NHS
East of England
Clinical Senate

Independent clinical review of redevelopment proposals for West Hertfordshire Hospitals NHS Trust.

Report of the Clinical Senate clinical review panel held on 5 August & 9 September 2020.

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EXECUTIVE SUMMARY

The clinical review panel fully supported the Trust's case for change, and the need to invest in the Trusts' estate. The panel agreed that the current dysfunctional and aged nature of the Trust's estate was of concern and without doubt creating issues of patient safety which needed to be addressed as a matter of urgency. However, there needed to be a balance between addressing the current urgency with providing a sustainable long-term solution for the next twenty to twenty-five years.

The panel was satisfied that the Trust had looked at its options in terms of prioritisation of investment in a great deal of detail. The panel was fully supportive of the plans to concentrate acute activity onto one site in order to deliver the clinical benefits of colocation with all the relevant co-dependencies and in order to deliver workforce efficiencies and resilience.

The panel was of the view that investment in digital transformation should be seen as a real priority and supported the Trust's desires to invest significantly in this area. It recommended that the Trust ensured that its plans for diagnostic facilities were in line with the current thinking on Rapid Diagnostic Centres (RDC), the concept of Community Diagnostics Hubs and the emerging Imaging Networks.

The panel commended the West Hertfordshire system for its level of engagement and system working. The panel agreed that there was clearly effective clinical leadership, and strong, positive partnership working across the health and care system in the design and delivery of care.

The panel agreed that whilst it had heard the evidence, including plans to streamline services and pathways, it could not support fully the proposal to continue with the three-site model on a long-term basis. The panel considered that a two-site solution with a single planned care centre for medical and surgical care on a new site would be the most appropriate and beneficial long-term solution for the needs of the population.

In terms of the degree of ambition, the panel recognised the constraints resulting from a limited capital fund currently on the table but was very much of the view that whilst pace was important, the aim should be for a long-term, future proof solution.

The panel had sympathy for the difficult position the Trust found itself in, in relation to a current very suboptimal estate for the provision of modern high-quality treatment and care.

The panel made a number of recommendations that are summarised below, the full version can be found in section six of the report and which should be read in the context of the summary information in section five of the report.

Recommendation One: the Trust reconsider its proposals for the three-site model and consider more ambitious long-term solutions that were fully future proofed and would meet the needs of a growing population.

Recommendation two: the Trust should prioritise and accelerate the planned replacement and updating of its IT system to enable use of modern technology and software and reduce the potential for patient risk.

Recommendation three: the intended benefits for patients, including improved outcome measures are clearly described.

Recommendation four: the Trust clearly describe how the proposals would address the range of important current estate related risks particularly as they related to patient safety.

Recommendation five: further illustrative redesigned patient pathways be described to help demonstrate how the changes to the estates would bring benefits to patients, relatives, carers and staff.

Recommendation six: a full workforce model be described and that it should be linked to the workforce benefits of the two-site model.

Recommendation seven: patient, family, carer and staff access is fully considered and addressed in all planning changes to the estate.

The recommendations above should be read in the context of the broader findings of the clinical review panel as laid out in the key findings section of this report.

End.

1. Foreword from Clinical Senate Review Panel Chair

The Clinical Senate was asked to review the West Hertfordshire Hospitals NHS Trust (WHHT) plans for investment in their estate. It was clear to the panel that there was a very strong case for change, with the current estate falling well short of modern standards for an optimal health care environment. Furthermore, it was clear that the current estate poses a risk to patient safety which the WHHT team have worked hard to mitigate.

The WHHT team have been through a long process, over many years, seeking to improve their estate. They have worked hard to engage with their local population and system-wide stakeholders in developing their plans.

Health and Social Care in the East of England including in West Hertfordshire, like the rest of the United Kingdom and indeed most countries in the world, have had to face immense challenges over recent months and will no doubt continue to do so for many months ahead as a result of the COVID-19 pandemic. This has understandably highlighted the need for new ways of working and emphasised the need for protected elective facilities.

Funding for the NHS overall and specifically regarding capital spending, is constrained with many legitimate requests for investment. In this context it is understandable that the funding for completely new facilities to cover all secondary care provision is not currently available, meaning that the WHHT team have had to prioritise their spending plans. This means that their longer-term plans require a staged approach with future capital investment needed to reach the optimal future state.

Through the process, including studying a detailed information pack, hearing presentations from, and asking questions of the WHHT team, the panel were able to prepare themselves for detailed discussions to identify their key findings and recommendations. I hope that these findings and recommendations help the WHHT to achieve their aims of building better facilities to deliver high quality care for their patients.

I would like to thank the WHHT team for their hard work and responsiveness in preparing appropriate information pack, providing additional information and responding to the panels' questions.

I would also like to thank all the Clinical Senate's review panel members for engaging in such an active way with the process, asking searching questions and contributing with their wide and varied expertise and of course in giving up their time.

We wish WHHT well with their ongoing work, with their plans to improve services for the population they support and hope we can assist them again in the future with further transformational work.

Dr Bernard Brett

East of England Clinical Senate Chair and clinical review panel Chair

2. Review background and scope.

2.1 West Hertfordshire Hospitals NHS Trust (WHHT or the Trust) is a large acute trust providing hospital services to around 500,000 people living in Hertfordshire and north London. The Trust provides a wide range of acute emergency and planned services, with emergency care primarily provided at Watford General Hospital, St Albans City Hospital as its surgical elective care centre and outpatient, diagnostic and urgent care services provided at Hemel Hempstead Hospital. This three-site model supports local care provision, though the configuration of services across sites is in part a result of history and so creates some fragmentation.

2.2 WHHT faces significant challenges due to the age, out-dated design and poor condition of its buildings. The Trust recognises that this has a potentially detrimental impact on the delivery of safe, effective, responsive and efficient care and that there are real risks to continuity of service as a result of the existing environment. The ability of the Trust to improve services and make the most of new technologies is also constrained by the condition of the estate.

2.3 Despite that, the Trust has made significant investment in improving services within the existing constraints, resulting in the Care Quality Commission moving the Trust up from 'special measures' [1] category to requiring improvement, with an increasing number of 'good' ratings across a range of clinical services.

2.4 The improvement journey of West Hertfordshire Hospitals' estate has been a long one going back to the 1990's and not without significant challenge and strong local opinion. In 2009, acute emergency care for West Hertfordshire was centralised at Watford, since then the Trust with its commissioners and stakeholders have worked together to develop financially viable proposals that would improve the quality and safety of clinical services.

[1] https://www.cqc.org.uk/provider/RWG

2.5 From this background and at this key stage of the journey with its outline business case in development, WHHT requested Clinical Senate to provide it with an independent view on the proposed future clinical model and emerging design principles – with a focus on the impact on patient outcomes and the level of ambition to make the most of this opportunity for change.

2.6 Although the scope of this review was focused on the clinical model, the Trust estate and options for delivery of services on a single, two or three site model was integral to the model and so discussed by the review panel. Outside the scope of the review however, and so not discussed by the review panel, was the decision-making process for the shortlist of options for redevelopment of the estate. So, whilst the panel discussed options in terms of the clinical benefits of investment in a one, two or three site model, it did not seek to understand or question the Trust's decision-making process on its four options to meet the £350 million financial limit.

2.7 The scope of this review was to consider the clinical model for planned and emergency care, including services at Watford General Hospital, St Albans Community Hospital and Hemel Hempstead Hospital. The review panel was not asked to make recommendations on a specific site for the services under review or any specific estates recommendations.

2.8 The review panel was asked the following questions (as laid out in the Terms of Reference seen at Appendix 1):

1. Does the proposed model make clinical sense and, based on the evidence presented, is it likely to result in safe and high-quality services and outcomes for patients once implemented?
2. Does the clinical model form a robust basis for moving to a more detailed development and implementation across the three hospital sites?
3. Are the plans sufficiently ambitious – are there further opportunities to improve care that we should consider?

3. Review methodology and governance

3.1 The clinical review panel was initially scheduled for April 2020. With the emerging COVID-19 pandemic, it was mutually agreed to defer the review panel until a more appropriate time.

3.2 The April review panel would have taken place in person with 14 panel members. Terms of Reference for the review were agreed between Dr Bernard Brett, Chair of East of England Clinical Senate and Helen Brown, Deputy Chief Executive for West Hertfordshire Hospitals NHS Trust (Appendix 1).

3.3 A reconvened date was discussed and with the continued need for social distancing it was agreed to hold the clinical review panel virtually by (Microsoft) Teams. In order to make this manageable, a number of panel members had to be stood down. We would like to acknowledge their understanding of the situation and convey our thanks (See appendix 2).

3.4 It was also agreed that a full day virtual meeting would be difficult and agreed to split out the panel over two separate half days. Unfortunately, with August leave and panel member availability there was a longer gap between the dates (5 August and 9 September 2020) than we would normally have scheduled but overall this arrangement worked satisfactorily and provided us with some valuable learning for future review panels.

3.5 With the clinical review panel members identified (Appendix 2) and having signed conflict of interest and confidentiality declarations (Appendix 3) a pre-panel call was held in July to identify the key lines of enquiry for the first panel day.

3.6 The first clinical review panel took place on 5 August 2020. The WHHT team gave an overview and context setting presentation to the panel. The proposals were discussed with the panel in more detail, the WHHT team responding to questions providing further supporting and contextual detail.

3.7 This was followed with a second panel day on 9 September with panel members only.

3.8 Sections of the draft report were sent to clinical review panel members for review and confirmation of accuracy and to WHHT team for review for points of accuracy on 14 September 2020.

3.9 The final draft of the report was submitted to a specially convened meeting of the East of England Clinical Senate Council on 3 November 2020. Senate Council agreed that the clinical review panel had fulfilled the Terms of Reference for the review and accepted the report.

3.10 East of England Clinical Senate will publish this report on its website at the appropriate time as agreed with the sponsoring organisation.

4. Summary of key findings

4.1 The panel thanked the WHHT team for its presentation and their open and honest approach to the questions. WHHT had helpfully addressed in its presentation the points raised by the panel in the key lines of enquiry and had provided a comprehensive evidence document that clearly laid out the clinical case for change, and the need for that at some pace.

4.2 Estate and infrastructure

4.2.1 The West Hertfordshire Hospitals Trust (WHHT) operates from three main sites, Watford General Hospital, Hemel Hempstead Hospital and St Albans City Hospital. The three hospitals are within ten miles of each other and provide acute healthcare to a population of around 500,000 people across west Hertfordshire.

4.2.2 Watford General Hospital (WGH) provides urgent and emergency care services, an acute admissions unit, complex or higher risk elective care, Women's and Children's services and the full range of outpatient and diagnostic services.

4.2.3 Hemel Hempstead Hospital (HHH) provides services including endoscopy, outpatients and ante-natal and community midwifery. It has an urgent treatment centre, diagnostic support with X-Ray, ultra-sound, CT and MRI scanners and non-urgent pathology. HHH has a small number of intermediate care beds run by Central London Community Healthcare NHS Trust. At the time of this review, HHH also had a GP run respiratory centre for patients with COVID-19 symptoms.

4.2.4 St Albans City Hospital (SACH) is a dedicated centre for low risk and day case elective surgery and ante-natal and community midwifery services. It has a minor injuries unit (which at the time of this review was shut due to COVID-19), two surgical wards, an outpatient's department and cancer and diagnostic services including X-Ray, ultrasound, mammography, blood and specimen collection. Although SACH does not currently have CT or MRI scanner facilities,

the panel heard that a mobile CT scanner was planned for later this year and there was a plan to install an MRI scanner.

4.2.5 The panel heard that the WHHT estate is not deemed functionally suitable for modern clinical practice with poor clinical adjacencies and fragmented clinical services, staff and teams were spread across the sites and patients needed to be transferred too often to get the care they need. Operating theatres are non-compliant for size, clinical layout, adult/child segregation and lack resilient ventilation systems. The panel heard that 57% of the WHHT estate had been assessed to be below the minimum acceptable condition.

4.2.6 Responding to the COVID-19 pandemic had highlighted many of the estate related issues and emphasised the need for flexible design in the building to enable changes and separation of 'hot' (i.e. emergency and potentially COVID-19 positive) services and 'cold' services (i.e. planned and COVID-19 safe pathways). The panel heard that during the COVID-19 pandemic the Trust had implemented the use of tele-medicine for some services and would continue to use tele-medicine where and when appropriate. The panel felt that this did not sound particularly ambitious and wondered if the scale of ambition was tempered by the current low level of digital maturity.

4.2.7 The panel was of the view that the case for change and, in particular, the need to invest in the Trusts' estate, was very clearly made and fully supported.

4.3 Digital transformation and information technology (IT)

4.3.1 The panel heard that the current IT infrastructure and systems were "dysfunctional", outdated and not able to share information across software systems. The Trust recognised that the lack of fully functional IT generally was one of the major frustrations for staff. Lengthy log-in times and the need to log-in to multiple systems to access patient records and diagnostic information often led to delays in accessing relevant patient information, especially in the Emergency Department. The ageing IT servers and operating systems did not support modern up to date software available for some clinical specialties.

4.3.2 The panel was advised that the Trust had in place a combined estate and digital transformation governance board that oversaw both programmes to ensure there was alignment. It was the Trust's intention to replace the current outdated analogue telephony with a digital system and to have in place a full Electronic Patient Record system within the next two years ahead of the completion of any new buildings.

4.3.3 The panel was of the view that investment in IT should be seen as a real priority and supported the Trust's desire to invest significantly in this area. As IT is needed to enable the clinical model, the panel emphasised the need for rapid replacement of the critical IT infrastructure and systems. The panel recommended that the Trust ensure that a joint governance board arrangement for estates and digital transformation would not slow down or hold back the replacement of IT whilst attempting to align IT with estates development (see recommendation 2).

4.3.4 Despite all the constraints described above, the Trust had made significant improvement to the care it delivers, moving out from special measures in 2016 and now rated as 'requires improvement[2]'.

4.4 Engagement in development of the clinical model

4.4.1 The proposed model for acute care and service configuration for West Hertfordshire brought by WHHT to Clinical Senate for review was the latest in a long and challenging journey to bring about improvements to clinical services across the estate. The current proposals had been developed with clinicians and local stakeholders and were underpinned by the Hertfordshire and West Essex STP 'A Healthier Future' strategy (2018) and the Herts Valley CCG 'Your Care, Your Future' programme (2016).

4.4.2 The clinical model of care sat within a wider plan to develop a 'House of integrated care' to deliver more care out of hospital. The panel heard examples

[2] CQC 20 June 2020 https://www.cqc.org.uk/provider/RWG

of several pathways already implemented that were successfully moving towards the new model of care including diabetes, frailty, musculoskeletal, dermatology and gynaecology care pathways. The panel complimented the Trust on its operating model for general medicine / older people services.

4.4.3 The panel heard from WHHT that there had been good system engagement in the process with patients and residents and across community, primary and secondary care in the emerging ideas and design process of the clinical model and use of the Trusts' estate. This included significant engagement with clinicians to ensure that the design of services was clinically the most appropriate model for staff and patients. The panel agreed that there had been really good engagement with stakeholders in developing the clinical model. It agreed though that although the proposal clearly and strongly laid out the case for change, it could still be significantly strengthened with detail of the expected improvements in outcomes and benefits for patients and staff.

4.4.4 In response to a question from the panel on inclusion of adults with learning disability or autism, the WHHT advised the panel of the Hertfordshire 'Purple Folder' scheme. The purple folder contained information about the individual's health and care needs and was used when they saw any health professional including doctors, community nurses, opticians, pharmacists or social care workers. The panel was advised that the principles of the purple folder scheme would be embedded into future clinical pathways and applied to all the new and refurbished buildings so that all areas were learning disability, autism and dementia friendly.

4.4.5 The panel commended the West Hertfordshire system on its level of engagement and system working in developing the clinical model. The panel agreed that there was clearly effective clinical leadership, and strong, positive partnership working across the health and care system in the design and delivery of care.

4.5 Patient safety, service quality and outcomes

4.5.1 The panel agreed that the current dysfunctional and aged nature of the Trust's estate and IT was of concern and without doubt creating issues of patient safety which, it further agreed, needed to be addressed as a matter of urgency. The panel recognised however that there needed to be a balance between addressing the current urgency with providing a sustainable long-term solution for the next twenty to twenty-five years. It appreciated that this would be a challenge for the Trust but considered that addressing clinical risks and patient safety was paramount.

4.5.2 In discussion, WHHT had referred to some of the benefits of the investment in services including reduction in waiting times, infection rates and cancellations and improved safety and outcomes for patients and working conditions for staff. The panel felt that information on specific intended outcomes was lacking in the evidence and the Trust should look to include the detail to support its further public engagement and regulator evaluations. (see recommendation 3).

4.6 Development of the clinical model in the context of the Trusts' estate and funding

4.6.1 In 2018, the Trust's refreshed strategic outline case had a financial limit of £350 million, the maximum it could work to in line with its 2017/18 turnaround. In 2019, WHHT was named as one of the six hospital trusts in the Health Infrastructure Plan[3] and was pledged £400 million.

4.6.2 The Trust had shortlisted a number of options for investment that could be achieved within the £350 million limit including a one, two or three site model on existing sites. It had also looked at other potential options including a greenfield single site new build but that was estimated to cost upwards of £700 million and so not feasible within the financial limit.

[3] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/835657/health-infrastructure-plan.pdf

4.6.3 WHHT advised the panel that emergency care services at WGH saw the highest volume of clinical activity in the Trust and treated patients with the most complex and urgent needs. The Trust was clear that investment in emergency care at WGH was essential to alleviate the clinical risks in the present clinical environment. The panel fully supported the clinical rationale for concentrating emergency and complex care on one site given the co-dependencies and workforce considerations. The panel understood that, after extensive consideration, the Trust had determined the best location for this emergency site was for it to remain at WGH. The key inter-dependencies including operating theatres, diagnostics, vascular, cardiovascular, renal and critical care facilities and the workforce to provide emergency care would be located on one site, reducing their need to travel and building in enhanced resilience.

4.6.4 The panel heard that the investment in emergency care at WGH would include new clinical buildings housing operating theatres and critical care as well as women's and children's services and improved standardised inpatient ward accommodation of an appropriate size with an increased ratio of side rooms.

4.6.5 WHHT advised the panel that in addition to the investment in WGH, a smaller proportion of the investment would be made to enhance both HHH and SACH, including increasing the provision of diagnostics at both hospitals, so retaining a three-site model.

4.6.6 The plans for investment in care services included HHH becoming a planned medical care centre with services consolidated into redeveloped accommodation, including a newly enhanced urgent treatment centre. SACH would be enhanced as a planned surgical facility including a new cancer and surgical centre with diagnostic suite and refurbished theatres and inpatient beds with a small high dependency unit.

4.6.7 In response to its request for clarification on the proposals for endoscopy, the panel was advised that all emergency surgery, and any planned endoscopy with potential risk of hospital admission, would continue at WGH. Patients for planned (or 'cold') endoscopy would attend SACH. The panel supported the

consolidation of elective non-high risk endoscopy onto one site. The panel agreed that providing Gastroenterology services on all three sites was not the optimal way forwards for patients or staff. In addition, it is important to maintain the close working relationship between Medical and Surgical Gastrointestinal specialist colleagues that could be negatively impacted by the continuing need for Medical Gastroenterologists to work across three sites and to hold outpatients on a different site to their surgical colleagues.

4.6.8 The panel heard about the Trust's plans to streamline cancer pathways with a rapid diagnostic centre. WHHT acknowledged that current pathways were convoluted and complex with different diagnostics available on different sites, and some patients needing to attend the Lister Hospital in Stevenage or Mount Vernon Cancer Centre for diagnostics and / or treatment as well as more than one site within the Trust's own estate.

4.6.9 WHHT had made clear its intent to improve and expand diagnostic facilities across all three sites, despite the lack of sufficient appropriate radiology staff. The panel agreed that consolidation of some investigations onto two sites with investment in more and better diagnostic equipment, supported by improved IT, would not only provide greater resilience for equipment failure or suspension for maintenance, but improve workforce capacity and resilience. The panel agreed that the Trust needed to ensure that its plans for diagnostic facilities were in line with the current thinking on Rapid Diagnostic Centres (RDC) for rapid assessment of patients with cancer symptoms or suspicious results. The Trust should also ensure its plans for diagnostic facilities take into account the concept of Community Diagnostics Hubs (for separation of diagnostic facilities for acute and planned care) in response to the report of Professor Sir Mike Richards[4], and also align with the emerging Imaging Networks.

[4] https://www.england.nhs.uk/2020/10/nhs-to-introduce-one-stop-shops-in-the-community-for-life-saving-checks/ Published 1 October 2020

4.7 Prioritisation of estate development

4.7.1 The panel was advised that in developing its clinical model, the Trust had considered both a two-site model and current three-site model and that a key consideration for the 2019 Strategic Outline Case were the relative merits of investing in emergency care facilities or in a single planned care centre. The Trust had shortlisted four options:

a) prioritise emergency care – retain three sites
b) move to a two-site model with planned care consolidated at SACH
c) move to a two-site model with planned care consolidated at HHH
d) move to a two-site model with planned care on a new site.

4.7.2 WHHT advised the panel that the Trust and local health system had recognised the merits and the potential clinical outcome benefits of moving to a single planned care centre and had given extensive consideration to investing in refurbishing existing site/s or moving to a new build planned care centre. However, the Trust and local health system, after an extensive review, had agreed that there were even greater benefits for patients and more potential for clinical risk mitigation in investing in emergency care facilities. The funding envelope was not sufficient to cover both the much needed upgrade to emergency care facilities and the desire to move to a single elective care centre, although the latter remains a longer-term objective of the Trust.

4.7.3 The panel appreciated that in the time it had available (for the review) and from the evidence provided by WHHT, detailed as it was, it had only reviewed at very high level the information and detail that the Trust had considered and reviewed to inform its prioritisation. The panel agreed that, for this independent review, it was not appropriate to have been provided with all the evidence the Trust and its stakeholders had considered. The panel felt assured that the Trust together with partners and stakeholders had made the decision to invest in emergency care over a new, or refurbished, single centre for planned care after having carefully considered all relevant and available information and detail, including the likely funding envelope. It was clear that the focus had been on providing the most benefit for patients.

4.7.4 The panel agreed however that the proposals it had reviewed for the Trust could ideally be more ambitious and strongly encouraged support for more ambition from NHS England and NHS Improvement. The evidence showed that the Trust was clearly constrained by the financial envelope.

4.7.5 The panel agreed that whilst it had heard the evidence for planned care across the three sites, including plans to streamline services and pathways, it could not fully support the proposal to continue with the three-site model on a long-term basis. The panel further agreed that whilst the plans to prioritise investment in emergency care would clearly address some of the more immediate and short term clinical and operational uses, the Trust should use this as an opportunity to develop plans to provide sustainable services for much longer-term requirements (i.e. 20-25 years plus), particularly given the predicted population growth in the area. The panel considered that a two-site model, providing a single planned care centre for both medical and surgical care, most likely in a new location, would help provide more sustainable, efficient and high-quality services. The panel recognised that sufficient funding at this point in time had not been made available for this option (see recommendation one).

4.8 Travel and access

4.8.1 The panel understood that the three WHHT hospitals were within ten miles of each other, which although relatively close in comparison to the distance between hospitals in other areas, was still an issue for some patient groups. The WHHT team had provided the panel with travel distance and time information that the panel agreed was helpful but it recommended that the Trust continue discussion with the local authority and transport providers to look at options for better public transport links between the sites for patients, carers and staff. In particular, consideration should be given to the impact that inequalities might have on differential access (see recommendation 7).

4.9. Finance and the impact on options

4.9.1. Whilst finance *per se* was not within the remit of Clinical Senate reviews, in this case as it was a fundamental part of the proposals the panel considered it appropriate, and necessary, to include in its discussion in a general way.

4.9.2 In August, the panel heard from the WHHT team that recently the Trust had been advised by regulators that an option to include more new build at WGH, including replacing rather than refurbishing the main clinical block (costing in the region of £590 million), could be included within the Trust's outline business case submission[5]. However, there was no guarantee from the regulators that additional funding would be made available, nor, if it were, how much it would be granted. The panel agreed that with no guarantee that it would receive anything over the promised £400 million the Trust was in a very difficult position that could potentially set back its plans. The panel did agree and recommended that including the additional cost (in the Trust's Strategic Outline Case) for a new rapid diagnostic centre with up to date diagnostic equipment to meet current standards, would make clinical sense and could potentially be considered favourably by regulators.

4.9.3 Notwithstanding the above, the panel recognised that the Trust had developed proposals to address patient safety and operational risks that the poor condition of the current estate was creating. The panel understood that the Trust needed to develop its business case around the amount of capital monies that might be available but urged the Trust to also consider whether the proposals provided a sustainable, long-term solution for the investment. The panel were of the view that additional investment to deliver a more ideal solution was likely to provide higher quality outcomes for patients and indeed could in the longer term be more cost-effective.

[5] *In response to a follow up question from the review panel at its 9 September meeting, WHHT confirmed that it had not had any further clarification on this matter*.

4.10 Workforce

4.10.1 The panel heard that in September 2019 the Trust was recognised by the Nursing Times as 'Best UK Employer of the Year'. The panel congratulated the Trust on its extremely low vacancy rates and heard that the Trust frequently had high numbers of appointable applicants for most Consultant vacancies, the exception tending to be areas of national shortage including anaesthetics, emergency care and care of the elderly. The Trust continued with its UK and oversees recruitment programme.

4.10.2 WHHT advised the panel that with the exception of a few anaesthetists, the medical workforce would work across both planned and emergency care. The Trust was looking at 'Green days' or 'Blue days' for staff to ensure there was not cross-infection. The Trust's People Strategy had recently been updated and would be considered by the Trust Board in September.

4.10.3 Whilst the panel supported the rotation of staff across planned and emergency care, it was concerned that a three-site model would be spreading some staff groups out too thinly and that splitting clinical teams should be avoided as much as possible (also refer to para 4.2.5).

4.10.4 WHHT advised the panel that during the COVID-19 lockdown, Watford Football Club (whose site is adjacent to Watford General Hospital) had opened up its buildings and spectator stands for Trust staff to have off-site space for breaks, this had included rooms set aside for counselling. The panel heard that this had magnified for the Trust the need for that type of staff facility going forward and was something it would actively build upon.

4.10.5 The Trust recognised that it was a major local employer and was committed to developing its staff and building on retention.

5. Panel response to the questions posed

5.1 The Trust had posed three questions to Clinical Senate in relation to its proposals:

1. Does the proposed model make clinical sense and, based on the evidence presented, is it likely to result in safe and high-quality services and outcomes for patients once implemented?
2. Does the clinical model form a robust basis for moving to a more detailed development and implementation across the three hospital sites?
3. Are the plans sufficiently ambitious – are there further opportunities to improve care that we should consider?

5.2 In responding to the questions, the panel agreed that had there been sufficient funding available then a two-site model with a new single planned care centre would be the most appropriate and beneficial long-term solution for the needs of the population. Furthermore, the panel felt that the location of a planned care centre might be best located on a new separate site to allow for optimal access for the population and staff. The panel recognised the constraints the Trust had in terms of improvements to the estate for clinical services given the proposed funding. With that in mind, and having considered and discussed the evidence, the clinical review panel agreed that it was not able to provide direct responses to the questions being asked of it. Instead the panel wished to make the following response which should be read alongside the recommendations that cross-link to the response.

5.3 The panel recognised the urgency of the need for improvement and that the relevant evidence in relation to risk and risk assessment presented highlighted the real need to improve in emergency care facilities. The panel did not however feel it had reviewed sufficient information to determine whether the Trust was correct in agreeing to prioritise the issues around emergency care against the potential benefits of a planned care centre. The panel were shown evidence that the Trust had taken time to consider in detail the options available within the funding envelope and described several of the key factors in this process. The panel acknowledged that the prioritisation process had been the subject of

significant internal discussions within the Trust and its partners and stakeholders, in developing the 2019 Strategic Outline Case and that they had considered in detail the full range of information and evidence in coming to that decision. The panel had sympathy for the difficult position the Trust found itself in, in relation to the current very suboptimal estate for the provision of modern high-quality treatment and care.

5.4 The panel was very much persuaded of the very real need to invest in facilities for both emergency and planned care and did agree that there were significant patient benefits in providing services from a separate planned care centre, particularly with the need now for COVID-19 infection free areas (a protected planned care 'cold' site). The panel was of the view that a planned care centre for patients with both medical and surgical conditions would make more clinical sense than to have two separate planned care centres (whilst recognising the constraints described by the Trust that had informed the prioritisation of emergency care at this time).

5.5 In terms of the degree of ambition, the panel recognised the constraints resulting from a limited capital fund currently on the table but was very much of the view that whilst pace was important, the aim should be for a long-term, future proof solution. The panel agreed that a two-site solution with a single planned care centre for both medical and surgical care made far more clinical sense in terms of quality, safety, workforce and outcomes. The panel felt that the plans described for digital transformation were not as ambitious as they could be.

6. Panel recommendations

6.1 Recommendation One

The panel recognised both the urgency of need for improvements in emergency care and the benefits of a separate planned care centre. The panel fully supported the plan to concentrate emergency care on one site in view of the co-dependent clinical services and workforce factors. The panel recommended that the Trust consider more ambitious long-term solutions that were future proofed and would meet the needs of a growing population. If the funding available does not at this stage allow this then the current plans should be linked to a longer-term plan for a two-site model. A two-site solution with a protected planned care centre for medical and surgical care was strongly recommended to deliver the highest quality, safe and efficient care, making the best use of the workforce and to build in additional resilience. The chosen locations for a two-site solution should take account of the current and future population, access and the potential to help reduce inequalities.

6.2 Recommendation two

The panel recommended that the Trust continue to prioritise and accelerate the planned replacement and updating of its IT infrastructure and systems to enable use of modern technology and software and reduce the potential for patient risk. Given the potential for further delay to the estate development, and the potential for digital technology to drive service change, the panel further recommended that the Trust should consider splitting out the IT upgrade programme from the joint estates' development and digital solutions programme. The panel recommended that, if it had not already, the Trust engage with NHSX[6] and NHS Digital to explore areas where it could be supported.

6.3 Recommendation three

The panel recommended that the Trust clearly describe the intended benefits for patients, including improved outcome measures. The panel recognised that

[6] https://www.nhsx.nhs.uk/ https://digital.nhs.uk/

several expected benefits were described and were supported but considered that these would benefit from being more specific regarding the level of ambition.

6.4 Recommendation four

The panel recommended that the Trust clearly describe how the proposals would address the range of important current estate related risks particularly as they are linked to patient safety. In addition, the interim mitigation plans whilst the estate was being upgraded should be described in detail.

6.5 Recommendation five

The panel recommended that further illustrative redesigned patient pathways be described to help demonstrate how the changes to the estates would bring benefits to patients, relatives, carers and staff. This may further support the case for additional funding as well as help illustrate the benefits during stakeholder engagement and public consultation. This does not need to be an exhaustive list that could delay progress but should include several additional pathways.

6.6 Recommendation six

The panel recommended that a full workforce model be described and that it should be linked to the workforce benefits of the two-site model. The panel recognised that the Trust had mentioned a people plan that may cover much of this already.

6.7 Recommendation seven

The panel recommended that patient, family, carer and staff access is fully considered and addressed in all planning changes to the estate. The panel recognised the relatively short distances between sites but were also aware of the levels of congestion and the potential impact on health inequalities for those having to use public transport. Additional work with the relevant local authorities and transport planning offices may help to further improve access and help to determine the most appropriate site for services.

End.

APPENDIX 1: Terms of Reference for the review

East of England Clinical Senate

Independent clinical review of redevelopment proposals for West Hertfordshire Hospitals NHS Trust

5 August & 9 September 2020

Terms of Reference

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CLINICAL REVIEW FOR WEST HERTFORDSHIRE HOSPITALS NHS TRUST (WHHT)
TERMS OF REFERENCE

Title: Independent clinical review of redevelopment proposals for West Hertfordshire Hospitals NHS Trust

Commissioning organisations: West Hertfordshire Hospitals NHS Trust (WHHT)
Herts Valleys CCG

Senior Responsible Officer: Helen Brown, Deputy Chief Executive

Signature:

Terms of Reference agreed by: Panel chair

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

Signature

Date: 9 July 2020

Supporting / background information for the clinical review for completion by commissioning organisation.	
When is the advice required by? Please provide any critical dates	TBC
What is the name of the body / organisation commissioning the work?	West Hertfordshire Hospitals NHS Trust (WHHT) Work has been completed in partnership with Herts Valleys CCG, who will also be represented at the Clinical Senate event.
How will the advice be used and by whom?	The advice will be used by WHHT to provide assurance to the Trust Board and other key partners that plans for its redevelopment scheme are appropriately robust, will lead to improvements in patient care and are sufficiently ambitious.
What type of support is Senate being asked to provide: a) Assessment of clinical services b) Early advice to inform a clinical service model c) Review of proposed clinical model/s (or follow up review from b above) d) Support for case for change, including the appraisal of the clinical evidence within e) Informal facilitation to enable further work f) Clinical reconfiguration or integration related to merger of trusts g) Advice on complex or (publicly) controversial proposals for service change g) Other?	C: Review of proposed clinical model. Note: There is a high level of public interest in the Trust's redevelopment plans. There is a judicial review currently underway.
Is the advice being requested from the Senate a) Informal early advice or a 'sense check' on developing proposals b) Early advice for Stage 1 of the NHS England Assurance process c) Formal clinical review to inform Stage 2 of the NHS England Assurance process and/ or your Consultation Business Case d) Other?	A – Formal NHSE assurance and public consultation not currently thought to be required, subject to outcome of judicial review.
Does the matter involve revisiting a strategic decision that has already been made? If so what, by whom and when?	There have been reviews of healthcare provision in West Herts dating back many years. Acute emergency care was centralised at Watford Hospital in 2009 and the current configuration of services, with planned care at Hemel Hempstead and St Albans City Hospitals dates back to this time.
Is the matter subject to other advisory or scrutiny processes?	Yes

Aims and objectives of the clinical review

West Hertfordshire Hospitals NHS Trust (WHHT) is a large acute trust providing hospital services to 550,000 people living in Hertfordshire and north London. The poor quality of the environment from which WHHT provides services is self-evident and urgent improvement is required to enable the Trust to continue to provide high quality care to its local population over the coming years. Discussion has been underway for some time, dating back well before the 2009 consolidation of emergency care for West Hertfordshire at Watford Hospital.

The Trust provides a wide range of acute emergency and planned services, with emergency care primarily provided at Watford Hospital, St Albans City Hospital as its surgical elective care centre and outpatient, diagnostic and urgent care services provided at Hemel Hempstead Hospital. This three-site provision supports local care provision, though the configuration of services across sites is in part a result of history and so creates some fragmentation.

There are real risks to continuity of service as a result of the existing environment; ability to improve services and make the most of new technologies is also constrained. The urgency of the need for improvement at West Herts is widely recognised and as such, the Government recently confirmed that WHHT would be included as one of six schemes to receive funding under the Health Infrastructure Plan programme (first wave).

In line with its 2019 Strategic Outline Case the Trust is currently planning to invest a significant amount of money in improvements to emergency care services, with more limited investment in planned care services at present. Having considered other options, the preferred clinical model is broadly to maintain the same overall service configuration as at present, but to reduce fragmentation of services where appropriate. The Trust has engaged with clinicians throughout the development of its redevelopment plans, regarding the future model and clinical design principles to underpin the new hospital design.

At this key stage WHHT is seeking an independent view on the future clinical model and emerging design principles – with a focus on the impact on patient outcomes and the level of ambition to make the most of this opportunity for change.

Scope of the review

The scope of this review is to consider the clinical model for planned and emergency care, including services at Watford General Hospital, St Albans Community Hospital and Hemel Hempstead Hospital.

Out of scope

Specific site-based elements (e.g. diagnostic equipment) of the services under review will be provided to the panel as part of the context of the overarching three-site model. However, the review panel is not asked to make recommendations on a specific site for the services under review or any specific estates recommendations.

Purpose of the review

The Clinical Senate is being asked to review the available evidence, discuss with the members of the programme and make appropriate recommendations to the programme from its findings. The central questions the Clinical Senate is being asked to address in this review are:

1. **Does the proposed model make clinical sense and, based on the evidence presented, is it likely to result in safe and high-quality services and outcomes for patients once implemented?**

2 Does the clinical model form a robust basis for moving to a more detailed development and implementation across the three hospital sites?

3 Are the plans sufficiently ambitious – are there further opportunities to improve care that we should consider?

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 Service Change 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 agreed that there was an overriding risk in any of those areas that 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 a clear vision for the proposals, i.e. what is the intended aim?
- Are the expected outcomes and benefits of delivery for patients of this proposed model clear and are there clear plans for how it / they will be measured?
- Is there evidence of clinical leadership and engagement in the development of the options / preferred model?
- Is there evidence that the proposals will improve the quality, safety and sustainability of care? (e.g. sustainability of cover, clinical expertise).
- Is there evidence that the proposed model will ensure equity in access to services for the population you serve, and how it could reduce inequalities in health?
- If there is a potential increase in travel times for some patients, is this outweighed by the clinical benefits?
- Do the proposals support better integration of services from the patient perspective?
- Do the proposals explain how the model will be staffed? Is there appropriate information on recruitment, retention, availability and capability of staff and the sustainability of the workforce?
- Do the proposals reflect up to date clinical guidelines and national and international best practice e.g. Royal College reports?
- Will these proposals meet the current and future healthcare needs of their patients within the given timeframe of the planning framework (i.e. the next ten years or more)?
- Do the proposals align with the local strategies and delivery plans (e.g. Sustainability and Transformation Plans / Integrated Care System strategy and plans)? Do they demonstrate alignment / integration of services (e.g. the link between primary care / social care / mental health services and acute provision including information systems)?

- Do the proposals demonstrate good alignment national policy and planning guidance?
- Does the options appraisal consider a networked or Alliance approach - cooperation and collaboration with other sites and/or organisations?
- 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?
- Is there an analysis of the clinical risks in the proposals, and is there an adequate plan to mitigate identified risks?

The clinical review panel should assess the strength of the evidence base of the clinical case for change and proposed models and make clear its key findings and recommendations in a report to the commissioning organization.

Timeline: The clinical review panel will be held in two sessions. The first on 5 August 2020 with the panel members and WHHT members and the second on 9 September for panel member discussion. The panel date was rearranged from 22 April 202 due to the COVID19 incident.
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 most appropriate methodology for the review will be agreed with the commissioner of the review and Senate Council. There are a number of options, the most usual methodology will be a face to face clinical review panel, providing the commissioner of the proposals the opportunity to have a two-way discussion of the proposals with the review panel. In this case, the review will be undertaken by a combination of:

- desk top review of the documentation (evidence) provided,
- a pre-panel teleconference for panel members to identify the key lines of enquiry and
- a review panel meeting to enable presentations and discussions to take place.

Other approaches may include a desktop review, and short review by teleconference. Full methodology will be agreed in all cases.
Report of the clinical review: A draft report will be made to the commissioning organisation for fact (points of accuracy) checking prior to publication.
Comments / correction must be received from the commissioning organisation within ten working days. The report will be submitted to Clinical Senate Council on 23 September 2020 to ensure it has met the agreed Terms of Reference and to agree the report.
The final report will be issued to the commissioning organisation following the Council Senate Council meeting of. The commissioning organisation forthwith becomes the owner of the report.
Communication, media handling and Freedom of Information (Act) requests:
Communications in respect of the review will be managed by the commissioning organisation. Clinical Senate will publish the report once the service change proposal has completed the full NHS England process, or at a time that is appropriate to the proposals. This will be agreed with the commissioning organisation. The commissioning organisation, as the owner of the report and any evidence and or data provided for the review, will be responsible for handling any formal requests for information under the Freedom of

Information Act 2000, irrespective of whether the request is received by either the Clinical Senate or commissioning organisation. (note: NHS Commissioning Board known as NHS England is the statutory body with responsibility for FOI requests received either directly or by the Clinical Senate and will be advised of all such requests received directly by the Clinical Senate and confirmation that the commissioning organisation will be responding to the request).

Confidentiality: Notes of the discussion will be taken on the day in order to develop a report. Once the final report has been issued to the commissioner of the review, they will be securely destroyed along with the evidence set provided.

All clinical review panel members will be required to sign a Confidentiality Agreement and declare any interests, potential or otherwise. The detail of any potential, or actual, conflict of interest will be discussed with the commissioning organisation and agreement made between them and the Clinical Senate as to whether or not the member may join the review panel.

Resources: The East of England Clinical Senate will provide administrative support to the clinical 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 commissioning organisation. Any requests will be appropriate to the review, reasonable and manageable. The review panel will not ask the commissioner of the review to provide new evidence or information that it does not currently hold.

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 commissioning organisation, who will be the owners of the final report.

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

Functions, responsibilities and roles of the parties

The **commissioning organisation** will

i. provide the Clinical Senate review panel with the clinical case for change, options appraisal and relevant background and current information, identifying relevant best practice and guidance. Is it recommended that the evidence supports the questions laid out above. The level of detail though will be appropriate and in proportion to the stage of development of the proposals. For NHS England Service Change Assurance process ‘Stage 2’ reviews, Clinical Senate provides supporting information on the evidence it would expect to see
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. be responsible for responding to all Freedom of Information requests related to the review and proposals and

v. 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 commissioning 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 include 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. consider the review recommendations and report and consider whether the clinical review panel met the Terms of Reference for the review
iii. provide suitable support to the panel
iv. issue the final report to the commissioning organisation and
v. promptly forward any Freedom of Information requests to the commissioning organisation.

Clinical review panel will

i. undertake its review in line with the methodology agreed in the Terms of Reference
ii. follow the report template and provide the commissioning 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.

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 and
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.

Clinical review panel members: Members of the clinical review panel sit in their own personal or professional capacity; they do not represent the opinion of their employing or professional body. All clinical review panel members sign an agreement of confidentiality and declare any (potential interests).

Appendix A – Key Dates		
Action	Date (no later than)	Who
1. Commissioning team request clinical review – date & methodology agreed with Senate	**Require minimum of 8 weeks lead in for review**	**WHHT** team and Senate office
2. Terms of Reference for review completed, agreed and signed off	**Date**	**WHHT** team and Senate office
3. All panel members identified and confirmed, confidentiality agreements and declarations of interest signed	**Date**	Sue Edwards
4. All papers and evidence for the review panel to be with Sue Edwards	**No later than two weeks before panel date** **Date**	**WHHT** team
5. Panel papers etc to panel members	**Date 9 July 2020**	Sue Edwards
6. Pre-panel teleconference call	**Date 14 July 2020**	Panel members only – **WHHT** not involved-
7. Lines of Enquiry / Agenda for Clinical Panel review day issued	Follows 6 above **Date 15 July 2020**	SE to ALL
8. Clinical Panel Review	**Day one 5 August 2020 with WHHT** **Day two 9 September 2020 panel members only**	
9. Draft report to **WHHT** lead for points of accuracy	**14 September 2020**	SE/Chair
10. **WHHT** response on points of accuracy	**18 September 2020**	**WHHT** & Panel member
11. Clinical Senate Council consider report	**Date 23 September 2020**	Clinical Senate Council

APPENDIX 2: Membership of the clinical review panel

Clinical Review Panel Chair:

Dr Bernard Brett
Dr Bernard Brett, Chair of East of England Clinical Senate, is Deputy Medical Director and a Consultant in Gastroenterology and General Internal Medicine based at the Norfolk and Norwich University Hospitals NHS Foundation Trust, and also works at the James Paget University Hospitals NHS Foundation Trust.

Bernard has held several senior management posts over the last fifteen years including that of Medical Director, Responsible Officer, Deputy Medical Director, Divisional Director, Director of Patient Flow and Appraisal lead. He continues with an interest in Appraisal and Revalidation. Bernard has spoken at regional and national meetings on the topic of 7-day working and been an invited speaker on the topic of improving colonoscopic adenoma detection rates.

Panel Members:

Professor Erika Denton
Professor Denton is Medical Director and Consultant Radiologist, with a Special Interest in Breast Imaging, at Norfolk & Norwich University Hospital Trust. Erika's appointment to the role of Medical Director in 2019 follows 2 years as Associate Medical Director.
Erika has been advising NHS Improvement since 2016 where she has convened and chairs the National Imaging Optimisation and Productivity Delivery Board. She leads work to improve imaging services across England.

Dr Richard Goodwin
Having trained at UCL and St George's Hospitals Richard was appointed as a consultant musculoskeletal radiologist at Norfolk & Norwich University Hospital in 2006. He became Clinical Director/Chief of Service for Imaging at NNUH in 2015 and is currently Chief of Division for Clinical Support Services and Chair of the Norfolk Imaging Alliance. He completed an Executive MBA from Cranfield School of Management in 2018. He has given talks on leadership and management, imaging networks and musculoskeletal radiology at national meetings.

Dr Indi Gupta
Dr Gupta qualified in 1992 and has been a Consultant Geriatrician and Physician at Basildon and Thurrock University Hospitals since 2004. She led the Geriatric Medicine and Stroke Department for five years from 2009 till 2014 and has been the Divisional Director for Medicine since then. Dr Gupta is actively involved in the redesign and reconfiguration of clinical pathways in her local STP in Essex i.e. MSB.

Dr Stuti Mukherjee
Stuti is a General Practitioner, a Macmillan GP and Joint Clinical Lead for Cancer at Cambridgeshire & Peterborough CCG. She enjoys working as a Generalist, and has a special clinical interest in cancer, dermatology and end of life care.

Karen Smith
An independent nurse consultant, Registered Nurse and Health Visitor with a wide range of experience from over 35 years in the NHS. She was a Clinical Quality and Patient Safety Manager and the Regional VTE Programme Lead for the East of England SHA which became an exemplar organisation for the prevention of venous thromboembolism in 2010. She also worked with Kings College Hospitals VTE Exemplar Network as its manager, helping to develop the Nursing and Midwifery sub-group and to promote learning and sharing of best practice.

Karen was Head of Patient Safety and Clinical Effectiveness at the two Suffolk Clinical Commissioning Groups, as a member of the Chief Nursing Officer team. She is currently continuing work in the health and care sector as an independent nurse including conducting reviews of mental health and learning disability services as an independent chairperson. She remains passionate about continuing to support the enhancement of quality and patient safety and the continuous improvement of services.

Mr Paul Tisi
Mr Paul Tisi was appointed as Consultant Vascular and General Surgeon at Bedford Hospital and Luton and Dunstable University Hospital in 2001. Following leadership roles as Associate Medical Director and subsequently Divisional Medical Director for Planned Care he was appointed as Medical Director for Bedford Hospital NHS Trust in 2016. Following a successful merger which was completed at the peak of the Covid-19 pandemic he is now in post as Joint Medical Director and Responsible Officer at Bedfordshire Hospitals NHS Foundation Trust. Aside from his board role he maintains a clinical practice with specific interest in management of venous disease. He is an editor for Cochrane Vascular and represented Midlands and East on the National Clinical Reference Group for Vascular Surgery for 6 years. He was appointed to the East of England Clinical Senate Council in 2019.

Clinical Senate Support Team:

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

Panel members stood down due to COVID-19:

Dr Jag Ahluwalia
Abigale Bedford
Dr Gareth Corbett
Miss Gill Clayton
Charlotte Etheridge
Jo Francis
Megan Gingell
Mike Hewins
Dr Simon-Peter Hosein
Mr Mahesh Kumar
Sarah Lincoln
Lisa Llewelyn
Dr Louise Scovell

APPENDIX 3: Declarations of Interest

All panel members were required to declare any interests, **none were declared.**

APPENDIX 4: Review panel agendas

A G E N D A

Panel day one of the independent clinical review of redevelopment proposals for West Hertfordshire Hospitals NHS Trust

Attending: Senate panel members and WHHT team

Panel day one: Wednesday 5 August 2020

Time: 09.00 hrs to 12.30 hrs for panel members &
09.20 hrs to 12.10 hrs for WHHT team

Clinical Senate is being asked to address the following questions:

1. **Does the proposed model make clinical sense and, based on the evidence presented, is it likely to result in safe and high-quality services and outcomes for patients once implemented?**
2. **Does the clinical model form a robust basis for moving to a more detailed development and implementation across the three hospital sites?**
3. **Are the plans sufficiently ambitious – are there further opportunities to improve care that we should consider?**

Wednesday 5 August 2020	
Time	**Item & who**
09.00 – 09.15	Dial in (arrival) for panel members
09.20 – 9.30	Dial in (arrival) for WHHT members. Welcome, introductions & outline of the proceedings for the review panel from panel chair Dr Bernard Brett
09.30 – 10.00	Overview presentation 30 mins by WHHT team to panel
10.00 – 10.10	Break
10.10 – 11.00	General questions from panel to WHHT team

11.00 – 11.10	Short break (if required)
11.10 - 12.10	Panel questions & informal discussion with WHHT
12.10 – 12.25	WHHT team leave the meeting Summary and close for review panel members

Key Lines of Enquiry.

The clinical review panel raised a number of points on its pre-panel call 14 July 2020. These have been developed into key lines of enquiry for the WHHT to address through its presentation and discussion with the panel on 5 August. The Trust is welcome address any of these by email prior to the panel day. The discussion on 5 August will not be restricted to these areas alone.

Information Technology:

The panel would like further detail on the Trust's digital strategy and ambition for integrated IT solutions (e.g. single electronic patient record across Trust sites, integration with primary and secondary care etc)

Patients impact, outcomes and involvement:

What is the Trust aiming to achieve through the proposed changes in terms of patient related outcomes, how will the Trust measure the impact on patients and staff?

How have patients, carers and public been involved in development of proposals?

The panel would like clarification on why older people's services is shown as sitting only in the 'Cold' site (in the model figure 13) and not across hot and cold (i.e. with direct access to A&E, ambulatory care) and

clarification regarding the interface between Gastroenterological surgery and medicine particularly if on two different sites for elective work.

A few more examples of patient pathways would be helpful.

Estate:

The panel would like a better understanding of the Trusts' long-term strategy for its estate, has a two-site model been excluded and why and is there confidence that a three-site model would be sustainable?

The panel would like to know about the expected duration for safe operation of diagnostic and imaging equipment and facilities at the respective sites;

It would like more detail on the geographical and time distance between the three sites and any access and transport issues that have been identified (for patients and staff) including car parking:

How do the proposed changes support the Trusts (likely) intention to manage future pandemic situations i.e. protecting 'Green' elective care;

Workforce:

Does the Trust have an organisational development plan that takes into account training development for new ways of working?

Has the impact of the proposals on workforce recruitment, retention and training been assessed and modelled; have the current gaps been identified and what is the Trust's target in terms of filling the gaps etc.

Leadership and Implementation: Does the Trust have the leadership resource and capability for major changes to pathways and estate? What are the associated risks?

Next steps (following 5 August 2020 panel):

1) The clinical review panel members will reconvene (by TEAMS) on Wednesday 9 September 2020 to discuss and agree its key findings and recommendations.

2) Any additional questions raised by panel members in the meantime will, with the agreement of the Clinical Review Panel Chair, be forwarded to the WHHT team for a response. The question, and response, will be shared with all panel members. Should it be likely that the panel would wish to discuss any matters further, the WHHT team will be invited to join the panel on its call on 9 September 2020.

A G E N D A

Panel day two of the independent clinical review of redevelopment proposals for West Hertfordshire Hospitals NHS Trust

Attending: Senate panel members only

Panel day two date: Wednesday 9 September 2020

Following panel day one with the West Hertfordshire Hospitals NHS Trust team, the clinical review panel is convened to discuss and agree its key findings and recommendations. Clinical Senate is being asked to address the following questions:

1. **Does the proposed model make clinical sense and, based on the evidence presented, is it likely to result in safe and high-quality services and outcomes for patients once implemented?**
2. **Does the clinical model form a robust basis for moving to a more detailed development and implementation across the three hospital sites?**
3. **Are the plans sufficiently ambitious – are there further opportunities to improve care that we should consider?**

Wednesday 9 September 2020	
Time	**Item & who**
09.00 – 09.15	Dial in (arrival), introductions and welcome from panel chair
09.15 – 10.30	Recap (from panel chair) and summary of panel day one and Panel discussion: key findings and recommendations
10.30 - 10.45	Break
10.45 – 12.00	Summary of key findings and recommendations
12.00 – 12.15	Next steps and close.

Next steps – information for clinical review panel members and WHHT team:

1) A draft report will be sent to WHHT team and clinical review panel members for points of accuracy check no later than Monday 14 September with five-day turnaround for panel members and WHHT team.

2) Final draft report will be provided for specially convened Clinical Senate Council meeting on 23 September 2020 for Council to confirm that the clinical review panel met the Terms of Reference for the review (NB Council cannot make any material changes to the report or its recommendations but may make additional comment or recommendations.)
3) Final report provided to WHHT team by 24 September 2020.

West Hertfordshire Hospitals Trust team members (attending 5 August 2020)	
Name	**Role**
Dr Michael Van Der Watt	Medical Director & Consultant Cardiologist, WHHT
Dr Freddie Banks	Associate Medical Director & Consultant Urologist, WHHT
Dr David Evans	Managing Director, Herts Valleys CCG
Dr Trevor Fernandes	GP & Herts Valleys CCG Board Member (Deputy Clinical Chair)
Esther Moors	Redevelopment Programme Director, WHHT

End of report.

Glossary of abbreviations used in the report

CCG	Clinical Commissioning Group
CT	Computerised Tomography (scanner)
HHH	Hemel Hempstead Hospital
IT	Information Technology
MRI	Magnetic resonance imaging (scanner)
RDC	Rapid Diagnostic Centres
SACH	St Albans City Hospital
STP	Sustainability and Transformation Partnership
WGH	Watford General Hospital
WHHT (or the Trust)	West Hertfordshire Hospitals NHS Trust