NHS
East of England
Clinical Senate

Review of Clinical Services between Colchester Hospital University NHS FT and Ipswich Hospital NHS Trust

Report of the Independent Clinical Senate Review Panel – 1 November 2017

11 December 2017 – final draft

england.eoeclinicalsenate@nhs.net

Document Version Control

Version	Author/s	Date	Status
V1	Brenda Allen	08/08/17	Draft Template
V1.1	SE	31/10/17	Updating
V2	SE	02/11/17	Post panel first draft
V3	SE	06/11/17	Recs and Findings drafted – to chair
V4	SE	14/11/17	Foreword and formatting – to BB & DT final check before CHUFT & panel
V5 final draft	SE	16/11/17	DT amends – version to SG CHUFT
FINAL	SE	11/12/17	Final version with amend to para 4.21 – to Council

Glossary of abbreviations used in the report

A&E	Accident and Emergency
AHP	Allied Health Professional
CCG	Clinical Commissioning Group
CHUFT	Colchester Hospital University NHS Foundation Trust
CQC	Care Quality Commission
ED	Emergency Department
FBC	Full Business Case
GP	General Practitioner
IHT	Ipswich Hospital NHS Trust
KLOE	Key lines of enquiry
OBC	Outline Business Case
PACs	Picture archiving and communication system (for imaging)
STP	Sustainability and Transformation Partnership
'The Trusts'	Refers to Colchester Hospital University NHS Foundation Trust and Ipswich Hospital NHS Trust as a collective

Table of Contents

1. FOREWORD BY DR DEE TRAUE, CLINICAL SENATE REVIEW PANEL CHAIR

Both nationally, and in Suffolk and North East Essex, the NHS is facing an unprecedented increase in demand. In the context of workforce and financial constraints, innovative approaches to service delivery are essential to meet the changing needs for high quality acute healthcare.

Colchester Hospital University NHS Foundation Trust (CHUFT) and Ipswich Hospital NHS Trust (IHT) have been successfully collaborating for some time to address local clinical challenges, as evidenced by the improved rating received by CHUFT following their most recent CQC inspection. The Trusts are committed to building on this by integrating services across both hospitals with a view to develop new ways of working that will benefit patient care.

In 2016, the Trusts committed to entering a long-term partnership and at the time of the review were at an advanced stage of moving towards a merger to form a single Trust with two hospitals. The preferred model for the partnership is full clinical integration. However, the clinical model will maintain Emergency Department (ED) services, obstetric-led maternity services and 24/7 acute medical take on both hospital sites. This merger is supported by both local Clinical Commissioning Groups and the wider Sustainability and Transformation Partnership.

The East of England Clinical Senate was asked to provide independent clinical advice on the proposals for the initial integration of services in six clinical areas – cardiology, endoscopy, oncology, stoke, trauma & orthopaedics and urology. The Trusts have been proactive in their engagement with clinicians from both organisations, holding a number of workshops to collectively develop proposals for new models of service delivery. The panel saw the potential benefit in bringing clinical teams from both trusts together to provide more resilience and sustainability and to support sub-specialties services and training.

Although the full clinical integration model proposed allowed for “full clinical services consolidation, including a reconfiguration of service and centralisation where appropriate”, it was acknowledged that the proposals presented to the Clinical Senate did not demonstrate major changes to current services and potential benefits to patients were not clear. The Trust team highlighted that these were a starting point and welcomed the challenge from the panel to be more ambitious and innovative in their journey to develop clinical services through the partnership.

I would like to thank the team from the two Trusts for their early engagement with the Senate, the information they provided and their open and informative response to our panel’s questions. The panel hopes that the constructive feedback and challenge provided at this stage will facilitate the ongoing development of innovative models for the provision of sustainable and high quality healthcare for Ipswich, East Suffolk and North East Essex. The Clinical Senate looks forward to engaging with the Trusts in the future as they develop their proposals further.

I am also grateful to all the panel members, in particular our experts by experience, who contributed their time and knowledge to the review process.

Dr Dee Traue

Clinical Senate Review Panel Chair
Clinical Senate Council Member

2. BACKGROUND AND ADVICE REQUEST

2.1 Colchester Hospital University NHS Foundation Trust (CHUFT) and Ipswich Hospital NHS Trust (IHT) provide acute healthcare services in the Suffolk and North East Essex Sustainability and Transformation Partnership (STP) area. They provide secondary services including emergency departments, maternity services, general medicine and general surgery.

2.2 The two Trusts have different CQC ratings. As overall scores, CHUFT was rated as 'inadequate' and at the time of the review panel in 'special measures'[1]; IHT has been rated as good, with an inspection due during summer 2017. The Trusts share a Chief Executive and Chair.

2.3 Both Trusts needed to respond to a number of challenges including increasing difficulty in recruiting and retaining staff and managing financial sustainability.

2.4 In May 2016 the boards of both CHUFT and IHT committed to entering into a long-term partnership, building upon the foundation of collaborative working developed over recent years.

2.5 In October 2016, the two boards approved a strategic outline programme. The first phase of the programme identified a range of scenarios that could provide a viable future through a partnership between the two trusts.

2.6 Clinical Senate was requested to provide a clinical 'sense check' on the developing model for full clinical integration of the two trusts. The scope of the review was the high level model for integration of six clinical services, Endoscopy, Cardiology, Oncology, Stroke, Trauma and Orthopaedics and Urology. Clinical Senate was not being asked to review any other clinical services, formulate or propose any alternative options nor did the scope of the review include consideration of any financial implications, either negative or positive.

[1] *The day following the review panel (2 November 2017) a press release confirmed that the Trust had been removed from special measures following the recent CQC inspection; the Trust had now been given an overall rating of "Requires Improvement" with three quarters of the 40 areas inspected now graded as "Good".*

2.7 The clinical review panel was initially scheduled to take place on 18 September 2017. However, on 5 September 2017, it was agreed with NHS England Midlands and East that the panel would be postponed as there was an imperative for proposals for the another system member to have Clinical Senate input prior to an NHS England Regional Assurance meeting scheduled for 25 September 2017. The date of the review panel for CHUFT / IHT was subsequently agreed to be 1 November 2017.

2.8 Clinical Senate would like to formally thank and acknowledge the CHUFT / IHT team for its flexibility and agreement to move the scheduled panel from 18 September to accommodate the Mid and South Essex STP review.

3. METHODOLOGY & GOVERNANCE

3.1 The Director for Integration and Clinical Senate agreed that the most appropriate methodology would be a single panel to review the high level proposals.

3.2 The CHUFT / IHT team was invited to send representatives to attend the panel, make a short presentation and to respond to questions from the review panel.

3.3 Terms of Reference for the clinical review were agreed and signed.

3.4 Once potential clinical review panel members (Appendix 2) had been invited and accepted they made declarations of interested (Appendix 3) and signed confidentiality agreements. Panel members were then provided with the evidence set from CHUFT/IHT.

3.5 A preparatory telephone conference with panel members was held prior to the panel day to identify key lines of enquiry (KLOE) for the panel consistent with the Terms of Reference for the review. These were included in the final agenda as indicative, but not exclusive areas for discussion.

3.6 The clinical review panel was held in private on 1 November 2017.

3.7 A draft report was sent to panel chair and the CHUFT / IHT team to check for matters of accuracy.

3.8 This, final report, was submitted to the East of England Clinical Senate Council on 13 December 2017 for it to ensure that the clinical review panel met and fulfilled the Terms of Reference for the review. The report was then submitted to the sponsoring organisation and owner of the report, CHUFT / IHT team on 14 December 2017.

3.9 East of England Clinical Senate Council will publish this report on its website at a time agreed with the sponsoring organisation in the Terms of Reference.

4 OVERARCHING KEY FINDINGS

Key Findings

4.1 The panel welcomed the presentation from and discussion with the CHUFT / IHT team (the team) and agreed that it had brought to life the evidence provided for the panel. The panel agreed that the Trusts clearly understood their respective populations and had respect for the needs of the localities.

4.2 The panel supported the direction of travel and agreed that the team was clear that it still had much more work to do. The panel understood that the planning for, and detail of, the merger of clinical specialities was still at a high level stage running in parallel to the formal, technical, legal merger of the Trusts (which was not within the scope of this review). The team confirmed that it saw this review panel as an opportunity to reflect on the Trusts' planned approach with independent external clinical expertise.

4.3 The team advised the panel that the proposal was for one single organisation with two separate hospitals each retaining their own local identity and continuing to provide key services including emergency departments, obstetric led maternity services, general medicine and general surgery on both sites. There was very little planned movement of services from one site to another in the immediate future.

4.4 The team was clear that this was the start of a longer journey; the formal coming together of the Trusts was subject to a lengthy approval and assurance process. However in parallel, the Trusts were keen to start on clinical integration of some services and had been working with clinicians to identify barriers that clinicians came across on a daily basis, looking at how they could be removed, as well as opportunities for joint working across the sites. There were already good examples of teams from both sites working together as a single team delivering improved benefits for patients – the panel heard detail of joint team working in spinal surgery, cardiology and foot and ankle surgery services.

4.5 The panel was advised that the Trusts had in place a five year stretch target to help decrease demand and pressure on the hospitals by reducing face to face outpatient appointments, and a target for 50-60% reduction in follow up appointments. Options being considered included better and increased use of technology, for example virtual clinics and responses from Consultants (to referrals) in IT form, more multi-disciplinary team working, particularly with GPs and primary care.

4.6 The panel heard that the Trusts were working on developing standardised pathways for services across both sites.

4.7 **Workforce:** The panel heard that there was an overall (clinical) vacancy rate across the Trusts of around 15%. The Trusts recognised that recruitment was an issue and intended, through the merger, that they would become a more attractive place to work. The Trusts intended to achieve this by way of providing enhanced career development through training and increased clinical sub-specialisation. The Trusts were also developing stronger links with the University of Suffolk to support the training and development. The panel heard that the Trusts aimed to halve the vacancy rate to around 7%. There was no intention for the majority of clinical staff to have to travel between the hospitals on a regular basis, although there may be some cross site working to support sub-specialisation and training.

4.8 The panel agreed that the Trusts' plans for workplace based training were innovative and could be attractive to staff. However it cautioned that as other Trusts were also developing similar ideas, in order to make the Trusts more attractive, the team needed to ensure its own plans were timely and demonstrated how they would differentiate from proposals from other Trusts.

4.9 Although the panel heard that where both Trusts currently had separate arrangements for overseas recruitment, this was being combined, it agreed that there appeared to be little evidence of other clear plans to support recruitment or retention, particularly in the immediate and short term. The

panel felt that the Trusts' had not taken into account the need to recruit more junior staff, particularly nursing staff, to enable staff to take time out of the clinical areas for training and development. The panel also agreed that there did not appear to be a clear plan for recruitment of medical staff or other specialist Allied Health Professionals, notably Speech and Language Therapists and clinical psychologists to support stroke services.

4.10 The panel recommended that there should be a very clear timeframe for the workforce development in short term and that the Trusts should ensure the training and development of existing nursing and AHP staff to take on traditionally medical roles, would not result in a vacuum for younger and less experienced staff. The panel also recommended the Trusts ensure the plans take into consideration that overseas trained staff would take longer to upskill.

4.11 Overall, whilst it commended the Trusts on their plans for improving training and development, the panel agreed that it was not able to see how, by continuing to run most services at two centres and possibly two departments, the proposals were going to resolve the vacancy and workforce issues. It agreed that as the proposals for upskilling staff, although good, were not going to be imminently implemented, and would therefore take some time to deliver, the plan did not appear to address the current workforce vacancy gaps, or identify how there would be sufficient capacity to safely cover staff released to undertake training and development. This could lead to an even greater retention issue in the short term which had not been addressed.

4.12 **Engagement:** The panel heard that the Trusts had involved a wide range of stakeholder groups including local authorities, primary care, GPs, the Ambulance Trust, Healthwatch and Clinical Commissioning Groups and had established a Clinical Reference Group with membership from all stakeholders. The merger was part of the wider Suffolk and North East Essex Sustainability and Transformation Partnership (STP) plan and had support from CCGs. The panel heard that the Trusts had encountered some challenge with engagement of mental health providers and continued to work on that.

4.13 The team advised that as a partner member of the community health provider for Suffolk with West Suffolk Hospital and Suffolk GP Federation, Ipswich Hospital was well placed and had been successful in engaging with Suffolk County Council around joint working for health and social care. The panel however noted that reference was not made to engagement with Essex County Council which also covered the STP area.

4.14 The team confirmed that it was aware that the mid and South Essex STP was also developing proposals for acute service provision at its three sites and in particular for Stroke services. The team recognised that, either way, the proposals could have an impact on the system and confirmed that it was in dialogue with mid and South Essex.

4.15 The panel expressed concern that the merger plans could have a destabilising effect on the third acute provider in the area, West Suffolk Hospital. The panel heard that West Suffolk Hospital had been involved and engaged in the planning through the STP; that the merger was not considered to be an exclusive arrangement, and the intention was that there should be ongoing collaboration.

4.16 The panel heard that the team recognised that there needed to be wider engagement with patients and carers, and were keen to do so. The Trusts' boards had agreed to take undertake public engagement even though, at this stage, there appears to be no requirement for formal public consultation.

4.17 **Access:** The panel heard that there was not an intention to transfer services from one site to another in the near future. The majority of patients would continue to undergo diagnostic procedures and interventions in their local hospital, although some more specialised procedures may need to be centralised at one or other hospital in the future.

Currently some patients already needed to travel outside of the area for specialised diagnostics and procedures not available at either hospital, which was unlikely to change. The panel heard that both hospitals already ran services out of other (more local) sites, and again that was unlikely to change.

4.18 The panel heard that there had been some discussion with local authorities on public transport, although not to any level of detail or agreement; the Trust recognised that further transport analysis would be required for the full business case. A representative from the Ambulance Trust was a member of the Clinical Reference Group and sighted on any potential plans for increased demand on the Trust. The panel was advised that detailed modelling of services and a transport analysis would be undertaken and that detail included in the full business case (FBC). The team also confirmed that detailed Quality and Impact Assessments would be undertaken as the clinical pathways developed and included in the FBC.

4.19 **Information Technology (IT):** The panel heard that a joint director of IT had recently been appointed and that the plans for development of IT were reasonably well thought through; it congratulated the team on its positive and collaborative working on this area. The team had explained that a solution had been identified that enabled the two (different) clinical record systems to be viewed by staff at both sites.

4.20 The panel heard that information from pathology services could be read across the sites (including West Suffolk Hospital), and that a recently procured system would enable (PACs) radiology imaging to be read across both sites. The team heard that IT development was linked to the STP IT workstream and advised that its vision was to have patient information read across the entire system including primary care.

4.21 The panel heard that the Trust was mindful of the potential opportunities that Telemedicine could provide across a range of clinical areas and this would be considered at a later time. Any consideration would include an audit of current equipment, an understanding of what would be required and the costs involved.

5 Key findings related to the six clinical areas.

5.1 The panel heard that the six clinical areas identified were selected on the basis that they offered the greatest opportunities for improvement. Whilst recognising that approach, the panel agreed that the inclusion of diagnostic services as the enabler and a dependency of all services would have been beneficial and should be considered as soon as possible.

5.2 The panel also agreed that proposals for some clinical services could be more radical and suggested that it would be beneficial to reconsider the proposed options as early as possible rather than incremental changes later.

5.3 Stroke services

5.3.1 The panel heard that both Trusts currently performed well on stroke services with a Hyper Acute Stroke Unit on each site (HASU). While national guidelines recommended increasing the scale of HASUs to cover larger populations, the Trusts agreed that the current high level of performance demonstrated the effectiveness of the existing model. The Trusts planned to standardise the pathway and will explore developing a single new (level two) stroke rehabilitation unit.

5.3.2 The panel understood that currently the sites had different out of hours arrangements, with Ipswich Hospital using Telemedicine and Colchester having a face to face model.

5.3.3 The panel noted that there were workforce issues in stroke services and expressed concern that the current level of performance may not be sustainable unless the workforce issues were addressed.

5.3.4 The panel agreed that in the shorter term, providing a standardised pathway was implemented and workforce issues were resolved, it may be reasonable to continue under the current model. However, the panel agreed that the current model was unlikely to be sustainable in the medium to longer term and consideration should be given to a more radical approach.

5.4 Cardiology

5.4.1 The panel heard that although the cardiology service had different pathways around acute discharge on each site, it was a single team approach. The Trusts were keen to develop repatriation options of some activity from Papworth Hospital and Essex cardiothoracic centre at Basildon and Thurrock Hospital for local access to implantation and follow up.

5.4.2 The panel felt that the case for expansion was not supported with clear plans, for example where interventional radiology would be sited and with current Trust workforce challenges, it was not clear that the required medical, nursing and AHP staff were available to expand the clinical services offered by the Trust and repatriate work from specialist centres.

5.5 Endoscopy

5.5.1 The panel heard that with an ED on both sites, acute endoscopy would best be retained on both sites. Specialist Endoscopic Ultrasound (EUS) would be on a single site, but there were no other plans at present to split emergency and elective procedures. The panel agreed that, again, the plans for the service needed to be aligned with interventional radiology provision.

5.5.2 The team advised that the Trusts had plans to upskill the nursing workforce to be able to provide nurse endoscope practitioners to provide additional capacity.

5.6 Urology

5.6.1 The panel understood that as an outcome of recent pathway changes Southend Hospital now provided specialist urological (cancer) services for Essex. The panel supported the plans for a 'one stop service' approach (for diagnostics) and development of nurse specialist roles to improve access to services.

5.6.2 The panel urged the team to be more ambitious for this service, working with all relevant stakeholders including Urology Consultants, GPs and primary care. The panel agreed that development of a one stop (diagnostic) solution together with a nurse led community service would enable the Trust to pursue a single site model for urology services.

5.7 Oncology

5.7.1 The panel understood that oncology services would continue to be provided from two sites albeit through one single integrated team which would enable more sub-specialisation and expertise.

5.7.2 The panel supported the two site single team approach but agreed that the plans could be more ambitious. For example, consideration could be given to moving some tumour sites to one location rather than two. Working with stakeholders including Macmillan and community services, the Trust may be able to develop ambitious plans for cancer care at home.

5.8 Trauma and orthopaedics

5.8.1 The panel recognised that in-depth analysis has taken place on this area and supported the proposals to have larger teams in sub-specialities with some sub-specialities delivered from a single site. Having a single on-call rota would provide quicker access to emergency surgery for patients and enable increased theatre throughput.

5.8.2 The panel heard that the Trusts had around 1400 fractured neck of femur admissions a year; the capacity issue of needing to manage that volume had helped to inform the proposal to retain elective and non elective surgery on both sites.

5.8.3 The team acknowledged that inpatient length of stay still required improvement and the panel advised that in support of that, there was an opportunity for further discussion and consideration on the development of a surgical elective centre.

6 RECOMMENDATIONS

6.1 The panel agreed that the plans provided and described by the team would be deliverable as fundamentally there was little change early on. The panel agreed that some of the plans lacked ambition and felt that there was a risk that the Trusts were not making the most of the opportunity the merger presented.

6.2 The panel acknowledged that the proposals were still at an early stage of development and were pleased to be able to be invited to provide some input at this point in the planning process. It recognised that following the merger innovation and change would naturally emerge and evolve, but agreed the Trusts needed to undertake, sooner rather than later, more detailed modelling and have in place a number of supporting plans moving forward.

The recommendations of the clinical review panel below have been proposed to support the Trusts in their next steps in developing the cases for clinical integration.

Recommendation 1

6.3 **Communication:** the panel recommended that the Trusts develop a communication strategy for staff, patients, carers and stakeholders. It should set out a clear vision for the clinical integration, what that will look like, what that means and the benefits to each of the stakeholder groups - patients in particular.

6.4 It may be appropriate to lay out this information aligned to the stages of the merger, e.g. next six months, six to 18 months, 18 months to five years.

Recommendation 2

6.5 **Workforce**: the panel recommended that an organisational development plan be developed as early as possible to support the modelling and proposals and provide some reassurance and support for the workforce.

6.6 With retention and recruitment of workforce paramount to delivery of services and moving forward, the plan should include detail of immediate recruitment of medical, nursing and Allied Health Professional staff as well as the medium and longer term plans.

6.7 The panel expressed particular concerns about whether the plans to address the current level of vacancies were realistic and achievable in the short term. The panel therefore recommended that the Trusts undertake detailed modelling to understand the level of cover required to be able to support planned training and development in the short, medium and longer term.

6.8 The Trusts should also consider whether the training and development plans would potentially have an unintended outcome of creating a greater vacuum of junior staff in the interim period.

6.9 In addition, the panel recommended that the organisational development plan be clear on the scale of change required, including the degree of cultural change required to bring the two Trusts into a single organisation.

Recommendation 3

6.10 **Stakeholders and engagement:** The panel recommended that further engagement with stakeholders and especially GPs, primary care, community services, neighbouring STPs and West Suffolk Hospital take place as pathways are developed and that the modelling includes potential impact on those groups. The Trusts should ensure that the intention to reduce face to face outpatient and follow-up appointments in the local hospitals does not result in a shift of workload to GPs, primary care and community services especially.

6.11 The Trusts should also pursue engagement with Suffolk and Essex County Council is respect of transport. The modelling should include both routine and emergency transport of patients between hospital sites and repatriation after specialist treatment.

Recommendation 4

6.12 The panel recommended that diagnostic services be included in this early phase of clinical integration as it would be key to the successful integration of all other clinical services.

Recommendation 5

6.13 The panel recommended that the team look to and take any lessons from the experience of similar mergers and clinical integration of acute Trusts both within and outside of East of England.

6.14 Clinical area specific recommendations

Recommendation 6

6.15 **Stroke Services:** The panel agreed that although the stroke services currently performed highly on both sites, with the workforce issues it may be challenging to sustain that level of delivery in two centres.

6.16 The panel recommended that the Trusts give consideration to a more ambitious and radical service configuration for the medium to long term, for example a single specialist centre. In the interim, the Trusts should look to remove any unnecessary variation across the two centres.

Recommendation 7

6.17 **Cardiology**: The panel recommended that the Trusts look to establish seven day diagnostics provision and standardise the service across the sites before considering repatriation of services. Plans for the cardiology service should be aligned with interventional radiology provision.

Recommendation 8

6.18 **Urology** – the panel recommended that the Trusts explore in more detail one stop diagnostics service and single site working. This should be linked to developments in community services.

Recommendation 9

6.19 **Oncology:** The panel recommended that consideration be given to sub-specialisation of some tumour sites to one location rather than two.

Recommendation 10

6.20 **Trauma and Orthopaedics**: The panel recommended that the team review the option of an elective centre.

6.21 Risks

6.22 The panel was also asked to identify any risks that may have emerged during the discussion, not covered in the recommendations above.

6.23 While the panel supported the proposal for more nurse led services (i.e. endoscopy and urology) it considered there could be a risk that nursing staff were being expected to fill some of the (other) medical gaps.

6.24 The panel also felt there was a risk that the merger could be seen as a 'take-over' by one or other of the Trusts and that the culture and ways of working of that Trust would dominate the new Trust.

6.25 Both the above risks, the panel agreed, could be mitigated through clear messages in the communication strategy and organisational development plan.

6.26 Whilst outside the scope of this review panel and therefore not appropriate to include as a formal recommendation, the panel wished to highlight a potential risk around the formal functional merger to do with consensus and equality across the patch. The panel considered that whilst obviously a single STP, Suffolk and North East Essex appeared to be in different places with some of their respective stakeholders, there was a risk that if a single, unilateral approach was adapted across the work it could result in some inequalities across the two areas. The panel considered that some input needed to be given at specific local levels and with some stakeholders.

END.

APPENDIX 1: Terms of Reference for the review

East of England Clinical Senate

Independent clinical review of the outline Business Case for the Partnership between Colchester Hospital University NHS Foundation Trust and The Ipswich Hospital NHS Trust

01 November 2017

Terms of Reference

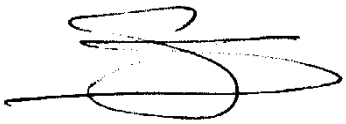
CLINICAL REVIEW: TERMS OF REFERENCE

Title: Clinical review of the Outline Business Case for the Partnership between Colchester Hospital University NHS Foundation Trust (CHUFT) and The Ipswich Hospital NHS Trust (IHT)

Sponsoring bodies: Colchester Hospital University NHS Foundation Trust (CHUFT) & The Ipswich Hospital NHS Trust (IHT)

Terms of Reference agreed by: Shane Gordon

Signature



Dr Shane Gordon, Director of Integration, on behalf of Colchester Hospital University NHS Foundation Trust (CHUFT) & Ipswich Hospital NHS Trust (IHT)

and

Signature 

Dr Bernard Brett, East of England Clinical Senate Chair, on behalf of East of England Clinical Senate

Date: 24 October 2017

Clinical review panel members

Clinical Review Panel members	
Dr Dee Traue (Chair)	Panel Chair, Consultant in Palliative Medicine, East & North Herts NHS Trust Clinical Senate Council member
Dr Baz Barhey	GP and CCG Clinical Director Luton
Teresa Budrey	Regional Director Royal College of Nursing
Dr Daniel Dalton	Psychiatrist & Clinical Director, Hertfordshire Partnership NHS FT
Janet Driver	Head of Surgery, Addenbrookes Hospital
Sara Dunling-Hall	Public Health Registrar, Public Health England
Allaina Eden	Physiotherapist, Papworth Hospital
Dr Catherine Ford	Clinical Psychologist in Stroke
Mike Hewins	Expert by Experience
Mr Tom Holme	Surgeon the Lister Hospital
Mr Pattabiraman Maheshkumar	Consultant Urologist, Queen Elizabeth Hospital Kings Lynn
Ragna Page	Practice Development Nurse Surgery, Queen Elizabeth Hospital Kings Lynn
Dr Raj Shekhar	Consultant Stroke Physician, The Queen Elizabeth Hospital, King's Lynn
Caroline Smith	Expert by Experience
Lisa Webb	Occupational Therapist, Hertfordshire Community NHS Trust
Dr Jennifer Yip	Public Health Consultant, Public Health England

Aims and objectives of the clinical review

In May 2016 the boards of Colchester Hospital University NHS Foundation Trust (CHUFT) and the Ipswich Hospital NHS Trust (IHT) committed to entering into a long-term partnership, building upon the foundation of collaborative working developed over recent years.

In October 2016, the two boards approved a strategic outline programme. The first phase of the programme identified a range of scenarios that could provide a viable future through a partnership between the two trusts.

Clinical Senate has been requested to provide a clinical 'sense check' on the developing model for full clinical integration of the two trusts. The scope of the review was the high level model for integration of six clinical services, Endoscopy, Cardiology, Oncology, Stroke, Trauma and Orthopaedics and Urology.

Scope of the review

The scope of this review is on six clinical service areas only: This includes

- Cardiology
- Endoscopy
- Oncology
- Stroke
- Trauma & Orthopaedics and;
- Urology

Clinical Senate was not being asked to review any other clinical services, formulate or propose any alternative options nor did the scope of the review include consideration of any financial implications, either negative or positive. Any other clinical areas are outside the scope of this clinical review.

Clinical senate is asked to respond to the following question:

Does the evidence demonstrate that the proposed high level model will deliver safe, high quality clinical services for patients (subject to development of detailed model and implementation plans)?

Based on the evidence submitted, Clinical Senate is asked to provide advice and recommendations; this should include, but not be limited to:

i. Any areas of clinical risk the Trusts should give careful attention to during development of the Full Business Case and

ii. Any additional considerations the Trusts should make during the development of the Full Business Case and implementation plans; this might include, for example, the approach to clinical engagement, impact assessment and risk management.

When reviewing the case for change and options appraisal the clinical review panel (the panel) should **consider whether these proposals deliver real benefits to patients. The panel should also identify any significant risks to patient care in these proposals.** The panel should consider benefits and risks in terms of:

- Clinical effectiveness
- Patient safety and management of risks
- Patient experience, including access to services
- Patient reported outcomes.

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). However, if the panel felt that there was an overriding risk this should be highlighted in the panel report.

Questions that may help the panel in assessing the benefit and risk of the proposals include (but are not limited to):

- Is there evidence that the proposals will improve the quality, safety and sustainability of care? (e.g., sustainability of cover, clinical expertise)
- Do the proposals reflect up to date clinical guidelines and national and international best practice e.g. Royal College reports?
- Will the proposals reflect further the delivery of the NHS Outcomes Framework?
- Do the proposals uphold and enhance the rights and pledges in the NHS Constitution?
- Will these proposals meet the current and future healthcare needs of their patients within the given timeframe of the planning framework (i.e. five years)?

- Is there an analysis of the clinical risks in the proposals, and is there an adequate plan to mitigate identified risks?
- Do the proposals demonstrate good alignment with the development of other health and care services, including national policy and planning guidance?
- Do the proposals support better integration of services from the patient perspective?
- 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?
- Does the options appraisal consider a networked approach - cooperation and collaboration with other sites and/or organisations?

The clinical review panel should assess the strength of the evidence base of the case for change and proposed models.

Timeline

The clinical review panel will be held on the 01 November 2017.

Reporting arrangements

The clinical review panel 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 combination of desk top review of documentation, a pre panel teleconference to identify the key lines of enquiry and a review panel meeting to enable presentations and discussions to take place.

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 (on 13 December 2017) 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 following the Council Senate Council meeting of 13 December 2017.

Communication and media handling

Communications will be managed by the sponsoring organisation. Clinical Senate will publish the report once the service change proposal has completed the full NHS England process. This will be agreed with the sponsoring organisation.

Resources

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

The clinical review panel 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 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 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. Background information may include, but is not limited to:

- relevant public health data including population projections, health inequalities, specific health needs,
- activity date (current and planned)
- internal and external reviews and audits,
- relevant impact assessments (e.g. equality, time assessments),

- relevant workforce information (current and planned)
- evidence of alignment with national, regional and local strategies and guidance (e.g. NHS Constitution and outcomes framework, Joint Strategic Needs Assessments, CCG two and five year plans and commissioning intentions, STP implementation plans).

The sponsoring organisation will provide any other additional background information requested by the clinical review panel.

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 panel during the review.

iv. Arrange and bear the cost of suitable accommodation (as advised by clinical senate support panel) 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 panel this may be formed by members of the Clinical Senate Council and Assembly, external experts, and / or others with relevant expertise. It will appoint a Chair of the review panel

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 panel 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 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 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

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 panel

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 of the clinical review panel 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

Chair of review panel:

Dr Dee Traue

Consultant in Palliative Medicine, East & North Herts NHS Trust.
Senate Council member

Involved nationally in the palliative and end of life care arena, working for the charity *Help the Hospices* and as part of the Association for Palliative Medicine executive committee and a member of the RCP Joint Specialty Committee for Palliative Medicine.

Panel Members:

Dr Baz Barhey
Dr Manraj (Baz) Barhey is a GP Trainer in Luton and currently a GP cluster chair. As chair of Luton CCG since authorisation, Baz has experience in strategy and development and has a real focus on clinical quality and keen to reduce variation in health care. His clinical interest is in skin surgery and dermatology.

Teresa Budrey
Teresa Budrey is the Regional Director for the Royal College of Nursing (RCN) Eastern Region, covering the East of England. She leads a team of Trade Unions Officers who provide professional and workplace support to nurses, midwives, HCA's and student nurses. In her role she engages with Lead nurses and Chief Executives across all of the NHS, Independent Sector and Universities, in the 6 East Anglian Counties.

Teresa has worked for the Royal College of Nursing since 2004 in both the East of England and the South East of England.

She trained as a Registered Nurse in Learning Disabilities (RNLD) in Norfolk in 1989 and worked across Norfolk in NHS Learning Disabilities Services for 20 years prior to joining the RCN.

Dr Daniel Dalton
Dr Dalton is a consultant forensic psychiatrist, working at the Broadland Clinic Forensic Service, in Norfolk. He specialises in the assessment and treatment of people with neurodevelopmental disorders. Dr Dalton is Clinical Director for Hertfordshire Partnership University NHS Foundation Trust's Learning Disability and Forensic Services, with a portfolio of IAPT, community learning disability and both acute and longer stay hospital based services, throughout Buckinghamshire, Essex, Hertfordshire, and Norfolk.

Dr Dalton is a member of the National Secure Mental Health Clinical Reference Group, involved in quality assurance, and developing service specifications and quality products for NHS England Specialised Services.

Janet Driver
Qualified as a Registered Nurse, Registered nurse (Child) and Registered Midwife , Janet has worked the majority of her career in maternity with a strong focus on Clinical Governance and Quality. Janet was Head of Midwifery prior to being promoted to Deputy Director of Nursing. She has implemented a new clinical Governance structure to the Trust and leads the Trust CQC action plan.

Following Trust merger Janet has recently been appointed as Head of Nursing for Surgery and is responsible for Nursing and AHPs in Surgery for three sites.

Sara Dunling-Hall
Sara is a Public Health Registrar currently working at Public Health England.

After working in Medical Education for five years, Sara took on an NHS workforce role that focussed on improving the health and wellbeing of NHS staff across the East of England. Following this she became the 'Making Every Contact Count' programme manager for the East of England public health team – a programme that supports staff to use their day to day interactions to encourage positive health and wellbeing behaviour change. In 2013 Sara joined the Public Health Registrar Training Programme, starting her training at Cambridgeshire County Council, before moving to Public Health England in August 2017.

Sara holds an MPhil in Public Health from the University of Cambridge and a BSc in Business Management from the University of East Anglia (Norwich).

Allaina Eden
Allaina is the Physiotherapy Service Lead for cardiothoracic surgery, critical care and cardiology at Papworth Hospital NHS Foundation Trust. Having graduated from University of Hertfordshire in 2001, she completed core physiotherapy rotations at Glenfield Hospital, Leicester, before relocating to Cambridge. She has worked at Papworth Hospital NHS Foundation Trust since 2003, having developed an interest in cardiothoracic respiratory physiotherapy early in her career.

Allaina works clinically in Critical Care, with a special interest in physiotherapy role development, early rehabilitation, and ECMO.

Dr Catherine Ford
Dr Catherine Ford is a Clinical Psychologist specialising in adult neuropsychological rehabilitation in the community and particularly community-based stroke psychology. She studied psychology (BA) and cognitive neuroscience (PhD) at the University of Cambridge, clinical psychology (DClinPsy) at the University of East Anglia and clinical neuropsychology (PGDip) at the University of Bristol.

She currently divides her time between her work as a clinical lecturer and tutor at the Department of Clinical Psychology in the Medical School of the University of East Anglia and clinical practice. She is employed by the Oliver Zangwill Centre for Neuropsychological Rehabilitation, CCS NHST and provides clinical psychology for stroke for the CPFT community neuro-rehabilitation service.

Dr Mike Hewins
Mike retired in 2006 after nine years with the East of England Strategic Health Authority as Education and Commissioning Manager for the East of England.

After a long career in senior management in the commercial sector he was a principal lecturer and consultant for five years at Sutton Coldfield FE College. Mike graduated from Birmingham University in 1966 with an MSc and PhD in chemistry.

Mike remains active in retirement both as a non-executive director of Healthwatch Cambridgeshire & Peterborough and a member of Citizens Senate [Eastern]. This continues his very strong interest in patient participation in voluntary roles within Cambridgeshire and beyond.

Mr Tom Holme
Mr Tom Holme is a Consultant General Surgeon at the Lister Hospital Stevenage. Tom has interests in surgical oncology and colorectal surgery. He is the Secondary Care Representative on CCG, CQC Specialist Advisor and Member Court of Examiners Royal College of Surgeons of England.

Mr Pattabiraman Maheshkumar
After completing his Specialist Urological Training in the West Midlands, was appointed as a Consultant Urologist at Bedford Hospital in 2008. He then moved to Queen Elizabeth Hospital in King's Lynn in 2010. Since then has been involved in various service developments and introduction of new pathways in the department.

He has been the Cancer Lead for urology and currently the Clinical Lead of the department. Actively involved in teaching Medical students from University of Cambridge and UEA.

Ragna Page
Ragna page is the Practice Development Nurse at The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust. Her current remit includes the International Nursing Programme, Mandatory Staff Training, Preceptorship for newly registered nurses and AHP's, Trust wide IV Medications Study days and the Trust's Venepuncture & Cannulation programme.

More recently Ragna has been seconded to be a member of the pilot cohort of the Health Education East of England Non Medical Quality Improvement Fellows; her project, Improving the Emergency Care Pathway for Patients, was formally recognised with a 2nd prize by Heath Education East of England out of all the Quality Improvement Fellows Projects for that year.

Dr Raj Shekhar
Dr Shekhar is lead stroke consultant at the Queen Elizabeth Hospital NHS Foundation Trust. He joined this Trust in 2008 following completion of his higher specialist training in Cardiff and Stroke Sub-specialist training at St Georges Hospital London. Under his innovative and skilled leadership stroke services were established for West Norfolk and the Trust. Since then, he has managed to sustain a nationally recognised consistently well performing comprehensive stroke service. Following pilot of Telemedicine stroke services for the East of England, he has taken the responsibilities of medical lead and successfully maintained this

service to provide out of hours stroke thrombolysis services for a number of hospitals in this region. Dr Shekhar is a principal investigator for stroke research at the hospital. Recently, he has taken clinical managerial responsibilities and following clinical director role for four years, now he has taken the role of Associate Medical Director for the Medicine Directorate.

He is a keen educator and enjoys teaching medical students from UEA and Cambridge medical schools, junior and senior medical trainees as well as stroke MDT. He is OSCE examiner for UEA medical school, MRCP PACES examiner for the Royal College of Physicians, London and is member of panel for Fitness to Practice pilot and OSCE for the GMC (General Medical Council, UK).

Caroline Smith

Caroline worked as a registered dietitian in the NHS for 23 years before retiring. Caroline has secondary progressive MS. I am a lay member of the MS Trust Forward View Project and am a member of the East of England Citizens Senate and the Bedfordshire neurological network.

Lisa Webb

Lisa is an HCPC registered Occupational Therapist (DipCOT, DMS, DipOT), with over 25 years' of Acute Hospital NHS experience. As a clinical therapy lead she has responsibility for both OT's and PT's - in all major in patient specialties and some outpatient services. Lisa has a thorough and complete understanding of the pressures, risks and role of AHPs to facilitate acute Hospital discharges at all stages of their pathway, through to patients' secondary care follow up with a strong emphasis on positive patient experience whist maintaining the highest possible standard of quality and governance within the therapy service from both a service management and staff perspective.

Dr Jennifer Yip

Jennifer is a Consultant in Healthcare Public Health at Public Health England, and an Associate Professor in Public Health Ophthalmology at London School of Hygiene & Tropical Medicine. Jennifer is a member of the Royal College of Ophthalmologists and a Fellow of the Faculty of Public Health of the Royal College of Physicians. She trained in ophthalmology and epidemiology in London, and public health medicine in Cambridge.

Previously, Jennifer was an NIHR academic clinical fellow and clinical lecturer at the University of Cambridge and Global Head of Clinical and Cost Effectiveness at BUPA. Jennifer has also served as NICE cataract clinical guideline committee member. She has published widely on ophthalmic epidemiology and public health, and is an editorial board member of the Royal College of Ophthalmologist Journal, Eye, and Ophthalmic Epidemiology.

In attendance at the panel:

CHUFT/IHT Team

Dr Shane Gordon, Director of Integration, CHUFT

Dr Crawford Jamieson, Medical Director, IHT

Nick Chatten, Special Projects Manager, CHUFT

Clinical Senate Support Team:

Sue Edwards, Head of Clinical Senate East of England, NHS England

Brenda Allen, Project Officer, East of England Clinical Senate, NHS England

APPENDIX 3: Declarations of Interest

Name	Personal pecuniary interest	Personal family interest	Non-personal pecuniary interest	Personal non-pecuniary interest
Dr Dee Traue (Chair)	None	None	None	None
Dr Baz Barhey	None	None	None	None
Teresa Budrey	None	None	None	None
Dr Daniel Dalton	None	None	None	None
Janet Driver	None	None	None	None
Sara Dunling-Hall	None	None	None	None
Allaina Eden	None	None	None	None
Dr Catherine Ford	None	None	None	None
Dr Mike Hewins	None	None	None	None
Mr Tom Holme	None	None	None	None
Mr Pattabiraman Maheshkumar	None	None	None	None
Ragna Page	None	None	None	None
Dr Raj Shekhar	None	None	None	YES*
Caroline Smith	None	None	None	None
Lisa Webb	None	None	None	None
Dr Jennifer Yip	None	None	None	None

* Dr Raj Shekar, declared an non personal non pecuniary interest in that Ipswich Hospital was part of the EoE Regional Telemedicine Service which supported its Stroke Services (Colchester is not).

APPENDIX 4: Agenda

INDEPENDENT CLINICAL REVIEW PANEL

Sponsoring body: Colchester Hospital University NHS Foundation Trust (CHUFT) & Ipswich Hospital NHS Trust (IHT).

FULL DAY A G E N D A

Date: Wednesday 1 November 2017

Time: Panel members 09.15 for 09.30hrs start to 16.30 &

CHUFT / IHT team from 10.00hrs (see below for end time options)

Venue: Bourne Bridge Room, TWI Granta Centre, Granta Park, Cambridge CB21 6AL

Clinical Senate has been asked to respond to the question:

Does the evidence demonstrate that the proposed high level model will deliver safe, high quality clinical services for patients (subject to development of detailed model and implementation plans)?

Based on the evidence submitted, Clinical Senate is asked to provide advice and recommendations; this should include, but not be limited to:

iii. Any areas of clinical risk the Trusts should give careful attention to in during development of the Full Business Case and

iv. Any additional considerations Trusts should make during the development of the Full Business Case and implementation plans; this might include, for example, the approach to clinical engagement, impact assessment and risk management.

**For members on overarching panel only*

Time	Item
09.30 – 10.00	**Granta Room. Review panel members** Welcome, introductions and outline of panel procedure from Clinical Review Panel Chair Dr Dee Traue
10.00 – 10.30 **30 mins**	**Granta Room Review panel members & CHUFT / IHT team** Presentation and context setting for the panel from the CHUFT / IHT team
10.30- 11.15 **45 mins**	General clarification questions from the panel to CHUFT / IHT
11.15- 11.30	Break
11.30 – 12.15 **45 mins**	Panel discussion in private to identify whether further information required from CHUFT / IHT team
12.15 – 13.00	Either: a) Time for further discussion with CHUFT / IHT team or b) Panel discussion resumes in private
13.15-13.45	Break for lunch
13.45 – 15.45 2 hours	Panel discussion resumes (with working break)
15.45 – 16.30	Summary and recommendations
No later than 16.30	Close

Next steps information for panel members:

1) Draft report to CHUFT lead and panel members for points of accuracy check no later than 15 November 2017 with five day turnaround

2) Final report to Clinical Senate Council 13 December 2017 (*NB Council cannot make any material changes to the report or its recommendations)*

Key Lines of Enquiry identified during the pre-panel teleconference 23 October 2017: ***NB: These are indicative and discussion will not be limited to these areas exclusively***	
i)	**Patient Outcomes and Experience** a) Clarity on the aim and intended outcomes for patients
ii)	**Workforce:** a) Medical, Nursing & Allied Health Professional staffing levels to support working across both sites, recruitment and retention plans and joint training and upskilling of staff b) Plans for supporting staff that will work across sites
iii)	**Engagement with stakeholders** **a)** In particular Social Care, CCGs, Primary Care and Ambulance Trust in modelling to identify capacity to enable effective and efficient delivery of the community model of care. **b)** Adjoining STPs and providers re impact of proposals.

APPENDIX 5: Summary of documents provided by sponsoring body as evidence to the panel

a. Final workshop outputs from the six facilitated clinical specialties
    i. Stroke
    ii. Trauma & Orthopaedics
    iii. Urology
    iv. Oncology
    v. Cardiology
    vi. Endoscopy
b. Posters of outputs and highlights from the six facilitated specialty workshops (ref i. to vi. above)
c. The Outline Business Case document in full**
d. Two page summary of the Outline Business Case
e. Draft Programme Initiation Document for the Full Business Case

**NB: *The version provided to clinical review panel members by Senate office had sections 7 & 8 (corporate model and financial case sections) removed as that information was not relevant to the clinical review panel discussion and to reduce the size of the document.*

END.