency Department (ED) for investigation and thrombolysis. The patient would be greeted by a stroke assessment team (a stroke trained doctor and specialist nurse) in ED who would have been pre-alerted by the Ambulance Service. The patient would be CT scanned, thrombolysed (if required /met the criteria) and then transferred to the single HASU. (NB later confirmed by the STP team that thrombolysis would be completed before transfer, the patient would not be transferred during thrombolysis).
- 3.4 The panel agreed that the estimated number of patients with conditions that mimicked strokes reported by the MSE STP team of around 7,000 per year across the three sites was exceptionally high at almost 3.8 stroke mimics per true stroke; a more usual ratio was 1:1 or 1:2. The panel recognised that if that was an accurate number, then access through a single unit would place considerable undue pressure on the entire system without significant changes to physical infrastructure and staffing levels. The panel recognised the benefit of being able to locally filter out the majority of patients with conditions that mimicked strokes. The panel was of the opinion that the STP should factor into its modelling that a number of patients with conditions that mimicked

strokes would need to be admitted to a stroke bed until all investigations were complete and diagnosis confirmed.

- 3.5 **Travel time.** The panel agreed that the additional travel time direct to a single HASU was minimal and, alone, was not a reason for maintaining access via three points as opposed to a single access. However, the panel recognised that even if a high percentage of the patients with conditions that mimicked strokes were filtered out at the local ED, the capacity of a single site to deal with all potential stroke admissions without significant capacity changes was a greater issue. The panel agreed that currently a single unit was unlikely to cope with the numbers described to the panel.
- 3.6 **Workforce:** The panel heard that the proposal was for a single stroke service across the three sites, a 'one team' approach; staff would be rostered across both the HASU and the two peripheral sites. The panel was advised that there would in effect be three rotas for the in-hours (9am to 5pm) service and one single rota across the three sites for the out of hours service, which would be supported by a senior consultant and telemedicine service (see para 3.8 below). While the panel was supportive of the 'one team' approach it agreed it had not seen evidence that demonstrated there was current or future workforce capacity to provide a 24 hour seven day week stroke reception team at all three EDs.
- 3.7 The panel agreed that fundamental to a clinically safe, successful service that delivered good outcomes for patients, was the availability at all times of highly skilled clinicians. In particular, highly trained nurses to support assessment and thrombolysis together with a robust telemedicine service to provide senior medical input, would be essential to the out of hours stroke service.
- 3.8 **IT/ telemedicine:** The panel heard that a Telemedicine service, although available for radiology from November 2017, was not currently enabled for stroke services; the intention was to extend this to stroke services through formal procurement. The panel was advised that stroke clinicians would receive training to read images. However the panel agreed that whilst this may be appropriate in 'straight forward' cases, an experienced radiologist needed to be available to interpret results of the more complex cases and

especially to support the out of hours stroke service. The review panel of 18 September had made recommendations on IT generally.

3.9 **Evidence:** The panel was disappointed that no externally validated evidence or data was available at the time of the panel to support, or otherwise, either a single point of access or three point access (drip and ship) model. The panel wished to make clear that its findings and recommendations were therefore made on the evidence presented which had been brought together by the MSE STP and from the discussions on the call with the MSE team.

3.10 **Professor Tony Rudd**, National Clinical Director for Stroke. Professor Rudd was able to join the panel as an expert advisor. Professor Rudd confirmed that the three units were currently performing well separately which, in effect made it more difficult for the clinicians to sign up to a single service, and he had been impressed by the local teams' thoughts, consideration and solutions to deliver the sort of change that was necessary to meet future demand.

Professor Rudd advised that in his opinion given the strength of the local clinical leadership, he considered the proposed model to be a reasonable approach.

3.11 The panel recognised that, in future, thrombectomy would be the 'gold standard' for many stroke patients. Whilst that was out of scope for this review panel, the panel agreed that essentially any proposals should be considered interim arrangements that may be reviewed as the thrombectomy service is developed and rolled out across the country.

3.12 In conclusion, and in response to the question put to the Clinical Senate, with the caveat that no external or validated evidence or data had been provided to support the considerations, the panel agreed that, subject to the recommendations (below) of this panel and those of the panel of 18 September being actioned, the proposed three access point ('drip and ship') model would be likely to provide, at least in the short to medium term, a clinically safe and sustainable service.

## 4. Recommendations

- 4.1 The recommendations of the clinical review panel (below) are supplemental to the recommendations of the clinical review panel of 18 September 2017 and should be taken in conjunction with those recommendations.

### Recommendation 1

- 4.2 The panel supported the 'one team' approach for a single stroke service across Mid and South Essex and recommended that the staff come under a single administrative centre to enable appropriate rotas and to ensure that capacity was maintained at all three sites.

### Recommendation 2

- 4.3 The panel recommended that detailed modelling on a number of areas be undertaken. This should include modelling to:
- a. identify the appropriate size of the HASU to support the proposed model and the required number of step down stroke beds at each site, incorporating the percentage of patients with conditions that mimic strokes that would need to be admitted to each unit;
  - b. model the appropriate size of a HASU for a single point of entry pathway to ensure this is considered during planning, especially of physical infrastructure and workforce, as this is a possible future state model of care depending upon the sustainability of workforce, patient outcomes and performance;
  - c. identify the staffing required to support the in-patient beds at all three sites and the Emergency Department stroke reception team to support the assessment areas and inpatient beds;
  - d. identify the capacity to manage and accommodate the subsequent repatriation of both actual stroke and stroke mimic admissions;
  - e. identify the capacity of the Ambulance service for the additional two journeys per patient (move from local ED to HASU and subsequent repatriation). (NB recognising that an option for an inter-hospital transfer service was being considered); and
  - f. note also the recommendation on modelling from the review panel of 18 September 2017.

### Recommendation 3

- 4.4 The panel agreed that an established, robust Telemedicine service was crucial to the success of the non-core out of hours element of the three point access (drip and ship) model; the panel recommended that MSE STP team develop a clear timeline for the procurement, implementation and testing of the Telemedicine service.

### Recommendation 4

- 4.5 The panel recommended that the MSE STP team incorporated ongoing reviews and appraisals (alongside the usual data collection); this would include monitoring transport times and the types and numbers of patients presenting with conditions that mimic strokes. This would help to ensure the outcomes were in line with expectations and, if necessary, future adjustments of the proposed model were made in a timely manner.

End.

## APPENDIX 1: Terms of Reference for the review

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### **Follow up clinical review panel on proposals for the Stroke pathway for the Mid and South Essex Sustainability and Transformation Partnership**

Terms of Reference for the Independent Clinical Senate Review Panel – 17 October 2017

\* Full stage 2 assurance clinical review panels to be convened before end of February 2018.

## CLINICAL REVIEW PANEL : TERMS OF REFERENCE

**Title:** Mid and South Essex Sustainability and Transformation Partnership

**Agreement between the sponsoring body:** Mid and South Essex Sustainability and Transformation Partnership (MSE STP)

**And the** East of England Clinical Senate

**Terms of reference agreed by:** Dr Bernard Brett

**Signature**



**on behalf of the East of England Clinical Senate and**

**Signature**

**Celia Skinner on behalf of Mid and South Essex STP**

**on behalf of Mid and South Essex Sustainability and Transformation Partnership (MSE STP)**

**Date:**

### Clinical review team members

<b>Mid and South Essex STP Clinical Review Panel 17 October 2017 Clinical Review Panel Members</b>	
Joanna Douglas	Panel Chair. Clinical Senate Council Member, Chief Executive Allied Health Professional Suffolk CIC
Dr Andrew Bateman	Physiotherapist & Neuropsychologist, Lead for Oliver Zangwill Centre for Neuropsychological Rehabilitation. Clinical Senate Council Member
Dr Jim Crawford	Emergency Medicine Consultant, James Paget Hospital <i>(Not on the call - desktop review comments)</i>
Dr Andrew Hill	Clinical Lead for Stroke Services, St Helens and Knowsley Teaching Hospitals NHS Trust <i>(Not on the call - desktop review comments)</i>
Dr Stuart Huntley	Consultant Physician and Head of Stroke Service Northumbria Healthcare NHS Foundation Trust
Dr David Mangion	Consultant Stroke Physician, United Lincolnshire Hospitals NHS Trust
Mr Nadim Noor	Consultant Vascular and Endovascular Surgeon Bedford Hospital NHS Trust & Luton & Dunstable Hospital NHS Foundation Trust <i>(Not on the call - desktop review comments)</i>
Michael Rattigan	Senior Paramedic Mentor, EoE Ambulance Service
Dr Ganesh Subramanian	Stroke Physician, Nottingham University Hospitals NHS Trust
Dr Wayne Sunman	Stroke Physician, Nottingham University Hospitals NHS Trust

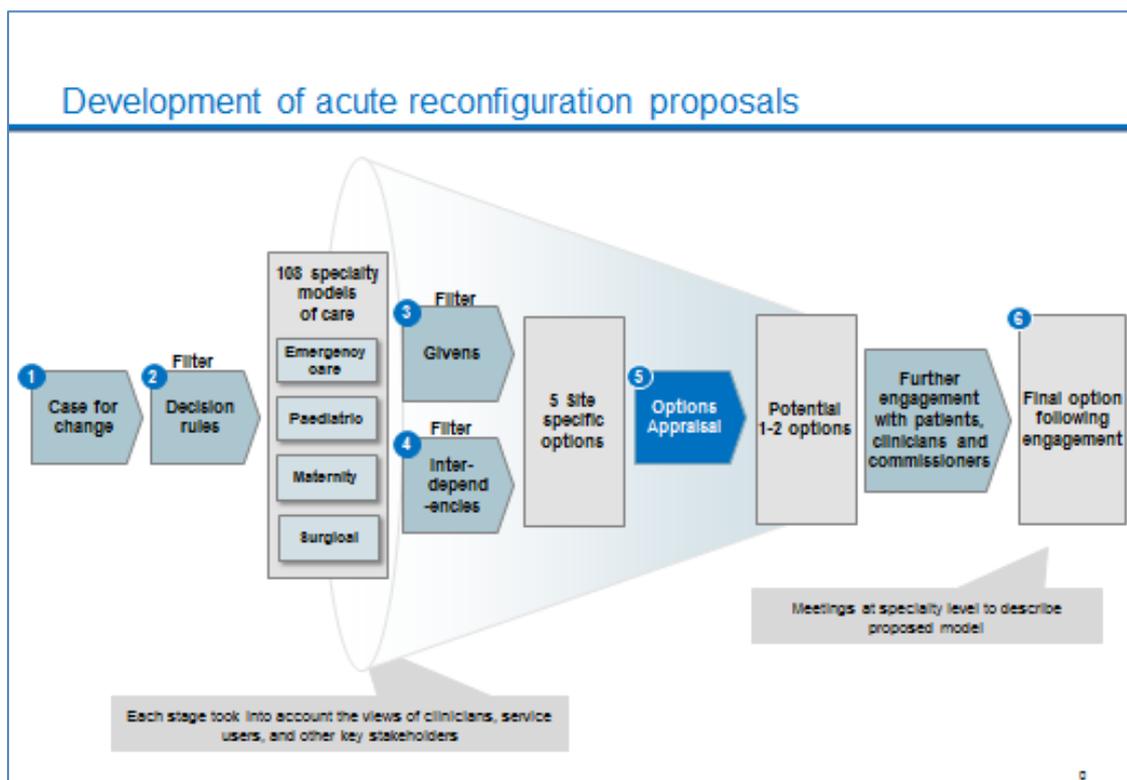
### Mid and South Essex team members

Dr Anita Donley	Independent Chair, Essex STP
Dr Celia Skinner	Chief Medical officer
Dr Ronan Fenton	Medical Director, Mid & South Essex Success Regime
Dr Donald McGeachy	Medical Director, NHS Mid Essex CCG
Tom Abell	Chief Transformation Officer
Dr Paul Guyler	Consultant physician (Stroke)
Andy Vowles	Programme Director

## Context, aims and objectives of the clinical review

As part of the Mid and South Essex Success Regime (now the Sustainability and Transformation Partnership), clinical leaders have been developing proposals for potential acute services reconfiguration. The proposals consider clinical services provided by the three main hospitals within the footprint – Basildon, Southend and Mid Essex (Chelmsford).

The over-arching aim of the work is to establish a model of care which helps to secure the clinical, financial and operational sustainability of the three hospitals and, where possible, to improve outcomes by consolidating some clinical services. The clinical model has been developed and iterated over the last 18 months. The following exhibit gives an overview of the process:



The Clinical Senate has to date reviewed the emerging proposals on three separate occasions:

- In June 2016, which focused on the early emerging thinking
- In October 2016, which considered in more detail the five potential configuration options that subsequently fed into the Programme's formal options appraisal process

- In September 2017, when the panel conducted a preliminary review of the programme's final pre-consultation proposals

The Panel that met in September 2017 broadly supported the Programme's revised proposals across a range of pathways. However, some concerns were expressed over the programme's proposals for stroke services.

Specifically, the panel concluded that although it supported the proposal to establish a single High Acuity Stroke Unit (HASU) for the 1.2m population of the STP, it noted that, based on the evidence presented to the panel, *"there was insufficient evidence to include stroke services in the... treat and transfer model"*.

The panel went on to recommend that *"thrombolysis be delivered either at or in close proximity to the proposed HASU"*. This was a departure from the Programme's proposal that all patients that have a suspected stroke should be seen at their local A&E, diagnosed, where relevant thrombolysed, and then transferred to the HASU for the first 48-72 hours of care.

Following the Senate's review in September 2017, the programme has been working to gather more evidence to inform its proposals for stroke services. This includes reviewing the published clinical evidence, seeking the views of national experts such as NHS England's National Clinical Director and identifying other areas of the country that have developed a similar model.

**The core purpose of the current follow up panel is to review the additional evidence available at the time of the panel on 17 October 2017, relating to the proposed stroke pathway.**

The Programme plans to ask the Senate to complete a full Stage 2 review of the final proposals in early 2018, post consultation but prior to any final decisions on configuration being taken.

### Scope of the review

The focus for this follow up clinical review panel is limited to the proposed stroke pathway. The core question to be addressed by the Panel is:

**Does the evidence submitted by the programme demonstrate that the proposed option for the acute stroke care pathway, with initial assessment and treatment including thrombolysis (when clinically indicated) delivered on three sites prior to transfer to a single HASU, is likely to provide a clinically safe and sustainable service compared to the current model?**

The Clinical Senate review panel is asked to review the evidence available, discuss this with members of the Programme and make its recommendations.

The clinical review panel is not expected to advise or make comment upon any issues of the NHS England assurance process that will be reviewed elsewhere (e.g. financial elements of risk in the proposals, patient engagement, GP support or the approach to consultation).

### Timeline

The clinical review panel will be held on 17 October 2017.

### Reporting arrangements

Clinical Senate Council has agreed that, due to the required swift turnaround of the report, an exception will be made to the normal governance procedures for review panel reports (i.e. prior to being submitted Clinical Senate Council considers the report to ensure that the review panel met the agreed Terms of Reference, agree the report and be accountable for the advice contained in the final report).

The Chair's action agreed by Clinical Senate Council for the Chair of the clinical review panel to review and submit the briefing note to the Mid and South Essex team before it has been considered by Senate Council, has been extended to this panel.

The Chair of the panel will discuss the report with the Chair of Clinical Senate prior to the supplementary report being taken to Council at its next meeting on 13 December 2017.

### Methodology

The review will be undertaken by a panel joining a teleconference to enable a review of the evidence and discussions to take place.

### Report

An initial draft report, as supplemental to the report of the clinical review panel of 18 September, will be provided to the STP team by 23 October 2017. Given the tight turnaround, the report will focus on the key findings and recommendations only.

Normally, Clinical Senate provides the sponsoring organisation with a draft of the report for it to respond, within an agreed timescale, on any matters of factual inaccuracy. Due to the exceptional turnaround requirements, this will not be possible. However if the MSE STP team considers there are any factual inaccuracies, these will be amended for the final report that will be considered by Senate Council on 13 December 2017.

The final report will be submitted to Clinical Senate Council to ensure it has met the agreed Terms of Reference and to agree the report, and will be issued to the MSE STP after the council meeting of 13 December 2017.

### Communication and media handling

Communications will be managed by the STP team. Clinical Senate will publish the briefing note / report once the service change proposal has completed the full NHS England process, or sooner if agreed by the STP team.

### 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 STP team has offered to assist the Senate as required.

## Accountability and Governance

The clinical review panel 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 briefing note to the sponsoring organisation, as described above.

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 agreed written evidence no later than 12 October 2017
- ii. undertake not to attempt to unduly influence any members of the clinical review team during the review.

**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 or agreed nominees** will

- i. appoint a clinical review panel, 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 panel** will

- i. undertake its review in line the methodology agreed in the Terms of Reference

- ii. follow the report template and provide the sponsoring organisation with a draft report to check for factual accuracy.
- 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 panel will subsequently submit final draft of the report to the Clinical Senate Council.
- iv. keep accurate notes of meetings.

**Clinical review panel 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 (*NB this is usual procedure but due to the exceptionally short preparation time these will be signed immediately prior to the panel. All panel members were advised of the confidential nature of this information when provided with the evidence pack and invited to discuss any potential conflicts of interest with the Head of Clinical Senate prior to the panel day.*)
- 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 (*as note above*).
- 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.

## APPENDIX 2: Membership of the clinical review panel

<b>Mid and South Essex STP Clinical Review Panel 17 October 2017</b> <b>Clinical Review Panel Members</b>	
Joanna Douglas	Panel Chair. Clinical Senate Council Member, Chief Executive Allied Health Professional Suffolk CIC
Dr Andrew Bateman	Physiotherapist & Neuropsychologist, Lead for Oliver Zangwill Centre for Neuropsychological Rehabilitation. Clinical Senate Council Member
Dr Jim Crawford	Emergency Medicine Consultant, James Paget Hospital <i>(Not on the call - desktop review comments)</i>
Dr Andrew Hill	Clinical Lead for Stroke Services, St Helens and Knowsley Teaching Hospitals NHS Trust <i>(Not on the call - desktop review comments)</i>
Dr Stuart Huntley	Consultant Physician and Head of Stroke Service Northumbria Healthcare NHS Foundation Trust
Dr David Mangion	Consultant Stroke Physician, United Lincolnshire Hospitals NHS Trust
Mr Nadim Noor	Consultant Vascular and Endovascular Surgeon Bedford Hospital NHS Trust & Luton & Dunstable Hospital NHS Foundation Trust <i>(Not on the call - desktop review comments)</i>
Michael Rattigan	Senior Paramedic Mentor, EoE Ambulance Service
Dr Ganesh Subramanian	Stroke Physician, Nottingham University Hospitals NHS Trust
Dr Wayne Sunman	Stroke Physician, Nottingham University Hospitals NHS Trust

## **Clinical Review Panel Chairman: Panel Members:**

### **Joanne Douglas - Chair**

Chief Executive Officer of Allied Health Professionals Suffolk CIC, and has led the service throughout its journey to form a social enterprise. She 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.

### **Dr Andrew Bateman**

Worked in research and clinical rehabilitation since 1990, the year he qualified as a Physiotherapist (East London). Completed a PhD in Neuropsychology in 1997 (Birmingham). Leading the Oliver Zangwill Centre for Neuropsychological Rehabilitation (Ely, UK) since 2002. Special interest in rehabilitation research – specifically outcome research & assistive technology. In the field of neuropsychology he has specialised in areas of executive functioning, dyspraxia & visual perception.

### **Dr Jim Crawford**

Jim Crawford has been a Consultant in Emergency Medicine at the James Paget University Hospital since 2008, having previously been a Specialist Registrar on the East of England scheme, rotating through QEH King's Lynn, NNUH and Ipswich Hospitals. He qualified in 1999 from Barts and the London School of Emergency Medicine.

He is a College Tutor and Examiner and has recently taken on the role of East of England Regional Chair for the Royal College of Emergency Medicine, as well as becoming Clinical Lead for Emergency Medicine at JPUH.

### **Dr Andrew Hill**

Dr Andrew Hill has been Clinical Lead for Stroke Services at St Helens and Knowsley Teaching Hospitals NHS Trust since 2014. He has been responsible for oversight of service transformation at St Helens and Knowsley resulting in improvements in performance as measured by the Stroke Sentinel National Audit from an 'E' (poorly performing) in 2013 to consistently delivering an 'A' (world class service) for the last 18 months. He has also led service reconfiguration as lead for the HASU provider within the Mid-Mersey (Alliance) STP; with successful migration to single site acute stroke working in line with the Manchester (Phase I) model: the service is currently in the late stages of performing the transition in line with the Manchester (Phase II) / London model for the St Helens, Knowsley, Halton and Warrington CCG areas.

More recently he has undertaken a role within the Royal College of Physicians Stroke Programme as Director of Clinical Informatics for the Stroke Programme, to assist with modernisation of the national audit and development of some of these concepts for national use.

**Dr Stuart Huntley**

Dr Stuart Huntley has been a consultant stroke physician at Northumbria Healthcare NHS Foundation Trust since 2001 and is currently Head of Service for Stroke at Northumbria and Stroke Clinical Lead for the North of England Clinical Networks

**Dr David Mangion**

A consultant physician in Stroke Medicine at Pilgrim Hospital, United Lincolnshire Hospitals NHS Trust. Qualified in 1978 and had training in internal and geriatric medicine in different hospitals in the UK. Took over responsibility for the Stroke service in 1995.

**Mr Nadim Noor**

Nadim is a consultant vascular and endovascular surgeon, at Bedford Hospital NHS Trust with Luton & Dunstable Hospital NHS Foundation Trust. He has a keen interest in healthcare management with a view to improve quality and patient experience.

**Michael Rattigan**

Michael started his career as a carpenter before joining the Royal Navy. After a long time as a Navy medic he left the forces to become a paramedic with East of England Ambulance Service. He is currently enjoying his new career as a senior paramedic mentor. He is studying for his master's degree in critical care. In his spare time Michael is in the medical wing of the RAF Reserves. He is passionate about making services better for the patient and their families.

**Dr Ganesh Subramanian**

Ganesh was appointed in 2002 as a Stroke Physician at Central Manchester University Hospitals. He was involved in setting up the Greater Manchester model from the outset.

Ganesh moved to Nottingham University Hospitals in 2010 as a Stroke Physician. He led the development of MT in East Midlands and is the Chair of Clinical Advisory Group for Stroke in East Midlands. A member of Clinical standards Committee of BASP Ganesh has written various standards including 'stroke service standards'.

**Dr Wayne Sunman**

## In attendance at the panel:

### Mid & South Essex STP Team:

Dr Anita Donley	Independent Chair, Essex Success Regime
Dr Paul Guyler	Stoke Consultant Southend Hospital
Dr Ronan Fenton	Medical Director, Mid & South Essex Success Regime
Tom Abell	Chief Transformation Officer
Dr Donald McGeachy	
Andy Vowles	Programme Director

### Clinical Senate Support Team:

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

## APPENDIX 3: Review panel agenda



### INDEPENDENT CLINICAL REVIEW PANEL

Sponsoring body: Mid & South Essex Sustainability &  
Transformation Partnership (MSE STP)

## A G E N D A

**Date:** Tuesday 17 October 2017

**Time:** Panel members 14.30 hrs to 16.30hrs & **MSE STP** team 15.00 hrs to 15.30 hrs.

#### **TELECONFERENCE:**

Free dial in **0800 9171 950** (from landline) or **0203 4639 697** (from mobile)  
Participant code

**Clinical Senate has been asked to follow up on the clinical review panel of 18 September, focusing on the stroke pathway, and consider whether:**

***“The evidence submitted by the programme demonstrates that the proposed option for the acute stroke care pathway, with initial assessment and treatment including thrombolysis (when clinically indicated) delivered on three sites prior to transfer to a single HASU, is likely to provide a clinically safe and sustainable service compared to the current model?”***

Time	Item
14.30	<p><b>Panel members only</b></p> <p><b>Clinical Review Panel Chair Joanna Douglas</b></p> <p>Welcome, introductions and outline of panel procedure &amp; key lines of enquiry</p>
15.00 – 15.30	<p><b>MSE Team join</b> and provide context setting for the panel</p> <p>General clarification questions from the panel to MSE STP</p>
15.30 – 16.15	<p>MSE members leave call</p> <p><b>Panel members only:</b> private panel discussion</p>
16.15 – 16.30	<p>Summary: key findings and recommendation</p>
16.30	<p>Close</p>
<p><b>Next steps information for panel members:</b></p> <ol style="list-style-type: none"> <li>1) Panel Chair will approve a briefing note for MSE STP / NHS England providing key findings and recommendations of this clinical review panel. This will be supplementary to the report of the clinical review panel of 18 September.</li> <li>2) 13 December 2017 Report to be considered by Clinical Senate Council (<i>NB Council cannot make any material changes to the report or its recommendations</i>)</li> </ol>	