



Mid & South Essex Sustainability and Transformation Partnership

Report of the Independent Clinical Senate (Preliminary) Review Panel held 18 September 2017

This page intentionally left blank

Glossary of abbreviations used in the report

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

Table of Contents

1. FOREWORD BY CLINICAL SENATE CHAIRMAN	4
2. ADVICE REQUEST / BACKGROUND.....	6
4 SUMMARY OF KEY FINDINGS & RECOMMENDATIONS: TRANSFER AND TREAT MODEL.....	9
5. STROKE SERVICES: SUMMARY OF KEY FINDINGS AND RECOMMENDATIONS.....	15

APPENDIX 1: Terms of Reference for the review..... Error! Bookmark not defined.

APPENDIX 2: Membership of the clinical review panel.... Error! Bookmark not defined.

In attendance at the panel:.....Error! Bookmark not defined.

APPENDIX 3: Declarations of Interest.....Error! Bookmark not defined.

1. FOREWORD BY CLINICAL SENATE CHAIRMAN

The Mid and South Essex Sustainability and Transformation Partnership (MSE STP) has undertaken a great deal of work as it continues to develop its plans to improve services for the population it serves. The Clinical Senate has seen its plans at two previous stages of development and recognises the stakeholder input that has led to a modification of the STP's proposal in the lead up to this clinical review.

We would like to thank the MSE STP team for the information it provided and the frank and honest response we felt we received to all of our questions. The panel agreed that the team was patient centred, enthusiastic and energetic. The MSE STP team was mostly consistent in its response although it was clear that there was still an understandable degree of debate around some elements of the proposals.

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 the MSE STP team to further develop its plans for the benefit of patients and the local population.

The case for change is strong and the panel agreed that a 'do nothing' option was not viable. The panel was supportive of the principles put forward underpinning the programme of change. The panel was also understanding of the desire from stakeholders to maintain local services as much as possible. The panel was however of the view that local services must always be balanced against the need to ensure robust, safe, high quality and sustainable services.

The concept of the consolidation of certain specialist and complex services onto one or two sites to improve patient outcomes and ensure sustainability was supported, as was the associated need to develop systems to identify, treat and transfer prior and during transfer, for a relatively small proportion of patients. The panel also recognised that making such changes took time and careful planning. Given the need for appropriate care and time and the stakeholder input, the panel understood the changes made to previous proposals. The panel was of the view however that in the longer term even bolder changes may lead to better outcomes and more sustainable services.

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 to the patients in Mid and South Essex.

I wish to thank all our panel members for giving up their time and giving their attention to this important review. The range of expertise was impressive and invaluable. 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 Mid and South Essex STP team our ongoing support in the further development of its plans and we look forward to assisting in the future with further reviews.



Dr Bernard Brett

**East of England Clinical Senate Chair
and clinical review panel Chair**



2. ADVICE REQUEST / BACKGROUND

- 2.1 This clinical review panel was convened for the Mid and South Essex Sustainability and Transformation Partnership (formerly the Mid and South Essex Success Regime - MSESr) to review the latest proposals for the acute services reconfiguration, namely the model for 'Triage, Transfer and Treat' and the early proposals for Stroke services, in particular proposals for Hyper Acute Stroke Unit/s (HASU). The panel also briefly considered the principle of consolidation of services across the three hospital sites.
- 2.2 Clinical Senate has reviewed proposals for the acute model on two earlier occasions, in June and October 2016. Following stakeholder input the Mid and South Essex Sustainability and Transformation Partnership (MSE STP) subsequently reconsidered the earlier proposals for Accident and Emergency (A&E) services and is asking the senate to consider these new proposals.
- 2.3 A clinical review panel had already been convened for 18 September 2017 with a full panel membership, to review proposals for another commissioning body. There was an imperative for clinical senate input on the MSE STP proposals for an NHS England Regional Assurance checkpoint on 25 September, and to meet other internal and external deadlines. On 5 September 2017 the Clinical Senate Chair and NHS England Midlands and East (East) Director of Commissioning Operations and the MSE STP Programme Director agreed to defer the (other) panel already in place and ask the panel to review, instead, the MSE STP proposals.
- 2.4 It was also agreed that this review panel would provide preliminary feedback on the MSE STP proposals prior to a full and formal 'Stage 2' assurance on the entire MSE STP proposals for acute services to be held later in the year.
- 2.5 The scope of this clinical review panel was again on acute reconfiguration options only (as at para 2.1); all other services were out of scope of this particular 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.

2.6 This report from the clinical review panel is provided to support the NHS England Midlands and East Regional Assurance checkpoint meeting for the Mid & South Essex STP scheduled to be held on 25 September 2017 and subsequent NHS England Investment Committee meeting to be held on 4 October 2017.

3. METHODOLOGY & GOVERNANCE

3.1 Clinical Senate Chair and the MSE STP Programme Director agreed that the given the short notice, a preliminary clinical review panel held on 18 September 2017 followed by 'Stage 2' assurance clinical review panels held at a later date over two days, would be the most appropriate approach.

3.2 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. Some of those had already agreed to be panel members for the previously arranged panel, others specifically Emergency Care clinicians, were recruited. A supporting letter from the NHS England Midlands and East (East) Director of Commissioning Operations was sent to the Chief Executive of two acute Trusts to request support for the panel from their clinicians.

3.3 Clinical Senate's normal procedure to ensure panel members do not have a conflict of interest is to provide a declaration for their signature once they have agreed to be a panel member. Panel members are also required to sign a confidentiality agreement. On this occasion, panel members were provided with the documents for their signature at the review panel.

3.4 Terms of reference for the review were drafted by the Programme Director and agreed by Dr Bernard Brett, Chair of East of England Clinical Senate and appointed Chairman of clinical review panel.

- 3.5 There was insufficient time between receipt of the evidence and the panel day to hold the usual pre panel teleconference to prepare members and discuss potential key lines of enquiry. Additional time was therefore built into the agenda for the panel day (Appendix 4) to include this.
- 3.6 The clinical review panel took place on Monday 18 September 2017. A draft report was sent to five members of the panel for review and confirmation of accuracy and approved by the Chair of the clinical review panel.
- 3.7 The final report is normally submitted to the East of England Clinical Senate Council for it to ensure that the clinical review panel met and fulfilled the Terms of Reference for the review and is then submitted to the commissioning body. In this instance due to the short turnaround time, Senate Council agreed Chairman's action for the Chair to approve the report. The report will be submitted to Senate Council at its next meeting on 11 October 2017.
- 3.8 East of England Clinical Senate will publish this report on its website as agreed with the sponsoring organisation, the Mid and South Essex STP, in the Terms of Reference.

4 SUMMARY OF KEY FINDINGS & RECOMMENDATIONS: TREAT & TRANSFER MODEL

Key findings:

- 4.1 The panel heard that the Mid and South Essex Sustainability and Transformation Partnership (MSE STP) had revised its earlier models for urgent and emergency care following feedback from stakeholders, including the public and staff. The revised model presented to the review panel was for a Consultant led Accident and Emergency Service on a 24 hour, seven day week basis at all three hospital sites. Each site would have areas of special interest, with one being largely focussed on specialist medical care, one specialist surgical care and the third with a focus on specialist cancer care with a Treat and Transfer model for the more complex and specialist patients, so consolidating the complex cases.
- 4.2 The STP team expected that most patients would be treated locally but recognised that the model would result in increased number of patients requiring transfer from one site to specialist centres. The panel heard that the frail elderly patients were the largest patient group presenting at A&E and amongst those admitted for non-elective care. With the proposed enhanced Ambulatory pathway in place, the STP team considered that hospital admissions could be reduced with more patients remaining in their local area. Enhanced self-care and community care was also planned to help reduce demand but this was only briefly discussed during the review panel as this was not a main focus of this review. Although also out of the formal scope of this review, the panel also discussed the potential impact on GPs and local primary care services and heard of measures to address some of the current, and potential, issues. The panel was very supportive of work towards these aims and felt this was an essential component in order to ensure there would be sufficient capacity to deal with potential demand.
- 4.3 The panel supported the attempt to reduce variation in care with a one team approach across the three sites, including common protocols, policies,

guidelines and pathways. The panel understood that this would include the creation of STP wide speciality teams to potentially aid recruitment, retention, support and training of the workforce and build resilience across the system. The panel agreed that Anglia Ruskin University's plan to open a new Medical School in Chelmsford in September 2018 would provide opportunities, in the medium to long term, to enhance recruitment, retention and training of a local workforce. The panel felt that the proposed changes should be taken as a real opportunity to help deliver enhanced multi-professional training at all sites. The panel felt that innovative training rotations and approaches would need to be developed recognising that some specialist services will no longer be available on the three sites but would be delivered in an enhanced form on one or two sites.

- 4.4 This panel supported the view of previous senate clinical review panels for the proposed separation of elective and emergency care as much as practicable to help smooth pathways. Ensuring that separation in practice may be more challenging with a less marked demarcation between sites than previously considered. The panel recommended that modelling should be undertaken to ensure proper consideration had been given to a) maximising theatre use, and b) ensuring capacity to cope with the needs of both emergency diagnostics and emergency surgery as well as inpatient beds.
- 4.5 The panel was supportive of the high level principles and the direction of travel to consolidate low volume, highly complex or high risk procedures onto one or two sites, as evidence suggests that this is likely to improve outcomes for patients and may have additional benefits for staff.
- 4.6 The panel was also supportive of the general principle to develop pathway specific triage, treat and transfer protocols and guidelines to enable patients to be treated in the most appropriate place. Where clinically beneficial, over a period of time, this should include some additional agreed pathways for a relatively small percentage of patients (at least in the first instance) that would be taken straight to a specialist centre rather than the local A&E in the first instance.

- 4.7 There was lengthy discussion on the complexity and practicalities of transferring patients between sites. This included, among other things, mitigation and management of the risks of transferring acutely ill patients, repatriation of patients following a completed episode of complex care to ensure there was proper flow into the tertiary hospital, impact on relatives and carers, and ensuring smooth transfers into appropriate care. This should ensure that, for example, patients did not end up spending time in one A&E department only to be transferred and spend time in the receiving A&E department before reaching the specialist unit they needed for optimal care. Concern was raised that palliative care patients could have an inappropriate transfer due to an acute presentation, potentially resulting in terminally ill patients dying in acute hospital beds, possibly a long way from home, when they may have wished to die at home. The STP agreed that appropriate protocols and training would ensure the best, and most appropriate, care for all patients including those in palliative care.
- 4.8 The panel heard that the STP was considering establishing its own inter-hospital transfer service to reduce the burden on the East of England Ambulance Service Trust (EEAST). The implications of providing such a service were discussed in some detail, including the complexity of managing the irregularity and unpredictability of transfer demand, the need to have appropriately skilled staff to assist with transfers and robust governance arrangements. The process to decide to transfer patients and then to action this should be robust and efficient and not lead to a burdensome and time-consuming bureaucracy for staff, and unnecessary delays for patients. The movement of staff involved in transfers was also discussed amongst the panel, the panel advised that the timely repatriation of staff to their base hospital and the impact of staff being offsite must be considered. The STP team was clear that this was still being scoped.
- 4.9 There was discussion on information systems; the panel heard that there was not a common IT system across the three sites, and that in addition current systems were unable to interface and share data and information with primary care or local authority systems. The panel felt that the sharing of clinical information across systems was an essential component to enable the

proposed cross-site working. In addition to direct patient related information, other information such as bed occupancy, diagnostic capacity etc would also be essential to enable staff to optimally manage patients.

- 4.10 The STP team advised that it was addressing the current variance across the sites in respect of the presence of both mental health and allied health professionals. It recognised the need to have common and appropriate standards for access for patients to mental health professionals particularly. The panel emphasised the impact on both patients themselves and demand and capacity of emergency services if the needs of those living with mental health concerns were not fully met.
- 4.11 The panel agreed that, given the changes in training, enhanced subspecialisation and workforce numbers, in the longer term, acute surgery was not likely to be sustainable on all three sites 24/7. The panel noted the possible plans to move emergency gastrointestinal surgery to one site but questioned the ability to maintain three surgical assessment units on a 24/7 basis – each still requiring the 24/7 availability of senior decision maker even if acute surgery was not available on that particular site. The panel did however feel that retaining three A&E departments was potentially sustainable in the medium to longer term, but would face the challenge of having fewer on-site specialist services which could further challenge recruitment, retention and training. The panel also discussed the possible option of providing some services less than 24/7.
- 4.12 The panel agreed that a more detailed analysis of current and projected activity and capacity, informed by new pathways as they are further developed should be undertaken. This should include for example a local detailed review of A&E attendance figures as this may prove useful to ensure that the STP was developing a service appropriate to needs, for example, local experience from elsewhere in the region was that there was a marked increase in the 0-5 year old patient group. The panel advised that this type of data analysis be sufficiently considered in the model.
- 4.13 The development of a system wide diagnostic hub was not referred to in the documentation provided for the panel but was mentioned in discussion. The

panel was supportive of this concept, especially for the more complex diagnostic imaging modalities as long as emergency care diagnostic imaging pathways were simultaneously enhanced.

- 4.14 The panel was given some modelling regarding bed numbers, patient transfers and theatre activity. The panel was also advised of the need to enhance the physical environment at the front door to accommodate the proposed range of acute assessment and diagnostic services including enhanced ambulatory care. The panel was not given detailed information regarding proposed changes to the estate but was supportive of the need for appropriate physical infrastructure to be put in place.
- 4.15 While the panel supported the direction of travel and principles of the proposals, it agreed that the benefits to patients needed to be more clearly articulated. The lack of detail on pathways, due to the early stage of development, made it difficult for the panel to judge whether the proposals would benefit patients. Furthermore the panel agreed that developing clear and well described benefits for patients would be crucial for both the public and staff to understand and support the proposals.

4.16 Recommendations

Recommendation 1

- 4.16.1 Inter-hospital transfers: The panel accepted that clinical pathways were still to be fully developed for the inter-hospital transfers but agreed that much more work was required to demonstrate a robust model that would deliver safe, appropriate, high quality services for patients. This should include detailed activity modelling on numbers, medical and nursing workforce, training implications and required skills, governance and resilience.

The panel recommended that the STP give serious consideration to the complexity and implications of running its own inter-hospital transport service and should ensure that risks and benefits are suitably assessed against alternative options.

Recommendation 2

4.16.2 Whilst the panel agreed with the direction of travel, and it recognised that there was a need to progressively differentiate and develop services over time; the panel felt that the longer term plans could be bolder. Previous clinical review panels have recommended Mid and South Essex (Success Regime) STP to consider more radical change, over a longer period of time¹. This independent clinical review panel was of the same opinion and reiterated its recommendation to use this as an opportunity to take a longer term view on how to create greater opportunities for improved patient outcomes and experience and indeed greater opportunities for staff development and individual careers.

Recommendation 3

4.16.3 The panel recommended that much more work in the area of information technology was be undertaken in order to have in place reliable, safe, real time transfer of patient information, essential for delivery the proposed reconfiguration of services. This information should be included in as part of the patient pathway development and should include the bed management system.

Recommendation 4

4.16.4 The panel recommended that the team make clear the arrangements that would be in place to support staff to work across the sites for the 'one team' approach, for example regarding travel, relocation and training and development opportunities.

Recommendation 5

4.16.5 The panel recommended that further engagement with neighbouring STPs take place and that as pathways are developed, modelling includes potential impact on STPs and other stakeholders particularly the Ambulance Trust.

¹ Clinical Review panel 4 & 5 October 2017report para 4.25

5. STROKE SERVICES: SUMMARY OF KEY FINDINGS AND RECOMMENDATIONS

Key findings:

- 5.1 The panel heard that although significant progress had been made on stroke services recently with individual stroke services performing well in comparison with national data. The STP considered this to be an opportunity to get an even better stroke service for its population.
- 5.2 Mid and South Essex traditionally had good SSNAP data for stroke patients; it had an 'A' rated median time of 35 – 47 minutes across the three hospitals, compared to the national median of 42 minutes (door to needle). The STP team considered that the developing service needed to focus on rapid interventions.
- 5.3 There was some discussion around the London and Manchester models and acknowledgement that the London model was successful in reducing length of hospital stays, mortality and disability primarily due to an expert clinical skill base in large, well-staffed specialist units rather than the speed at which patients were initially treated.
- 5.4 Given the size of the population (circa 1.2 million) the geography, national guidance and the need to ensure sustainable services, the panel agreed that there should ideally be one single Hyper Acute Stroke Unit (HASU) as suggested in the plans.
- 5.5 The panel agreed that there was insufficient evidence to include stroke services in the previously discussed Treat and Transfer model. The panel was concerned regarding the potential risk to patients if they were initially monitored in a non-HASU local environment during the first few hours post thrombolysis which is often the most unstable for patients.
- 5.6 The panel recognised the desire amongst the local population and staff to have, and keep, services as local as possible and therefore the rationale for trying to keep three acute stroke units. The panel did however agree that

consideration should be given to co-locating a single acute stroke unit in close proximity and on the same site as the single HASU (similar to the Scandinavian model²). Evidence had shown this to have better outcomes for patients. Furthermore, the panel questioned whether three smaller throughput acute stroke units would be able to sustain sufficient appropriately qualified and trained staff including the psychological support, speech and language therapy, occupational therapy and physiotherapy support required to meet national standards.

- 5.7 Understanding the potential impact of increased A&E attendances and admissions (of potential stroke patients, including stroke mimics) would be crucial to the ensuring a safe and sustainable model of care. The panel recommended that the STP team model the impact of having an potential additional 2-3 patients a day with conditions that mimicked strokes, in addition to the number of additional true stroke patients, on the clinical workforce numbers and skill base including the impact this would have on acute medicine, A&E, diagnostics and elderly care services.
- 5.8 The panel recognised that NHS England Specialised Commissioning would determine the short to medium term configuration of thrombectomy services. The panel heard of the successful low volume introduction of thrombectomy services and were informed verbally of good outcome data. The panel was supportive of attempts to, where possible, maintain workforce, skills and expertise in the region and to utilise such skills to deliver training. The panel was however of the unanimous view that if there was to be a within-STP thrombectomy service this should ideally be co-located with the single HASU.
- 5.9 The panel was also of the view that decisions regarding thrombectomy services should be made region-wide and should include detailed discussions with current, planned and potential providers of the service. The geographical location of such services should be chosen to maximise the benefit to the widest proportion of patients across the East of England and, where appropriate, beyond into other regions.

² The Scandinavian stroke unit model, which combines acute and rehabilitation stroke units, about 70–75% of Scandinavian stroke patients are treated at stroke units

5.10 The panel was provided with a copy of email correspondence sent to the Clinical Senate from individual clinicians in a provider organisation outside of the MSE STP. The email had expressed some concern at the proposal for provision of a thrombectomy service within the Mid and South Essex STP. The panel highlighted the importance of engagement with neighbouring STPs and provider organisations and the MSE STP team undertook to discuss this particular matter with them as soon as possible.

5.11 Recommendations

Recommendation 1

5.11.1 The panel did not feel that there was evidence to support the plan to provide thrombolysis on all three sites with subsequent patient transfers to a single Hyper Acute Stroke Unit, particularly as the six-hour post thrombolysis phase was the most unstable time for patients. The panel recommended that thrombolysis should be delivered either at or in close proximity to the proposed single Hyper Acute Stroke Unit.

Recommendation 2

5.11.2 The panel recommended that in developing its model of care, the MSE STP look to national guidelines and national and international best practice, particularly with reference to transfer of stroke patients. It advised the STP team that it would need to have a strong and very robust case developing any elements of the service that did not follow national guidelines.

Recommendation 3

5.11.3 The panel recommended that the STP team model the impact on acute medicine, A&E services, diagnostics and elderly care of having additional admissions for stroke including stroke mimics to the site hosting the Hyper Acute Stroke Unit.

Recommendation 4

5.11.4 The panel supported standardisation of the stroke pathway across the STP. The panel recommended that further work be undertaken on standardising the pathway for Early Supported Discharge and end of life care where appropriate.

Recommendation 5

5.11.5 The panel recommended that if proposals for a single HASU were to proceed, then further detailed modelling must be undertaken and the STP must engage with stakeholders to consider any impacts, not least the neighbouring STPs and Ambulance Trust. The panel further recommended that detailed work be undertaken to ensure appropriate governance structures and processes are put in place.

End.

APPENDIX 1: Terms of Reference for the review



Graphics removed to reduce file size

Preliminary* review of proposals for acute service reconfiguration for the Mid and South Essex Sustainability and Transformation Partnership

Terms of Reference for the Independent Clinical Senate Review Panel - 18 September 2017

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

CLINICAL REVIEW PANEL: TERMS OF REFERENCE

Title: Mid and South Essex Sustainability and Transformation Partnership

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

And the East of England Clinical Senate

Terms of reference agreed by: Dr Bernard Brett

Signature 

on behalf of the East of England Clinical Senate and

Signature

Celia Skinner on behalf of Mid and South Essex STP

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

Date:

Clinical review team members

Mid and South Essex STP Clinical Review Panel 18 September 2017 Clinical Review Panel Members	
Dr Bernard Brett (Chair)	Panel Chair. Clinical Senate Chair, Consultant
Dr Annie Chakrabarti	Stroke Consultant, Norfolk & Norwich University Hospital
Dr Jim Crawford	Emergency Medicine Consultant, James Paget Hospital
Ruth Derrett	Director of Transformation and Delivery – Urgent and Emergency Care, Cambridgeshire & Peterborough CCG
Dr Juliet Draper	Expert by Experience
Dr Claire Gillon	Trainee Doctor, Whittington Hospital
Dr Patrick Gompertz	Consultant physician (Stroke Clinical Lead), Barts and The London NHS Trust
Kirstie Hughes	Senior Sister Renal and Emergency medicine, James Paget Hospital
Dr John Lockley	Clinical Senate Council Member, Retired GP from Bedfordshire
Miss Clare Marx CBE DL FRCS	Orthopaedic Surgeon Ipswich Hospital
Linda Purdy	Consultant Ambulatory Care Nurse, The Queen Elizabeth Hospital, King's Lynn
Michael Rattigan	Senior Paramedic Mentor, EoE Ambulance Service
Dr Raj Shekhar	Consultant Stroke Physician, The Queen Elizabeth Hospital, King's Lynn
Dr Dee Traue	Palliative Care Consultant, East & North Herts NHS Trust.
Glenda Turner	Senior Sister Emergency Medicine James Paget Hospital
Lisa Webb	Clinical Lead, Occupational Therapist, Lister Hospital

Mid and South Essex team members

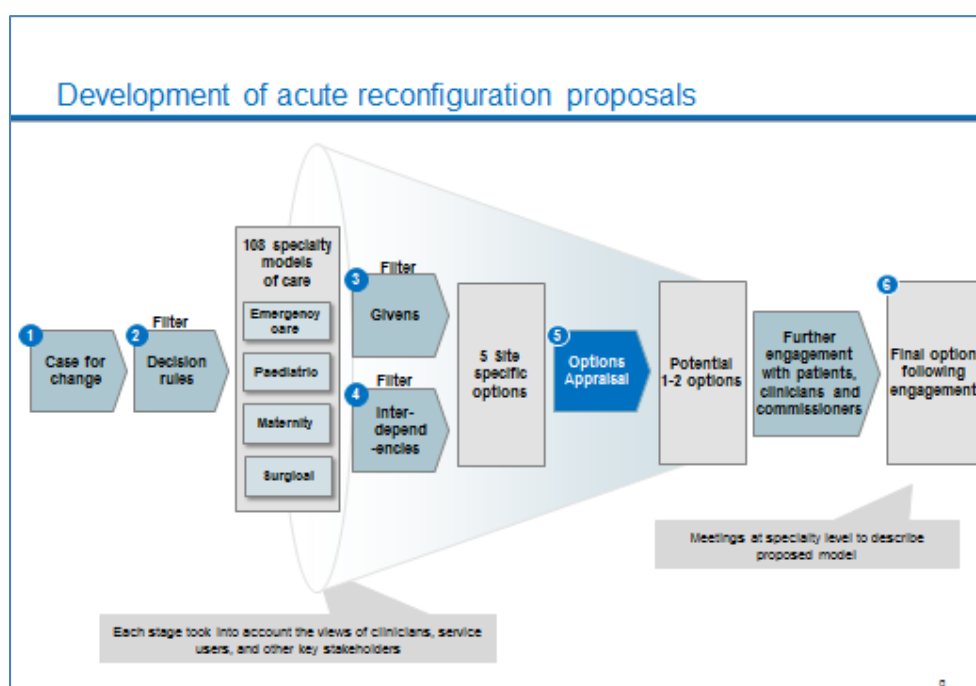
Dr Anita Donley	Independent Chair, Essex Success Regime
Dr Paul Guyler	Stroke Consultant Southend Hospital
Dr Ronan Fenton	Medical Director, Mid & South Essex Success Regime
Dr Donald McGeachy	Medical Director, Local Health and Care, Mid & South Success Regime
Dr Tom Abell	Chief Transformation Officer
Dr Hagen Gerofke	Clinical lead for A&E and acute medicine
Dr Ramanathan Kirthivasan	Consultant physician (Stroke)
Andy Vowles	Programme Director

Context, aims and objectives of the clinical review

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

The over-arching aim of the work is to establish a model of care which helps to secure the clinical, financial and operational sustainability of the three hospitals and, where possible, to improve outcomes by consolidating some clinical services.

The clinical model has been developed and iterated over the last 18 months. The following exhibit gives an overview of the process:



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

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

The Programme has recently made some significant changes to the proposed clinical model, in response to feedback from the public, stakeholder and clinicians. **It is these changes that form the focus for this initial Clinical Senate review.**

The Programme is aiming to commence public consultation by the end of October 2017. As such, an NHS England Regional Assurance Checkpoint is scheduled for 25 September 2017; the recommendations and findings of this clinical review panel will feed into that review.

The Programme plans to ask the Senate to complete a full stage 2 review of the final proposals in late 2017/early 2018, prior to any final decisions on configuration being taken.

Scope of the review

The Mid and South Essex STP 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, dementia. However, the scope of this review is on acute reconfiguration options only, and is limited to the changes that have been made since previous senate reviews.

The key service areas that are within scope and should form the focus of the Senate's deliberations are:

- The proposed 'triage, treat and transfer' process that will operate across all three emergency departments
- The revised proposed Stroke pathway including the intention to establish a single HASU on at Basildon hospital
- The principle of consolidating some complex/low volume procedures on a smaller number of sites*

*the panel may wish to explore at a general level one or two pathways as 'tracers' to test this overall principle, such as urology

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

The central questions the panel are asked to address at this point – recognising that a full Stage 2 panel will follow – are whether:

- **the proposed model and pathways make clinical sense and, based on the evidence presented, are likely to result in safe and high quality services**
- **the model forms a robust basis for moving to public consultation and detailed development**

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).

Questions/issues that may help the panel include (but are not limited to):

- the principle of consolidating high risk/low volume services and a smaller number of sites
- observations on the proposed model of 'triage, treat and transfer' for some patients attending their local A&E
- the proposals to consolidate complex stroke services in a single Hyper Acute Stroke Unit (HASU) at Basildon Hospital
- the robustness of the clinical pathways/blueprints that have been developed
- Observations on the anticipated activity volumes
- Observations on the access implications for patients
- Observations on workforce implications

Timeline

The clinical review Panel will be held on 18th September 2017.

Reporting arrangements

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

Senate Council has agreed a Chairman's action for the Chair of the review panel to review and submit the briefing note to the Mid and South Essex team by 21st September, before it has been considered by Senate Council. The briefing note will be taken to Council at its next meeting on 11th October 2017.

Methodology

The review will be undertaken by a review panel meeting to enable presentations and discussions to take place.

Report

An initial draft report will be provided to the STP team by Thursday 21 September 2017. Given the tight turnaround, the report will focus on the key findings and recommendations only.

Normally, Clinical Senate provides the sponsoring organisation with a draft of the report for it to respond, within an agreed timescale, on any matters of factual inaccuracy. Due to the exceptional turnaround requirements, this will not be possible. However if the MSE STP team considers there are any factual inaccuracies, these will be amended for the final report that will be considered by Senate council on 11 October 2017.

The final report will be submitted to Clinical Senate Council to ensure it has met the agreed terms of reference and to agree the report, and will be issued to the MSE STP by after the council meeting of 11 October 2017.

Communication and media handling

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

Resources

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

Accountability and Governance

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

The East of England Clinical Senate is a non statutory advisory body and will submit the briefing note to the sponsoring organisation, as described above.

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

Functions, responsibilities and roles

The **sponsoring organisation** will

- i. provide the clinical review panel with the agreed written evidence no later than 11 September 2017
- ii. undertake not to attempt to unduly influence any members of the clinical review team during the review.

Clinical Senate Council and the sponsoring organisation will

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

Clinical Senate Council or agreed nominees will

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

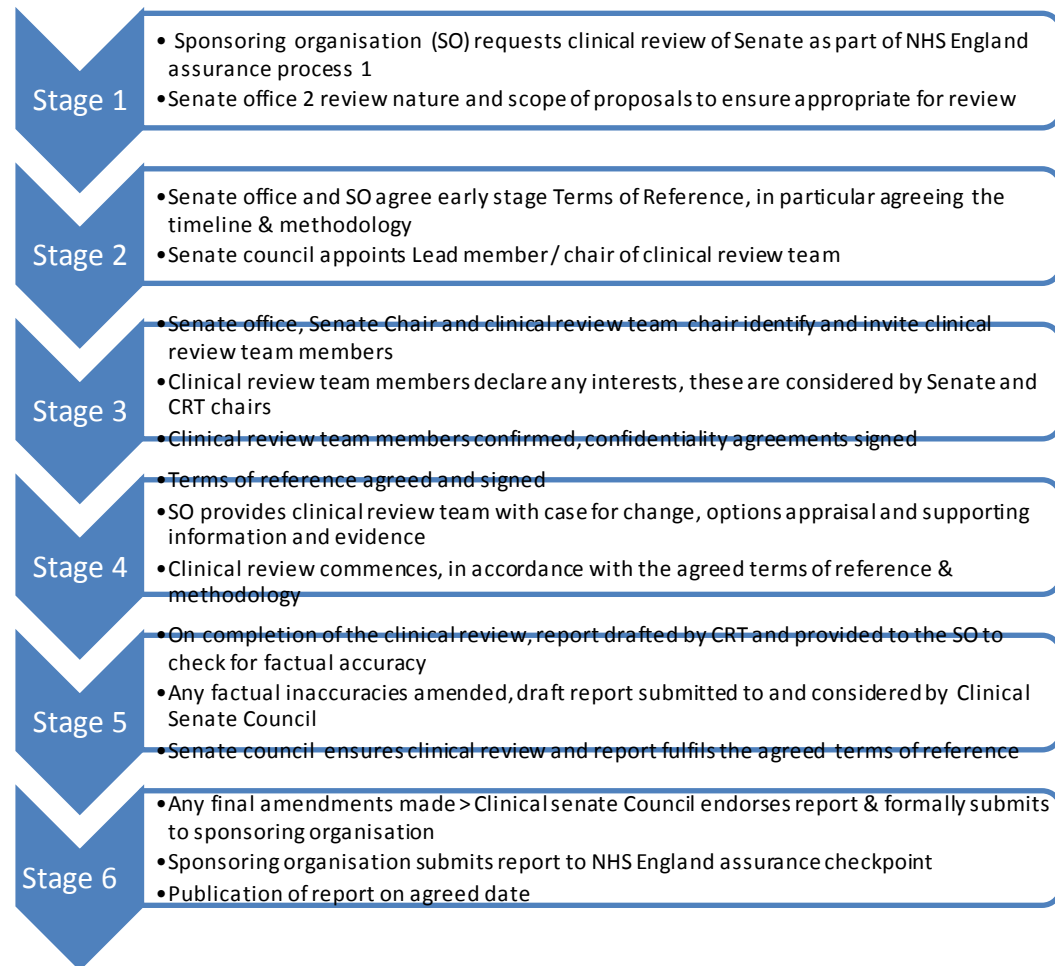
Clinical review panel will

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

Clinical review panel members will undertake to

- i. Declare any conflicts of interest and sign a confidentiality agreement prior to having sight of the full evidence and information (*NB this is usual procedure but due to the exceptionally short preparation time these will be signed immediately prior to the panel. All panel members were advised of the confidential nature of this information when provided with the evidence pack and invited to discuss any potential conflicts of interest with the Head of Clinical Senate prior to the panel day*)
- ii. commit fully to the review and attend all briefings, meetings, interviews, panels etc that are part of the review (as defined in methodology).
- iii. contribute fully to the process and review report (*NB due to the exceptionally short turnaround time, not all members will be able to review the report prior to submission to the MSE STP team.*)
- iv. ensure that the report accurately represents the consensus of opinion of the clinical review team (*as note above*)
- v. comply with a confidentiality agreement and not discuss the scope of the review nor the content of the draft or final report with anyone not immediately involved in it. Additionally they will declare, to the chair or lead member of the clinical review team and the Clinical Senate manager, any conflict of interest that may materialise during the review.

Summary of (usual) process



APPENDIX 2: Membership of the clinical review panel

Mid and South Essex STP Clinical Review Panel 18 September 2017 Clinical Review Panel Members	
Dr Bernard Brett (Chair)	Panel Chair. Clinical Senate Chair, Consultant
Dr Annie Chakrabarti	Stroke Consultant, Norfolk & Norwich University Hospital
Dr Jim Crawford	Emergency Medicine Consultant, James Paget Hospital
Ruth Derrett	Director of Transformation and Delivery – Urgent and Emergency Care, Cambridgeshire & Peterborough CCG
Dr Juliet Draper	Expert by Experience
Dr Claire Gillon	Trainee Doctor, Whittington Hospital
Dr Patrick Gompertz	Consultant physician (Stroke Clinical Lead), Barts and The London NHS Trust
Kirstie Hughes	Senior Sister Renal and Emergency medicine, James Paget Hospital
Dr John Lockley	Clinical Senate Council Member, Retired GP from Bedfordshire
Miss Clare Marx CBE DL FRCS	Orthopaedic Surgeon Ipswich Hospital
Linda Purdy	Consultant Ambulatory Care Nurse, The Queen Elizabeth Hospital, King's Lynn
Michael Rattigan	Senior Paramedic Mentor, EoE Ambulance Service
Dr Raj Shekhar	Consultant Stroke Physician, The Queen Elizabeth Hospital, King's Lynn
Dr Dee Traue	Palliative Care Consultant, East & North Herts NHS Trust.
Glenda Turner	Senior Sister Emergency Medicine James Paget Hospital
Lisa Webb	Clinical Lead, Occupational Therapist, Lister Hospital

Clinical Review Panel Chairman:

**Dr Bernard Brett, Clinical Senate Chair,
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 10 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 Annie Chakrabarti

Annie is a stroke consultant at the Norfolk Norwich University Hospital (NNUH). She is the lead consultant for the stroke rehabilitation service at Norwich and has set up a stroke spasticity service which in co-corporates offering botulinum toxin to selected stroke patients. Along with her colleagues, she currently leads on the development of stroke thrombectomy service at NNUH. Her specialist area of interest is stem cell therapy in stroke and was the principal investigator for PISCES-2 trial at NNUH.

Dr Jim Crawford

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

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

Ruth Derrett

Ruth has worked in the NHS since 1991 in a variety of roles across the East of England. Previous roles include Locality Director for Cambridgeshire and Norfolk, and Head of specialised services for Midlands and East. Ruth has a particular interest in the development of clinical networks and led on the planning and implementation of the Major Trauma Network, and the development of Vascular Networks in the local area.

Dr Juliet Draper

Julie has been a member of the EoE Citizens' Senate since its inception in 2013. She is a retired GP from Cambridge as well as having a number of chronic health conditions. She is a user of the psychological services for the elderly and is particularly interested in mental health and the interface between primary and secondary care. She is passionate about improving the mental health services in the region and is a member of several of the EoE forums and steering committees, for example, self-harm and suicide, dementia and first time psychosis.

She is also a member of her practice PPG and the Cambridge and Peterborough Rethink group for carers' of people with severe mental health illness. She has recently become a member of the EoE Clinical Senate Assembly.

Dr Claire Gillon

An FY2 Doctor interested in healthcare management and development of services. Claire is a member of the East of England Clinical Senate Assembly.

Dr Patrick Gompertz, Consultant physician (Stroke Clinical Lead), Barts and The London NHS Trust

Dr Joanne Farrow

Joanne is a general adult consultant psychiatrist working in acute inpatient services in Hertfordshire Partnership University NHS Foundation Trust. She is also the Clinical Director responsible for the West Strategic Business Unit (WSBU) which includes adult acute services, community adult services and IAPT services. *(NB due to exceptional circumstances Dr Farrow was unable to attend on the day)*

Kirstie Hughes

After 15 years senior experience in Emergency Medicine, Kirstie moved into Renal medicine working regionally and in the Middle East. She is now the senior sister, leading on Service Development for the renal service with remit of implementation of ANP's (Atrial natriuretic peptide) in majors/resus. During the last five years Kirstie completed BSC Honours Nurse Practitioner.

Dr John Lockley

John Lockley recently retired from GP practice in Bedfordshire, where he continues to teach medical students. He is Deputy Chair of the Bedfordshire and Hertfordshire LMCs Ltd. Former Chair of the SystemOne National User Group (SNUG) John remains in a senior role on the national committee. He is a member of the e-Referral Services's National Advisory Board (ERAB) and has recently started to research the informatics aspects of the coordination of healthcare delivery. A writer and broadcaster of many years' standing, John is currently Chair of the Society of Medical Writers.

Miss Clare Marx CBE DL FRCS

Clare Marx has just finished a 3 year term as President of the Royal College of Surgeons of England, the first woman to have held the post in their 2017 year history. During that time she was credited with changing the culture of the organisation to concentrate on a focus of excellence in patient care, . She continues this work through the faculty of Medical Leadership and Management where she has been a member of their Council for 5 years and has just been elected Chair..

Clare trained as a Trauma and orthopaedic surgeon in London and after a Consultant post at St Mary's moved to Ipswich Hospital in 1993 becoming clinical director of the combined A&E, Trauma & Orthopaedics and rheumatology directorate. A series of management and leadership posts followed and she is currently Associate Medical Director at the trust with a special remit for revalidation and appraisal.

Linda Purdy

A registered nurse for 29 years, Linda is an Emergency Nurse Practitioner and has worked predominately in Emergency and Acute Care. Formerly in the Emergency Department (ED), promoting quality, evidence based care and multiprofessional teamwork to enhance the patients journey through the ED to enduring secondary care or discharge. Latterly in Acute Medicine.

Having always enjoyed teaching, Linda undertook a Nursing Lecturer post at a HEI (2003) returning to the ED (2007) setting as an Emergency Nurse Practitioner and independent prescriber. Taking up an opportunity to become a practice development nurse, Linda worked

closely with the medical Consultants and Senior ED nurses and Matrons and in 2016 became a Nurse Consultant for Acute Medicine, operational predominantly in Ambulatory Care working alongside the Acute Medical Consultants and the nursing team providing ambulatory sensitive pathways through innovation and quality evidence based care.

Michael Rattigan

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

Dr Raj Shekhar

Dr Shekhar is lead stroke consultant and Associate Medical Director at the Queen Elizabeth Hospital NHS Foundation Trust, joining the Trust in 2008 following completion of his higher specialist training in Cardiff and Stroke Sub-specialist training at St Georges Hospital London. Under his innovative and skilled leadership stroke services were established for West Norfolk and the Trust. Since then, he has managed to sustain a nationally recognized consistently well performing comprehensive stroke services. Following pilot of Telemedicine stroke services for the East of England, he has taken the responsibilities of medical lead and successfully maintained this service to provide out of hours stroke thrombolysis services for a number of hospitals in this region. Dr Shekhar is a principal investigator for stroke research at the hospital.

Dr Dee Traue

Palliative Care Consultant, East & North Herts NHS Trust.

Senate Council member

A Consultant in Palliative Medicine at East & North Herts NHS Trust based at the Lister Hospital in Stevenage, Dee has previously worked extensively in hospice and community palliative care. Dee is involved nationally in the palliative and end of life care arena, as part of the Association for Palliative Medicine executive committee and previously the RCP Joint Specialty Committee for Palliative Medicine. Dee has experience of the voluntary sector, working for the national charity Hospice UK as well as being medical director of a charitable hospice for five years.

Glenda Turner

With 25 years' experience in Emergency Medicine, Glenda has led the James Paget Emergency department for 20 years. Glenda has been involved with 18 inspections of Emergency Departments nationally.

Lisa Webb

Awaiting bio

In attendance at the panel:

Mid & South Essex STP Team:

Dr Anita Donley	Independent Chair, Essex Success Regime
Dr Paul Guyler	Stoke Consultant Southend Hospital
Dr Ronan Fenton	Medical Director, Mid & South Essex Success Regime
Dr Donald McGeachy	Medical Director, Local Health and Care, Mid & South Success Regime
Tom Abell	Chief Transformation Officer
Dr Hagen Gerofke	Clinical lead for A&E and acute medicine
Dr Ramanathan Kirthivasan	Consultant physician (Stroke)
Andy Vowles	Programme Director

Clinical Senate Support Team:

Sue Edwards	East of England Head of Clinical Senate, NHS England
Jackie Campbell	Controlled Drugs Programme Lead, NHS England
Penny Thomas	Senior Quality Improvement Lead, NHS England

APPENDIX 3: Declarations of Interest

Name	Personal pecuniary interest	Personal family interest	Non-personal pecuniary interest	Personal non-pecuniary interest
Dr Bernard Brett	NO	NO	NO	NO
Dr Annie Chakrabarti	NO	NO	YES ³	NO
Dr Jim Crawford	NO	NO	NO	NO
Ruth Derrett	NO	NO	NO	NO
Dr Juliet Draper	NO	NO	NO	NO
Dr Claire Gillon	NO	NO	NO	NO
Dr Patrick Gompertz	NO	NO	NO	NO
Kirstie Hughes	NO	NO	NO	NO
Dr John Lockley	NO	NO	NO	NO
Miss Clare Marx CBE DL FRCS	NO	NO	Yes ⁴	NO
Michael Rattigan	NO	NO	NO	NO
Dr Raj Shekhar	NO	NO	NO	NO
Linda Purdey	NO	NO	NO	NO
Dr Dee Traue	NO	NO	NO	NO
Glenda Turner	NO	NO	NO	NO
Lisa Webb	NO	NO	NO	NO
*Both declarations were considered, it was agreed that neither required the individual to be excluded from any part of the panel discussion				

³ In relation to work as a Stroke Consultant at NNUH, using Telemedicine

⁴ As an employee of Ipswich Hospital NHS Trust (stroke service change could have an impact on future model of Colchester and Ipswich Hospitals Stroke Services)

APPENDIX 4: Review panel agenda



INDEPENDENT CLINICAL REVIEW PANEL

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

A G E N D A

Date: Monday 18 September 2017

Time: Panel members 09.00hrs to 17.15 &

MSE STP team 10.00 hrs to (no later than) 14.00 hrs.

Venue: Granta Room, Granta Centre, Granta Park, Great Abington, Cambridge
CB21 6AL

Recognising that a full Stage 2 Assurance clinical review will follow, Clinical Senate has been asked to respond to the following:

- Whether the proposed model and pathways make clinical sense and, based on the evidence presented, are likely to result in safe and high quality services, and
- whether the model forms a robust basis for moving to public consultation and detailed development.

Time	Item
09.00	Panel member arrival
09.15 – 10.00	Granta Room. All review panel members Welcome, introductions and outline of panel procedure from Clinical Review Panel Chair Dr Bernard Brett
10.00 – 10.30 10.30 -11.00	Granta Room All review panel members & MSE STP team Presentation and context setting for the panel from the MSE STP team General clarification questions from the panel to MSE STP
11.00 - 11.15	Short break
11.15 – 13.15	Further clarification and questions from panel to MSE STP team <i>Note: 2 hour session scheduled, MSE STP team may not be required for entire two hours and panel may commence private discussions during this time</i>
13.15 - 14.00	Break for lunch
14.00	Private panel discussion resumes then Summary and recommendations
No later than 16.00	Summary & recommendations
No later than 17.15	Close.
Next steps information for panel members:	
<ol style="list-style-type: none"> 1) Panel Chair will approve a briefing note for MSE STP / NHS England providing key findings and recommendations of this clinical review panel 2) Briefing note to Clinical Senate Council 11 October 2017 (<i>NB Council cannot make any material changes to the report or its recommendations</i>) 	