



East of England  
Clinical Senate



# Mid and South Essex Success Regime



## Report of the Independent Clinical Senate Review Panels of 4 & 5 October 2016

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CONFIDENTIAL



## **Glossary of abbreviations used in the report**

A&E	Accident and Emergency
BCG	Boston Consulting Group (supporting the Mid & South Essex Success Regime)
CCG	Clinical Commissioning Group
ED	Emergency Department
FAU	Frailty assessment unit
GP	General Practitioner
KLOE	Key lines of enquiry
MSESR	Mid and South Essex Success Regime
MLU	Midwifery led unit
PAU	Paediatric Assessment Unit
STP	Sustainability and Transformation Plan



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# 1. FOREWORD BY CLINICAL SENATE CHAIRMAN

The NHS and Local authorities are facing a very challenging future with a rising demand for services largely as a result of demographic changes, but also with the increasing development of novel therapies and they face this demand with significant financial constraints. The Mid and South Essex Success Regime (MSESR) is tackling deep-rooted systemic pressures, with the aim of improving health and care in a system that is financially significantly challenged.

The MSESR do not have the luxury of being able to consider significant capital investment in their estates to facilitate service reorganisation and need to consider key fixed or relatively fixed assets in its forward planning. In addition, the local health system has identified three highly specialised units that would be particularly difficult to re-locate which they have described as their 'givens'.

Clinical Senates have a unique and critically important role in providing independent clinical and patient focussed constructive advice. Our aim in this review was to provide advice and constructive recommendations to enable MSESR team to further develop its ambitious plans. We believe that if our recommendations are considered, with appropriate actions taken, this should help ensure that high quality patient outcomes and experience are delivered.

We thank the Mid and South Essex Success Regime team for asking the Clinical Senate to undertake the review and for providing us with a large amount of information. The panel felt that engaging with us at a relatively early stage should assist the team in developing high quality finalised plans.

I wish to thank all our panel members for giving up their time and giving their attention to this important review. The panel discussions were open, honest and frank and conducted in an appropriately professional and constructive manner. It was a pleasure to chair such an experienced, engaged and motivated group of clinicians and patients.



On behalf of the panel and Clinical Senate, I would like to wish the MSESr team our support in the further development of its plans and we look forward to assisting in the future as and when the proposals are ready for further review.



Dr Bernard Brett  
East of England Clinical Senate Chairman



## 2. BACKGROUND & ADVICE REQUEST

- 2.1 The Essex Success Regime is one of three such programmes in the country, the others are in Devon and Cumbria. The Success Regime is part of the Five Year Forward View<sup>1</sup>, the blueprint for the NHS to take decisive steps to secure high quality, joined up care. It sets out the challenges facing health and care nationally and how radical change is needed to sustain services into the future and improve care for patients.
- 2.2 Clinical Senate undertook a first set of clinical review panels for the Mid and South Essex Success Regime (MSESR) team in June 2016. Those panels reviewed and made recommendations on the initial proposals for Urgent and Emergency Care, Women's (services), Paediatrics and Elective and Emergency surgery.
- 2.3 The recommendations of the clinical review panels were well received by MSESR team. Proposals were subsequently further developed and in July 2016 the MSESR programme requested Clinical Senate to establish a further set of panels for four specific service change proposals to provide an expert clinical opinion, prior to submission of the pre consultation business case to NHS England (Stage 1 assurance) and public consultation.
- 2.4 The scope of this set of clinical review panels was again on acute reconfiguration options only and included a) Emergency medicine [front door, emergency surgery and inpatient services], b) Elective surgery [all types], c) Paediatrics and d) Women's services (maternity and gynaecology).
- 2.5 Other services were out of scope of this review. The scope of the advice did not include the East of England Clinical Senate formulating or proposing any alternative options, nor did the scope of review consider any financial implications, either negative or positive.

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<sup>1</sup> Five Year Forward View, NHS England, October 2014



### 3. METHODOLOGY & GOVERNANCE

- 3.1 Clinical Senate council and the MSESr team agreed that the methodology of a desktop review and panel day used for the clinical review panels held in June 2016 had been successful. It was therefore agreed that a similar but more in depth approach would be used for these clinical reviews with panels held over two days.
- 3.2 It was agreed to hold three separate panels. Two panels on 4 October would each review two service change proposals
- 3.2.1 Panel One: Paediatrics and Women's services and
  - 3.2.2 Panel two: Emergency medicine and Elective surgery
  - 3.2.3 A third, overarching, panel on 5 October to hear and consider the key findings and recommendations of the review panels in the wider scheme of the Essex Success Regime. MSESr was invited to send representatives to attend the panels, make a short contextual presentation and respond to questions from the panel.
- 3.3 Terms of reference for the review were drafted with Boston Consulting Group (BCG) on behalf of MSESr, agreed and signed by Dr Celia Skinner for the Mid and South Essex Success Regime, and Dr Bernard Brett, Chair of East of England Clinical Senate and appointed Chairman of third review panel.
- 3.4 Following receipt of the evidence set, it became apparent that due to the rapid progress of the work, the questions set out in the agreed Terms of Reference were no longer appropriate. Revised questions were agreed at the start of the panels on 4 October:
- a. *Is there clinical agreement with the concept of the red, amber and yellow configuration of care providing improved quality of care to the population of Mid and South Essex?*
  - b. *Comments on the clinical safety of the two preferred options:*
    - i. *Option 1 (red, amber & amber) and*
    - ii. *Option 2 (red, amber & yellow).*



- 3.5 Clinical review panel members (Appendix 2) from within and outside of the East of England Clinical Senate, and patient representatives (experts by experience) were identified. To ensure a diverse range of expertise, the panel included some members from the review panels held in June 2016 with the addition of clinical experts not on any earlier panels.
- 3.6 Once the potential panel members had been invited and accepted they made declarations of interest and signed a confidentiality agreement. The panel members were then provided with the documents and evidence provided by BCG as the evidence for the panel review.
- 3.7 Preparatory telephone conferences with panel members were held prior to the panel day to identify the key lines of enquiry (KLOE) for the panel consistent with the Terms of Reference for the review.
- 3.8 The first two clinical review panels considering service change proposals took place on Tuesday 4 October 2016 and the third panel on 5 October 2016
- 3.9 A draft report was sent to the panel chairs and the MSESr team to check for matters of accuracy.
- 3.10 This, final report, was submitted to the East of England Clinical Senate Council on 20 October 2016 for it to ensure that the clinical review panel met and fulfilled the REVISED Terms of Reference for the review.
- 3.11 This report was then submitted to the sponsoring organisation, Mid and South Essex Success Regime on 27 October 2016.
- 3.12 East of England Clinical Senate will publish this report on its website as agreed with the sponsoring organisation, the Mid and South Essex Success Regime, in the Terms of Reference.



## 4. OVERARCHING COMMENTS AND RECOMMENDATIONS

### Key findings:

- 4.1 This section contains findings and recommendations from the overarching panel held on 5 October 2016. It also includes general comments, findings and recommendations that were common to the other panels. Findings relating to the specific service change proposals panels follow in later sections respective to the service change proposal.

The findings and recommendations that follow in this and later sections of the report are intended to be supportive and not in any way critical of the huge amount of work clearly already undertaken.

- 4.2 The MSESr team was commended by the panel on the level of clinical leadership and involvement in the programme and service change proposals. It was clear that the multi-disciplinary team had looked at innovation and good practice, undertaken benchmarking and brought in external international expertise in quality improvement.

The panel welcomed the degree of openness and honesty shown by the MSESr team during its presentation and panel discussion; the additional information had been extremely helpful for the panel in understanding further context and detail of the proposed service changes.

- 4.3 The case for change was clear; MSESr had demonstrated through its evidence and panel discussions that it was fully cognisant that the degree of challenge in its health and care system included workforce challenges, patient access, experience and outcomes. The panel agreed that the case for change could be strengthened with clear system wide and service specific ambitions and outcomes, cross referenced to the Sustainability and Transformation Strategic Plan.



- 4.4 The need for pace of change was also clear. However, whilst recognising the significant system drivers and need for rapid transformation, the panel was concerned whether the desired proposed pace was achievable whilst appropriately balancing against the need to ensure that the right change and to the right degree was made to best ensure safe, sustainable services. The panel agreed with MSESER that satisfactory patient outcomes and experience should be maintained, with improvement wherever possible, and that the quality and safety of services was paramount – ensuring long-term sustainable services should take priority over speed. The panel agreed that it may be safer to make more radical changes than proposed but over a slightly longer period of time.
- 4.5 The panel understood and supported the direction of travel and, in principle, supported the stated aims of consolidation and re-designation (of services), where appropriate and possible. The panel recognised the value in higher volume, more subspecialised services to help drive quality and efficiency improvements in a sustainable manner.
- 4.6 The panel was advised by MSESER that with an initial five possible variants on two main options for the acute model for the three hospitals in Mid and South Essex, engagement events and discussion had so far identified four key criteria to be applied when considering the options or variants. The key criteria were: a) outcomes and safety, b) access c) workforce and d) efficiency and productivity. The panel was advised that staff and patient engagement so far strongly supported outcomes and safety and workforce as the priority criteria among these four.
- 4.7 The panel heard that a number of ‘givens’ (existing services on sites that would require significant capital investment to relocate) applied to the two primary options shaped the model to identify which services and inter-dependencies would need to continue to be provided on each site. These ‘givens’ were considered by the review panel and the MSESER team responded to a range of questions on this matter. In view of the lack of available capital investment and geographical factors, the reasoning behind the ‘givens’ were better understood. The panel felt that of the three ‘givens’



the location of the Burns unit seemed perhaps the easiest to reconsider but it was also recognised that this service covered a large geographical area and access from the northern end of the East of England needed to be taken into account.

- 4.8 All three clinical review panels had considerable discussion on the two primary acute hospital model options of red amber yellow (RAY) or red amber amber (RAA). Concerns specific to each panel are detailed in the respective sections of this report, with the overarching and common findings and recommendations in this section.
- 4.9 The panel was advised that a red hospital would provide 24 hour fully staffed Emergency Department, amber a fully staffed daytime Emergency Department with overnight ambulance attendances and GP referrals going to a red site and a yellow site providing a 24 hour walk in facility that would be able to stabilise patients for transfer when necessary and appropriate. The yellow site would have a Consultant presence during the day.
- 4.10 The panel heard that all three sites would continue to provide outpatients and ambulatory services, diagnostics, Urgent and Emergency care services, Paediatric Assessment Unit (PAU), a Medical Assessment Unit, a Surgical Assessment Unit, Elective day surgery, and intensive care.
- 4.11 The panel supported the principle of classification of hospitals with centralisation of higher risk / lower volume emergency and elective services with sub-specialisation. The panel supported the principle of having a red hospital for the more challenging and complex emergency work, although it recommended that detailed predicted activity analysis be developed to ensure that physical, workforce and access capacity would be sufficient to meet demand at all times of the day and year.
- 4.12 The panel also supported the principle of having a large elective centre that could treat a high volume of elective work. The panel stated that the regular rotation of a large proportion of staff across the sites would be essential and key to ensuring that workforce skill levels and job satisfaction were maintained across all three sites. The panel agreed that this opportunity could be fully



exploited to develop a centre for Essex that provided at scale, high quality services and care, first class training posts, developing expertise and a sense of pride among its workforce. This should create a centre that staff and patients would want to come to.

- 4.13 The panel could see the benefits of the red hospital and indeed the yellow hospital but felt there was less clear description of the role of the amber hospital in terms of its role within the system. The panel recognised that it had spent more time focussing on the red and yellow sites.
- 4.14 The panel felt that a move to the described red, amber, amber model would provide relatively little change to current provision and would do little to address workforce and sustainability issues. The panel felt that the red, amber, yellow model provided more opportunity for real transformation of services. The panel further felt that the changes could be bolder with greater potential benefits if there was less focus on continuing to provide virtually all current services on all three sites.
- 4.15 The MSESr clearly must determine its preferred location of services. The panel felt however that, based on the evidence and data provided, the lack of the potential for major capital investment, geography, travel times and the current location of services, the red hospital would be best placed on the current Basildon and Thurrock hospital site. Given the location of the radiotherapy bunkers, the proposed location of the cancer centre on the Southend hospital site made sense.
- 4.16 Overall, the panel agreed that neither of the primary models appeared to fully address the current workforce issues in Mid and South Essex. For example, with the current high vacancy rate in Emergency and Urgent Care workforce, the proposal to continue with three 24/7 Emergency Departments (of varying degrees) would not significantly reduce the required number of consultants to meet national guidelines or improve the vacancy rate – this would be dependent upon the hours of consultant presence and cover on each site.



- 4.17 The panel found that the three acute trusts and four mental health and community providers were already working together strategically. However, the panel agreed that there were several areas where further information and evidence would have been beneficial including information on engagement with other stakeholders particularly the East of England Ambulance Trust, social care services, primary care and neighbouring STPs. This is particularly in relation to the key role of these organisations in the successful delivery of MSESr's plans and also ensuring any potential impact on the respective plans and services of those bodies.
- 4.18 Recognising that the MSESr included local authorities, the panels noticed the absence of any local authority representation, and raised questions about the level of involvement of all parties in developing and supporting the proposals.
- 4.19 The panel was informed by MSESr that, in parallel to the service change proposals, other separate workstreams were in progress in respect of the cross cutting themes and enablers, including Estates and IT.
- 4.20 The panel was concerned that the full impact of the need for patient transfer across and within the system had not been worked through. Whilst recognising that it was not an indicator of the full picture, from the evidence provided it appeared that in the model, up to 40% of ambulance transfers would need to be re-directed and a significant number of in-patients would need to be transferred. MSESr advised there had been some discussions with the Ambulance Trust, and that the Trust had committed to undertake its own modelling to understand the impact of the proposals (on its service). There was also a 5-7 year programme in place to upskill ambulance crew in decision making to ensure patients were transported to the appropriate centre. However without the full detail of the model and no final decision on which model would be the preferred one, the panel was concerned that the level of detail was insufficiently worked up to assess the full impact on the Ambulance Trust. The panel also heard that the intention to negotiate with the County Council on public transport service provision had not yet commenced due to the detail of the model not yet being agreed.



- 4.21 There was a lack of clarity in respect of step down and intermediate beds and some contradiction from panel members and evidence. Similarly community hospitals were only mentioned at the overarching panel but, whilst not in the immediate scope of this review, were likely to be important in delivering efficient high quality patient pathways.
- 4.22 The panel noted that whilst the evidence provided detailed information on travel and patient access, it had not included information on any equality or quality impact assessments and risk assessments.

## 4.23 **RECOMMENDATIONS**

### **RECOMMENDATION 1**

- 4.24 The Mid and South Essex Success Regime should reconsider its pace of change. It should continually assess that the pace is balanced with assurance that the right change, and to the right degree, is being undertaken. An appropriately timed, risk assessed sequence of changes should be developed in the implementation plan.

### **RECOMMENDATION 2**

- 4.25 MSESr should look to be more bold and ambitious in its proposals. It should consider where more radical change, over a longer period of time, could provide greater opportunities for improved patient outcomes and experience and in meeting some of the other challenges in the health and care system. The sustainability of services, particularly in relation to workforce, could also benefit from such an approach. This could include for example consideration for consolidation of other sub-specialities such as renal and stroke services and could also consider more profound changes to the designation of its emergency, obstetric and paediatric services.



### **RECOMMENDATION 3**

- 4.26 MSESr should look to strengthen its case for change with clear system wide and service specific ambitions, showing how it linked to the strategic plan and how it would address current and predicted future areas where outcomes are less than optimal. The degree of ambition in terms of benefits needed to be clarified with a clear description and narrative around what will be better for patients, the public and staff.

### **RECOMMENDATION 4**

- 4.27 MSESr should undertake predicted activity modelling and analysis for the preferred model to ensure that physical, workforce and access capacity would be sufficient to meet demand at all times of the day and year on all sites.

### **RECOMMENDATION 5**

- 4.28 MSESr should develop a comprehensive risk assessment using a standardised approach, including the risks to the proposed final model and risks associated with transition. It should include a risk assessment of possible unintended impacts and consequences within and outside of the Mid and South Essex health and care system. It should undertake comprehensive equality and quality impact assessments.

### **RECOMMENDATION 6**

- 4.29 MSESr should undertake full modelling, impact analysis and risk assessments for access and transport, working with both the Ambulance Trust and County Council to ensure appropriate and adequate provision. This should consider the full range from Ambulance service requirements through to public transport, impact on road infrastructure and parking capacity.



## **RECOMMENDATION 7**

- 4.30 The detail of workforce planning is outside the scope of the Clinical Senate's review. However, we would expect that once a final option was chosen there would be a clear recruitment and retention strategy, plans for training and culture and organisational development. There needed to be a proper arrangement for staff across the sites to ensure skill levels were maintained for the 'one team' approach, with detail of how staff would be supported where additional travel and / or relocation would be required.

## **RECOMMENDATION 8**

- 4.31 MSESr should develop a communication strategy for the public, patients, staff and other stakeholders. This should cover the engagement and options appraisal process as well as the eventual implementation phase. Communication should include the need for change and the risk of doing nothing. It should describe the ambition of the programme and the outcomes and benefits that will be achieved. It should clearly describe the offer of each trust for its preferred model (i.e. red amber yellow or red amber amber), what that means for patients, where they go and how they access services.

## **RECOMMENDATION 9**

- 4.32 MSESr should ensure that terminology and colour coding system for acute trusts (e.g. red amber yellow) was consistent with that of neighbouring STPs and national guidance to ensure clarity for patients, the public and staff.

## **RECOMMENDATION 10**

- 4.33 The panel understood that IT was one of the separate enabling workstreams but recommended that the detail of how patient information would be joined up to support the patient journey should be included as part of the patient pathway development and overall communication strategy.



## 5. KEY FINDINGS AND RECOMMENDATIONS:

### Line of enquiry: urgent and emergency care

- 5.1 The panel recognised that it was difficult and challenging for any commissioner needing to make significant changes in urgent and emergency care provision. Commissioners had to balance the need to ensure that patients and the public had easy access, alongside the need to deliver safe, high quality, appropriate services, which are sustainable and viable in the longer term. Despite planning changes to improve the overall care provision there is always the significant chance of challenge for any proposal to scale down or change services on a given site. However, commissioners and Clinical Senate applied the same fundamental principle to service change proposals – ensuring that patient outcomes and experience and the safety and quality of services were paramount in its respective considerations.
- 5.2 The panel heard that over the last five years, Mid and South Essex had seen a 15% increase in A&E attendances and 12% increase in admissions, both of which were higher than the national trend. Four hour waiting times for A&E were below the national average and across the area there were significant medical and nursing vacancies. The Success Regime presented an opportunity to address those and other challenges through reconfiguration with economies of scale, more efficient utilisation of staff, enhanced training opportunities and greater specialisation of clinical staff and equipment.
- 5.3 The panel heard that in the red amber yellow model, a red hospital site would provide a 24 hour fully staffed Emergency Department with a full array of back up services, an amber site a fully staffed daytime Emergency Department with overnight ambulance conveyances going direct to a red site, and a yellow site provide a 24 hour walk in facility also accepting day time GP referrals that would be able to treat the majority of patients and stabilise patients for transfer when necessary and appropriate. The yellow site would have a consultant presence during the day.



- 5.4 The panel expressed several concerns regarding the yellow model.
- 5.4.1 Firstly it may be difficult to ensure robust processes were in place to deal with the occasional walk-in patient who had a serious underlying condition or those who had an apparent less serious condition with subsequent major deterioration (those with abdominal pain who were initially felt not to have an acute surgical abdomen who are then found to have a major illness was one group that was discussed).
- 5.4.2 Secondly, it may prove more difficult to maintain safe staffing levels on the yellow site as this may be a less attractive place to work as a clinician with an emergency interest.
- 5.4.3 Thirdly, patients and the public may over time come to consider the yellow A&E as providing less than a standard A&E or Emergency Department service. This could lead over time to the Walk In Centre experiencing a 'creep' of its activity and staff to other Emergency Departments elsewhere.
- 5.5 The panel questioned the long term sustainability and viability of a yellow site walk in centre. Taking into account the current high vacancy rates in Accident and Emergency departments across Mid and South Essex and the (above mentioned) potential 'creep' of patients to other Accident and Emergency facilities, this would have a negative impact on staff recruitment, retention and morale, leading to the possible need to use Agency staff resulting an under-utilised, less high quality and costly service. The panel believed it may well be safer, more sustainable and clearer to consider establishing a minor injuries and illness centre on the yellow site instead of attempting to maintain a full range of emergency services.
- 5.6 The panel found that, despite there being a frailty assessment unit (FAU) on all three sites, no clear pathway for redirection to other appropriate pathways or sites, from the FAU had been worked up. The panel discussed as an example Fractured Neck of Femur which accounted for the largest number of emergency surgical procedures. The panel found that Fractured Neck of Femur would be an 'Urgent Elective' case, and treated as an inpatient elective



at either an amber or yellow site. The panel reflected that the lack of clarity for the pathway was confusing and needed to be clearly defined. This patient group often needed the input of a full range of other emergency specialities.

- 5.7 The panel agreed that ensuring appropriate naming and ‘badging’ of a yellow site walk in centre was essential and would aid with patient and public expectations and drive behaviour. The wider communication strategy and detailed information on urgent and emergency care services should be explicit about which services were available and where.

## 5.8 RECOMMENDATIONS

**Below are the recommendations of the review panel specific to this service change proposal. Recommendations 1 – 10 also apply to this section.**

### RECOMMENDATION 11

- 5.9 If the preferred model for acute services included a yellow site with Walk In Centre, the MSESr should put in place careful and regular monitoring and evaluation of activity, patient outcomes and experience.

### RECOMMENDATION 12

- 5.10 MSESr should have well developed robust pathways for patient flow and transfer especially, but not exclusively, for:
- a) patients arriving at the yellow walk-in centre, who subsequently become more high risk after initial contact, e.g. patients with abdominal pain;
  - b) patients requiring transfer e.g. arriving at either a yellow walk in centre or amber site A&E out of hours;
  - c) patients arriving at the Frailty Assessment Unit and requiring transfer to other sites or redirection into other patient pathways.



### **RECOMMENDATION 13**

- 5.11 MSESr should undertake detailed predictive modelling to ensure sufficient volumes to justify the provision of a fully staffed 24 hour Surgical Assessment Unit at the yellow site which would not provide emergency surgery.

### **RECOMMENDATION 14**

- 5.12 MSESr should develop clear transition plans including timelines and communication strategy to ensure patients understand the changes, what it means for them and how and where they access emergency and urgent care services in their area.

### **RECOMMENDATION 15**

- 5.13 MSESr should ensure the appropriate naming and badging of a yellow site walk in centre facility to drive patient expectations and behaviour. The wider communication strategy and detailed information on urgent and emergency care services should be explicit about which services were available and where.



## 6. KEY FINDINGS AND RECOMMENDATIONS:

### Line of enquiry: Elective surgery

- 6.1 The panel felt that it had to consider emergency surgical services whilst looking at elective services because of the clear interaction, co-dependencies and workforce requirements.
- 6.2 MSESr confirmed that all three sites would provide a surgical assessment unit; that emergency surgery would be provided at the red site, daytime emergency and scheduled non-elective inpatient surgery at the amber site. A red hospital would provide elective surgery for a limited number of specific specialities only (e.g. spinal surgery, and possible vascular surgery). The amber and yellow sites would provide elective surgery, consolidated on a sub-specialty level. Elective day surgery would continue to be provided on all three sites.
- 6.3 The panel was informed that around 1500 operations were cancelled across Mid and South Essex annually and the three sites had varying degrees of patient outcomes. The Success Regime offered the opportunity to consolidate the services across the three sites.
- 6.4 As stated in para 4.12, the panel supported an at scale elective surgery centre. The panel found however that the opportunity for MSESr to develop and exploit the potential and benefits of such a centre for the local population had not been translated into any desired outcomes or benefits to service users or staff.
- 6.5 The panel supported the principle of staff working across the three sites but agreed that detailed workforce (and associated travel) modelling was a crucial element of the redesign and needed to be undertaken in line with pathway redesign. Consideration also needed to be given to staff who commonly worked in different speciality areas (e.g. cancer surgeons also carried out other major general surgery) and who could find that their caseload was split across sites due to the nature of the type of surgery required.



- 6.6 The panel agreed that there needed to be further modelling for the fit between emergency and specialist elective surgery. For example, the panel heard that major elective and emergency vascular surgery would be carried out on different sites, that thrombolysis would be on all three sites but with only one Hyper-acute stroke unit (HASU). There was currently no Interventional Radiology service in the area. The panel agreed that further detailed modelling needed to be carried out in particular on the stroke pathway.
- 6.7 Similarly, an amber or yellow hospital that did not carry out any emergency surgery may not be equipped with the appropriate surgical equipment to provide specialist elective surgery. This detailed level of information should be included in the capacity modelling.

## 6.8 RECOMMENDATIONS

**Below are the recommendations of the review panel specific to this service change proposal. Recommendations 1 – 10 also apply to this section.**

### RECOMMENDATION 16

- 6.9 MSESr should identify clear outcomes and benefits to patients, public and staff of an at scale elective surgery centre, linking back to how that fits with the delivery of the wider strategic plan.

### RECOMMENDATION 17

- 6.10 Once the final model is chosen, MSESr should undertake capacity modelling and detailed patient pathway redesign to ensure that the preferred acute model was fully informed. It should ensure that each sub-speciality should have its own framework and pathways.

### RECOMMENDATION 18

- 6.11 MSESr should ensure that its workforce modelling included adequate resource and resilience to support staff movement across and within the sites.



## 7 KEY FINDINGS AND RECOMMENDATIONS:

### Line of enquiry: Paediatrics

- 7.1 The panel heard that all three sites in Mid and South Essex currently provided a degree of paediatric care. With a high junior doctor and paediatric nurse vacancy rate of 10-13%, variable outcomes and increasing non-elective demand, the Success Regime offered an opportunity to improve services through reconfiguration.
- 7.2 MSESr advised that all three sites would have child assessment units, elective day surgery and outpatients. Areas still under consideration included whether to consolidate in-patient surgery to one or two sites (a yellow site would see, stabilise and transfer paediatric emergency patients requiring surgery, and have a 24 hour paediatric assessment unit for non-surgical patients, but would have no in-patient facility) and the detail of the paediatric emergency facility. The panel found that to inform that and aid pathway redesign, detailed analysis of case-mix review, re-admissions and early discharges was underway.
- 7.3 The panel supported the direction of travel but felt that the case for change needed to be strengthened including the expected improvements to measurable outcomes. The panel agreed that any benefits for patients or their families or carers had not been expressed, nor was there any detail on provision of and access to mental health services for children and young people. The case for change for separation of paediatric elective and emergency surgery was unclear and the panel felt that this also needed to be strengthened. Careful consideration needed to be made around maintaining and developing appropriate skills on each site for a range of staff including surgeons, anaesthetists, paediatricians and nurses.



- 7.4 The current expectation is that children under two years of age are only operated on in units with suitably qualified and experienced surgical and anaesthetic staff. The panel was further advised by the MSESr team that in future this recommendation may extend to children under five years of age. The panel further noted that the volume of many paediatric procedures was relatively low. These factors all supported the consideration of consolidation of paediatric surgical services for those under five years of age onto one site. The panel also felt that there would be benefits in the same site treating emergency and elective cases. Such change would have the potential to de-skill staff on other sites to stabilise and transfer children as and when required and how this could be safely planned for would need to be carefully considered.
- 7.5 MSESr informed the panel that in order to address some of the workforce challenges, it was looking at new ways of working and national good practice. Some nurses were already working across the sites. MSESr was having discussions with East of England Deanery on different opportunities for paediatric training e.g. GPs with Special Interest and with local universities. Work with primary care too was still in its infancy.
- 7.6 The panel was unclear on the level of engagement with and support from primary and community care

## 7.7 RECOMMENDATIONS

**Below are the recommendations of the review panel specific to this service change proposal. Recommendations 1 – 10 also apply to this section.**

### RECOMMENDATION 19

- 7.8 MSESr should strengthen the case for change for paediatric services. It should include the benefits for patients, their families and carers, and staff and include detail of mental health services for children and young people.



## **RECOMMENDATION 20**

- 7.9 The panel recommended that MSESr should look at how it could strengthen engagement with primary and community care to support admission prevention particularly.

## **RECOMMENDATION 21**

- 7.10 The MSESr should consider again the viability and value of maintaining a 24 hour paediatric assessment unit on the yellow site as this might be difficult to staff appropriately, could hamper attempts to resolve workforce issues and may not be as safe as consolidating all overnight and longer admissions on one or two sites.

## **RECOMMENDATION 22**

- 7.11 MSESr should carefully consider the interdependencies of obstetric and neonatal care. If obstetrician lead care was offered on any site this would require the continuation of at least a Special Care Baby Unit.



## 8 KEY FINDINGS AND RECOMMENDATIONS:

### Line of enquiry: Women's services

- 8.1 The panel heard that currently all three sites have a maternity unit. However the service faces considerable workforce challenges with high vacancy rates and financial pressures.
- 8.2 MSESr advised the panel that the majority of women's medicine would continue to be offered at all three sites, including routine and benign gynaecology, with some specialised obstetrics and gynaecology services consolidated onto one site. High risk obstetrics and foetal medicine would also be provided at one site.
- 8.3 The panel found that workforce numbers still had to be modelled; MSESr assured the panel that workforce modelling would be fully compliant with national standards and guidelines. MSESr team had also looked at national good practice.
- 8.4 The panel heard that a previous proposal for a free standing midwifery led unit (MLU) had been considered but discounted on clinical safety grounds. Instead, an obstetrician led unit of less than 2500 births alongside a midwifery led unit on one site was being considered. MSESr advised that model would enable the reduction of neonatal cover from Level 2 neonatal unit to special care baby unit (Level 1).
- 8.5 The panel felt that the case for change and evidence could have been strengthened with more reference to the 'baby' in the maternity model. There was also a lack of reference to neonatal services in the evidence provided.
- 8.6 The panel supported the desire to develop a Specialised Obstetric unit to deliver high quality care to mothers and their babies for higher risk pregnancies with greater senior obstetric, anaesthetic and neonatal paediatrician cover. The panel noted that this would require increased capacity and more hours of consultant cover.



## 8.7 **RECOMMENDATIONS**

**Below are the recommendations of the review panel specific to this service change proposal. Recommendations 1 – 10 also apply to this section.**

### **RECOMMENDATION 23**

- 8.8 MSESr should be clear on its staffing model and skill mix required to meet future demand for the Specialist Obstetric Unit.

**END**



## APPENDIX 1: Terms of Reference for the review



East of England  
Clinical Senate

# East of England Clinical Senate Independent clinical review panel(s) for the Essex Success Regime

Mid and South Essex Success Regime, Clinical Review Panels for services that make up part of the acute reconfiguration (NHS England service change assurance process Stage 1 check)

4 & 5 October 2016

## Terms of Reference



## CLINICAL REVIEW: TERMS OF REFERENCE

**Title:** Mid and South Essex Success Regime, Clinical Review Panels for services that make up part of the acute reconfiguration (NHS England service change assurance process Stage 1 check)

**Sponsoring body:** Mid and South Essex Success Regime

**Clinical senate:** East of England

**Terms of reference agreed by:**

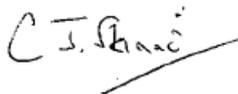
**Signature**



**Dr Bernard Brett, East of England Clinical Senate Chair**

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

**Signature**



**Dr Celia Skinner on behalf of Mid and South Essex Success Regime**

**Date: 19 September 2016**



## Clinical review team members

Panel One Paediatrics and Women's Services (maternity & gynaecology) 4 <sup>th</sup> October 2016	
Deirdre Fowler (Chair)	Panel Chair, Clinical Senate Council Member, Director of Nursing, Midwifery and Quality, Hinchingsbrooke Hospital
Dr Sandra Calvert	Consultant Neonatologist London (Retired)
Rev Erica Crust (papers only)	Manager Rainforest Children's Outpatient and Nurse led Unit, Paediatric Rheumatology Nurse, Peterborough and Stamford NHS Trust, Senate Assembly member
Dr Melanie Clements	Medical Director Hinchingsbrooke Hospital and Consultant Paediatrician (West Suffolk Hospital)
Joan Douglas ( <i>NB note similar name to chair of panel two</i> )	Head of Midwifery/Interim Lead Midwife for Safeguarding Children Surgery, Homerton Hospital
Angela Helleur	Improvement Director, NHS Improvement (London)
Angela Horsley	Head of Clinical Network – Maternity & Children East Midlands Clinical Networks & Senate
Dr Fatemeh Hoveyda	Consultant Obstetrician, Addenbrookes Hospital, Senate Assembly member
Dr Mike Lane	GP, Wandsworth CCG clinical lead, RCGP maternity lead for London
Trish Ryan	Head of Midwifery Luton & Dunstable Hospital, Senate Assembly member
Annemarie Smith	Expert by experience
Caroline Smith	Expert by Experience
Dr David Vickers	Consultant Paediatrician, Cambridge Community Services, Senate Assembly member
Ann Walker	Clinical Midwifery Manager, Norfolk & Norwich Hospital, Senate Assembly member



Panel Two Emergency medicine and elective surgery 4<sup>th</sup> October 2016

Joanna Douglas	Panel Chair, Clinical Senate Council Member, CEO Allied Health Professionals Suffolk CIC
Andrew Bateman	Clinical Senate Council Member, Chartered Physiotherapist and manager Oliver Zangwill Centre for Neuropsychological Rehabilitation (Ely, UK)
Gillian Bowden	Clinical Senate Council Member, Consultant Clinical Psychologist, Norfolk and Suffolk NHS Trust
Rev Erica Crust	Manager Rainforest Children's Outpatient and Nurse led Unit, Paediatric Rheumatology Nurse, Peterborough and Stamford NHS Trust, Senate Assembly member
Dr William Denby	Hampshire GP & practice lead for the local Vanguard/MCP
Ruth Derrett	Head of Transformation, The Queen Elizabeth Hospital King's Lynn, Senate Assembly member
Dr Robert Florance (papers only)	Consultant in Emergency Medicine, Queen Elizabeth Hospital Kings Lynn, Senate assembly member.
Claire French	Expert by Experience
Rachel Hulse	James Paget Hospital
Dr Adedayo (Dayo) Kuku	Respiratory Clinical Lead GP Bedfordshire Clinical Commissioning Group and Chair of Bedoc, Senate Assembly member
Joanne Pope	Senior Service Specialist, Specialised Commissioning NHS England – Midlands and East (East of England)
Lesley Standring	Integration Lead, West Suffolk Hospital, Senate Assembly member
Mr Rakesh Uppal	Cardiothoracic surgeon, St Bartholomew's London
Mr Martin Wood	Trauma and Orthopaedics Consultant, West Suffolk Hospital



Panel three Overarching panel 5<sup>th</sup> October

Dr Bernard Brett	Chair of Panel, Clinical Senate Chair, consultant.
Andrew Bateman	Clinical Senate Council Member, Chartered Physiotherapist and manager Oliver Zangwill Centre for Neuropsychological Rehabilitation (Ely, UK)
Gillian Bowden	Clinical Senate Council Member, Consultant Clinical Psychologist, Norfolk and Suffolk NHS Trust
Dr Melanie Clements	Medical Director Hinchingbrooke Hospital and Consultant Paediatrician (West Suffolk Hospital)
Rev Erica Crust	Manager Rainforest Children's Outpatient and Nurse led Unit, Paediatric Rheumatology Nurse, Peterborough and Stamford NHS Trust, Senate Assembly member
Dr William Denby	GP, Kent
Ruth Derrett	Head of Transformation, The Queen Elizabeth Hospital King's Lynn, Senate Assembly member
Dr Robert Florance	Consultant in Emergency Medicine, Queen Elizabeth Hospital Kings Lynn, Senate assembly member.
Claire French	Expert by Experience
Rachel Hulse	James Paget Hospital, Senate Assembly member
Dr Adedayo (Dayo) Kuku	Respiratory Clinical Lead GP Bedfordshire Clinical Commissioning Group and Chair of Bedoc, Senate Assembly member.
Dr Harriet Nicholls	Consultant obstetric anaesthetist, Luton & Dunstable Hospital, Senate Assembly member
Mr Nadim Noor	consultant Vascular and General Surgeon, Bedford Hospital
Joanne Pope	Senior Service Specialist, Specialised Commissioning NHS England – Midlands and East (East of England)
Caroline Smith	Expert by Experience
Dr David Vickers	Consultant Paediatrician, Cambridge Community Services, Senate Assembly member
Ann Walker	Clinical Midwifery Manager, Norfolk & Norwich Hospital



## Aims and objectives of the clinical review

The Essex Success Regime submitted initial proposals for the reconfiguration of services across Mid and South Essex to the Clinical Senate in June 2016. The Essex Success Regime is now seeking Stage 1 assurance (on a selected number of services – see below) prior to submission of pre consultation business case to NHS England and public consultation.

The Essex Success Regime will seek Stage 2 assurance post consultation in late 2016 / early 2017.

## Scope of the review

The Mid and South Essex Success Regime is a system wide programme encompassing prevention, primary, community, mental health and social care, acute reconfiguration, ambulance, 111 and out of hours, localities, frailty, maternity, cancer and dementia.

The scope of this review is on acute reconfiguration options only. This includes

- Emergency medicine [front door, emergency surgery and in-patient services]
- Elective surgery [all types]
- Paediatrics
- Women's services (maternity and gynaecology)

Clinical Senate has been provided with information on the wider programme but this is out of scope of these review panels and is for context only. This includes information on:

- Prevention, primary, community, mental health and social care, ambulance, 111 and out of hours, localities, frailty, maternity, cancer and dementia

These areas will be included at subsequent reviews.

Clinical Senate is asked to review the evidence provided and make its recommendations:



- i. Are the proposed models supported by appropriate evidence to demonstrate that it / they have a sound clinical evidence base?
- ii. Do the acute reconfiguration options meet the stated goals of redesignate, separate and consolidate?
- iii. Does the evidence demonstrate that the proposed high level model will deliver safe, high quality services (subject to development of detailed model and implementation plans)

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 review panels will be held on the 4 and 5 October 2016.

### Reporting arrangements

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

### Methodology

The review will be undertaken by a combination of desk top review of documentation 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 to ensure it has met the agreed terms of reference and to agree the report.

The final report will be submitted to the sponsoring organisation by 28 October 2016

### 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 team, including setting up the meetings and other duties as appropriate.

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

### Accountability and Governance

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

The East of England Clinical Senate is a non statutory advisory body and will submit the report to the sponsoring organisation.

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

### Functions, responsibilities and roles

The **sponsoring organisation** will



- i. provide the clinical review panel with the case for change, options appraisal and relevant background and current information, identifying relevant best practice and guidance. Background information may include, but is not limited to:
  - relevant public health data including population projections, health inequalities, specific health needs
  - activity data (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).

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

- ii. respond within the agreed timescale to the draft report on matter of factual inaccuracy.
- iii. undertake not to attempt to unduly influence any members of the clinical review team during the review.
- iv. Arrange and bear the cost of suitable accommodation (as advised by clinical senate support team) for the panel and panel members.

#### **Clinical Senate Council and the sponsoring organisation will**

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

#### **Clinical Senate Council will**

- i. appoint a clinical review team, this may be formed by members of the senate, external experts, and / or others with relevant expertise. It will appoint a chair or lead member.
- ii. endorse the terms of reference, timetable and methodology for the review



- iii. consider the review recommendations and report (and may wish to make further recommendations)
- iv. provide suitable support to the team and
- v. submit the final report to the sponsoring organisation

**Clinical review team** will

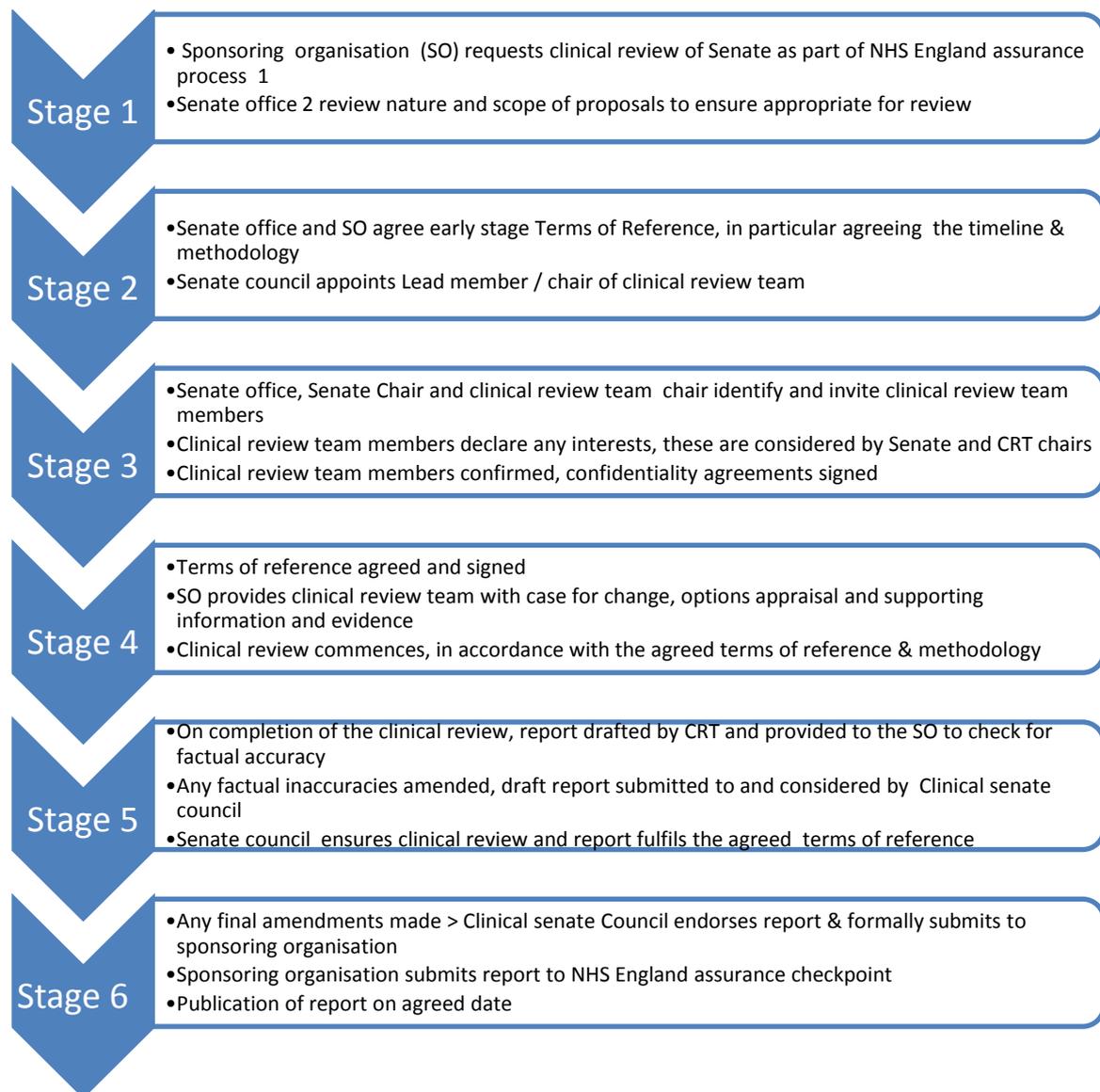
- i. undertake its review in line with the methodology agreed in the terms of reference
- ii. follow the report template and provide the sponsoring organisation with a draft report to check for factual inaccuracies.
- iii. submit the draft report to Clinical Senate Council for comments and will consider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

**Clinical review team members** will undertake to

- i. Declare any conflicts of interest and sign a confidentiality agreement prior to having sight of the full evidence and information
- ii. commit fully to the review and attend all briefings, meetings, interviews, panels etc. that are part of the review ( as defined in methodology).
- iii. contribute fully to the process and review report
- iv. ensure that the report accurately represents the consensus of opinion of the clinical review team
- v. comply with a confidentiality agreement and not discuss the scope of the review nor the content of the draft or final report with anyone not immediately involved in it. Additionally they will declare, to the chair or lead member of the clinical review team and the Head of Clinical Senate, any conflict of interest that may materialise during the review.



## Summary of process



## APPENDIX 2: Membership of the review panel

### Chairman of review panel:

#### **Dr Bernard Brett**

#### **Deputy Responsible Officer and Consultant Gastroenterologist James Paget University Hospitals NHS Foundation Trust**

Dr Bernard Brett is a consultant in Gastroenterology and General Internal Medicine based at the James Paget University Hospitals NHS Foundation Trust.

His clinical interests include Bowel Cancer Screening (he has been an accredited bowel cancer screening colonoscopist for the last 7 years), Therapeutic Endoscopy and ERCP. Bernard has held several senior management posts including that of Medical Director, Responsible Officer, Deputy Medical Director, Divisional Director, Director of Patient Flow and Appraisal lead.

### Panel members:

#### **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). Has led 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 Gillian Bowden**

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

#### **Dr Sandra Calvert**

A retired consultant neonatologist with a special interest in the respiratory management of babies. Qualified in 1976 from Cambridge University. She trained in many large internationally acclaimed neonatal units in the UK, Canada and the USA including Oxford Women's College Hospital, Toronto and the Women and Infant's Hospital, Rhode Island.

#### **Dr Melanie Clements**

#### **Medical Director at Hinchingsbrooke Health Care NHS Trust.**

A Consultant Paediatrician with an interest in improving quality and transformational change. She was the Clinical Director for the maternity, newborn, children and young people Strategic Clinical Network before moving within NHS England to her current role. She has held national roles as Clinical Lead for children and young people's emergency and urgent



with the NHS Institute for Innovation and Improvement and with the Royal College of Paediatrics and child health as part of their invited review team and as project executive for a quality improvement project.

### **Dr William Denby**

Qualified as a GP in Hampshire in 2016. His career so far has included foundation posts, a varied SHO level career including a GP Vocational Training Scheme in Portsmouth, and also 8 years' service in the Royal Navy. Clinically his interests are in Dermatology, Paediatrics and Occupational Health

### **Ruth Derrett**

### **Revd. Erica Crust Paediatric Sister**

#### **Paediatric Rheumatology Nurse at Peterborough and Stamford NHS Trust.**

Manage/lead the Rainforest Children's Outpatient and Nurse led Unit and is the Paediatric Rheumatology Nurse at Peterborough and Stamford NHS Trust. (shared care with Queens Medical Centre Nottingham) . Working on a 2 year CQUIN project for the transition of Children and Young People into Adult Services.

Previous experience includes the Paediatric acute assessment unit, Paediatric day surgery and Paediatric Inpatient services. Adult Accident and Emergency Dept., Geriatrics and Adult Renal Transplant and Dialysis.

### **Joan Douglas**

#### **Head of Midwifery/Supervisor of Midwives.**

A midwife for over 25years, working in a number of London maternity units. Privileged to be a part of one of the first caseloading midwifery teams providing homebirths alongside provision of midwifery care to women with mental health concerns in 1993. Spent the last 11 years working in East London at the Homerton University Hospital NHS Foundation Trust and 9 years as Head of Midwifery.

### **Joanna Douglas**

#### **Chief Executive, Allied Health Professionals Suffolk**

### **Dr Robert Florance**

#### **Consultant in Emergency Medicine, Queen Elizabeth Hospital Kings Lynn**

Senate assembly member.

### **Deirdre Fowler**

Director of Nursing, Midwifery and Quality at Hinchingsbrooke Health Care NHS Trust since May 2014. Co-chairs the Cambridgeshire and Peterborough STP maternity and neonatal clinical working group and has a keen interest in system-wide collaboration and transformation.

She has a wealth of experience in the NHS after registering as a nurse in Dublin in 1985 and subsequently as a midwife in 1994 at Croydon and Carshalton Faculty of Midwifery. In 2002 she joined the faculty of midwifery at the University of Nottingham as a lecturer before returning to the NHS as a matron in Lincolnshire in 2010. She went on to become Head of



Midwifery and GM for Women's Services at Doncaster and Bassetlaw NHS Foundation Trust in 2011, then in January 2013 gained a place on the Trust Board as acting Director of Nursing. She holds a BSc Hons, PGDip Ed and an MSc Midwifery.

### **Claire French**

#### **Expert by Experience**

Worked with the NHS, locally, regionally and nationally as an expert patient for fifteen years. Also the experiential knowledge that has been gained as a patient with a hereditary neurological condition is invaluable to these roles. Successfully gained a Health and Social studies degree and Disability Equality practitioner post graduate certificate.

Currently, involved with NHS Citizen and as the East of England Clinical Networks co-chair for Mental Health, Dementia, Neurological Conditions, Learning Disability and Autism steering group; and chairs her General Practice Patient Participation Group.

### **Angela Helleur (requested)**

### **Angela Horsley**

#### **Head of Clinical Network – Maternity and Children – East Midlands Clinical**

**Networks & Senate.** A registered nurse for over thirty years, many of which have been in a senior position. Worked in a variety of roles culminating in a national role as Senior Nurse, Children and Young People, NHS England. Also undertaken the role of Specialist Advisor for the Care Quality Commission.

### **Dr Fatemeh Hoveyda (requested)**

A Consultant obstetrician at Addenbrooke's Cambridge University Hospitals since 2012.

### **Rachel Hulse**

#### **Service Manager and Lead Allied Health Professional - Emergency Division**

#### **James Paget University Hospitals NHS Foundation Trust**

Working as a Service Manager and Lead Allied Health Professional at the James Paget University Hospitals NHS Foundation Trust. Qualified as a Radiographer in 1992, specialising in Ultrasound and gaining an MSc in Medical Imaging Science (Ultrasound). Following work for the Cancer Services Collaborative and Emergency Services Collaborative, moved into general management with a particular emphasis on Allied Health Professionals.

### **Dr Mike Lane (requested)**



**Dr Adedayo (Dayo) Kuku**  
**Respiratory Clinical Lead GP**  
**Bedfordshire CCG**  
**MBBS, DFFP, MRCP**

Respiratory Clinical Lead GP Bedfordshire Clinical Commissioning Group and Chair of Bedoc.

A practising GP with keen interest in respiratory medicine, who qualified in 1987. She was appointed as Respiratory Clinical Lead GP for Bedfordshire Clinical Commissioning Group (BCCG) in 2013 and currently chairs the local Respiratory Implementation Group promoting and facilitating the delivery of improved respiratory care for the people of Bedfordshire.

Dayo was appointed Chair of Council Bedoc (Out of Hours service) in April 2014, she also sits on the Bedfordshire and Luton Joint Prescribing Committee (JPC) .

**Dr Harriet Nicholls**  
**Consultant Anaesthetist**  
**Luton & Dunstable Hospital**

Dr Harriet Nicholls is a consultant obstetric anaesthetist, has led multi-disciplinary Human Factors cultural change programmes and is a qualified and practising executive coach and mentor. Harriet is an associate medical director of medical leadership and development at the Luton and Dunstable NHS FT.

**Nadim Noor**  
**Consultant Vascular and Endovascular Surgeon (Clinical Lead)**  
**Bedford Hospital NHS Trust and Luton and Dunstable Hospital NHS FT**

A consultant vascular and endovascular surgeon, with a keen interest in healthcare management with a view to improve quality and patient experience

**Joanne Pope**  
Senior Service Specialist for the Specialised Commissioning Team in East of England as part of the Midlands and East Regional Team of NHS England. A Renal / Haemodialysis Nurse by background and has worked in the area of Specialised Commissioning since 2005.

**Trish Ryan (requested)**  
**Head of Midwifery, Luton and Dunstable Hospital**

**Annemarie Smith**  
Member and past Acting Chair of HPFT MH Trust Carers Council and also sits on the Patients Care and Environment Committee for Lister Hospital, N and E Herts Acute Hospital. She also sits on a committee for NHS England and trains the new Leadership on



patient and carer issues in the Nye Bevan initiative. Also a member of the Citizens' Senate for East Anglia.

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

### **Caroline Smith**

#### **Expert by Experience**

Worked as a registered dietitian in the NHS for 23 years before retiring on the grounds of ill-health. A lay member of the MS Trust Forward View Project and a member of the East of England Citizens' Senate and the Bedfordshire neurological network.

### **Lesley Standring**

### **Mr Rakesh Uppal**

**Consultant Cardiothoracic Surgeon, Barts Heart Centre**  
**Lead for Life Sciences Barts Health**  
**Reader in Cardiovascular Surgery at the Medical School**

As Director of Professional Affairs for The Royal College of Surgeons, has been involved with service reconfiguration and was a member of the panel that undertook review of cardiovascular services in London.

### **Dr David Vickers**

A consultant community paediatrician with Cambridgeshire Community Services NHS Trust for whom he is also Medical Director. He has been a senior officer of the Royal College of Paediatrics and Child Health. Currently he is chair of a NICE Guidelines Committee on End of Life Care for Children and provides clinical advice to PHSO.

### **Ann Walker**

**Clinical Midwifery Manager/Matron Delivery Suite**  
**Norfolk and Norwich University Hospital**

A midwife since qualifying in 1988. Spent many years as a community midwife and completed a diploma and then a BSC in Advanced Midwifery Practice. Successful in being appointed to her first midwifery manager post in 2010 and spent 5 years at the James Paget University Hospital NHS Foundation Trust where she is responsible for the inpatient maternity services. Has undertaken a Leadership and Management Level 5 award with the Institute of Leadership and Management, followed by achieving a Master's degree with distinction in Leading innovation for Clinical Practitioners at the UEA. Matron for the delivery suite at the Norfolk & Norwich University Hospital NHS Foundation Trust since March 2015, and holds an Associate Lectureship post at the UEA.



**Mr Martin Wood**

Consultant Orthopaedic Surgeon West Suffolk Hospital since 1999. Previous Clinical Lead for Orthopaedic Surgery. Member of planning board for East of England Trauma Network. Royal College of Surgeons Professional affairs advisor for Orthopaedics and trauma in East of England.



## **In attendance at the panel:**

### **Mid & South Essex Success Regime:**

Roslyn Blackboro

Professor Richard Bohmer

Yvonne Bulcher

James Currell

Dan Doherty

Dr Rim El-Rifai

Dr Ronan Fenton

Dr Indrajit Gupta

Dr Ben Horner

Dr Debbie Jennings

Dr Donald McGeachy

Jerusha Murdoch-Kelly

### **Clinical Senate Support Team:**

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

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

Sarah Steele, Quality Improvement Manager, East of England Clinical Networks, NHS England

Penny Thomas, Quality Improvement Manager, East of England Clinical Networks, NHS England

Liz Bennett, NHS England



## APPENDIX 3: Declarations of Interest

Name	Personal pecuniary interest	Personal family interest	Non-personal pecuniary interest	Personal non-pecuniary interest
Bernard Brett	None	None	None	None
Andrew Bateman <sup>1</sup>	None	None	<b>Yes Minor</b>	None
Gillian Bowden	None	None	None	None
Sandra Calvert	None	None	None	None
Melanie Clements	None	None	None	None
Erica Crust	None	None	None	None
William Denby	None	None	None	None
Ruth Derrett	None	None	None	None
Joan Douglas	None	None	None	None
Joanna Douglas	None	None	None	None
Robert Florance	None	None	None	None
Deirdre Fowler	None	None	None	None
Claire French <sup>2</sup>	None	None	<b>YES*</b>	None
Angela Helleur	None	None	None	None
Angela Horsley	None	None	None	None
Fatimah Hoveyda	None	None	None	None
Rachel Hulse	None	None	None	None
Dayo Kuku	None	None	None	None
Michael Lane	None	None	None	None
Harriet Nicholls	None	None	None	None
Nadim Noor	None	None	None	None
Joanne Pope	None	None	None	None
Patricia Ryan	None	None	None	None
Annemarie Smith	None	None	None	None
Caroline Smith	None	None	None	None
Rakesh Uppal	None	None	None	None
David Vickers	None	None	None	None
Ann Walker	None	None	None	None
Martin Wood	None	None	None	None



<sup>1</sup> Andrew Bateman Manages the Oliver Zangwill Centre - a national specialist service (NHS) for survivors of brain injury. Occasionally Out-of-Area referrals may come from Essex.

<sup>2</sup> Claire French is an Essex resident. Head of Clinical Senate raised and discussed this with the MSESr team and it agreed (on 12 September 2016) that although there was a direct non-pecuniary benefit, it was acceptable that Claire French remained a panel member, subject to her withdrawal from the meeting should services she, or a close friend or relative, will knowingly access, be under discussion.



## APPENDIX 4: Key lines of enquiry

### **Key lines of enquiry for both paediatrics and women's services panels**

Note that these are indicative, and discussion will not be limited to these areas exclusively

#### **i) Accessibility and Equality Impact assessments and Risk**

- Impact assessment on transport i.e. ambulance service involvement and confidence level to meet requirements of proposed model
- Do the plans support the principle of equity of access and equality for patients across the patch? Does the travel information provided take into account the impact (of travel) of the new model (are there fully developed impact assessments and risk assessments with mitigation and management plans)?

#### **ii) Resilience: Is the intention for a transition of services or a stop / start of old / new?**

- What plans, risk mitigation, will be put in place to ensure that the services continue to provide safe quality care to patients during transition?

#### **iii) Workforce planning, modelling and recruitment: more clarity on staffing, recruitment, retention and workforce development.**

- Where will the required additional staff be drawn from, given the existing vacancy rate?
- What is the programme for recruitment, retention, upskilling of existing staff, and the level of confidence to achieve full capacity of staff?
- What is the plan for training rotation intention to ensure continued CPD for all staff across all sites?



## **Key lines of enquiry for both Emergency Medicine AND Elective Surgery**

These are indicative and discussion will not be limited to these areas exclusively

**NOTE: THE KLOE BELOW ARE CURRENTLY GENERIC – FURTHER SPECIFIC KLOES FOR THE EMERGENCY MEDICINE REVIEW PANEL MAY NEED TO BE DETERMINED**

- i) Patient Experience and Outcomes**
  - a. Clarity on the aim and intended improved outcomes for patients, how that will be measured.
- ii) Capacity Modelling, Accessibility and Equality Impact assessments and Risk**
  - a. Impact assessment on transport i.e. ambulance service involvement and confidence level to meet the likely increased volume.
  - b. Capacity modelling on the likely number of patients that need to be moved (and linked to a. above).
  - c. Impact /risk assessment on rest of system from bringing together elective surgery.
  - d. The ability and capacity to quickly move patients to the correct centre / pathway.
- iii) Interdependencies**
  - a. Detail on support services e.g. radiology and diagnostics
  - b. Detail of how Social Care has been engaged with and arrangements to ensure there is capacity to enable effective and efficient delivery of the community model of care.
  - c. The detail of the community model to support e.g. step down beds, support for primary care to deal with increased workload
  - d. (elective Surgery) Information on sub-specialities



## **APPENDIX 5: Summary of documents provided by Mid and South Essex Success Regime as evidence to the panel**

1. Submission for Clinical Senate Panel document
2. Presentation to panels

