NHS
East of England
Clinical Senate

Mid & South Essex Sustainability and Transformation Partnership

Report of the Clinical Senate Independent Clinical Review Panels held 25 & 26 April 2018 (and General Surgery follow-up review panel 1 May 2018).

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Glossary of abbreviations used in the report

A&E	Accident and Emergency *(used interchangeably with ED)*
CCG	Clinical Commissioning Group
ED	Emergency Department *(used interchangeably with A&E)*
EEAST	The East of England Ambulance Service Trust
EPAU	Early pregnancy assessment units (panel four)
ERCP	Endoscopic retrograde cholangiopancreatography
GI	Gastro-intestinal
ICU	Intensive care unit
KPI(s)	Key performance indicators (measures)
LoS	Length of (patient) stay
MSE STP	Mid and South Essex Sustainability and Transformation Partnership
MSB Group	Mid Essex, Southend and Basildon Hospitals Group – *note used interchangeably with MSE STP as appropriate.*
STP	Sustainability and Transformation Partnership
T&T	Treat & Transfer
UEC	Urgent and Emergency Care
24/7	24 hours a day, seven days a week.

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EXECUTIVE SUMMARY

The clinical review panels of 25 and 26 April 2018 found many positives in the progress made by Mid and South Essex STP team since 2017, not least the obvious team work across the three current trusts, a clear desire to improve services, standardise care and embed quality improvement. There was strong clinical leadership and an ambition to address inequalities in outcomes.

Whilst the panels strongly supported most of the proposals, including the consolidation of several services, there was a concern for patient safety around the plans to move emergency surgical services, and surgical inpatient beds, from Basildon Hospital. More information was requested to support this proposal and provided to a reconvened (on 1 May 2018) sub-panel of the surgical clinical review panel. The sub-panel did not however feel that the additional information and clarification completely removed this risk.

This report lays out the key findings and recommendations that apply to all or the majority of the work streams (Section four), including those described above. Further recommendations of the respective clinical review panels can be found in the relevant section (Section five to nine).

Summarised below are the six key recommendations – further detail of the key findings of the panel and the rationale for each recommendation can be found in section four.

Recommendation 1 (Acute surgical services):

The panel recommended that the MSB Group:

a) focus on the reconfiguration of emergency surgical services as a key priority, it reconsiders alternative options, provides more evidence regarding why its final option is chosen and works up the finalised proposals in more detail, including refinement of supportive data;

b) request a further independent clinical review from the Clinical Senate,

of this element of the plans before full implementation; and

c) consider gathering data and evidence before, during and after implementing its final model for a future research publication for the benefit of the wider NHS.

Recommendation 2 (Separation of elective from emergency care):

The panel recommended that further work be undertaken to enable a greater proportion of elective care to be separated from emergency care to help improve patient access to services.

Recommendation 3 (Outcomes):

The panel recommended that the intended patient focussed outcomes for each of the services be reviewed with a view to being more ambitious and with the subsequent development of clear, robust high level outcomes and key performance indicators to assess and measure both their impact and progress. These should include service level outcomes, real time KPIs and patient related and reported outcomes.

Recommendation 4 (IT Systems):

The panel recommended that the MSE team develop a robust IT plan to ensure first the easy access to clinical information across the three main hospital sites (preferably all using the same IT system) with a follow-on plan to ensure access between acute hospitals and community providers, mental health providers and ideally primary care and social care.

Recommendation 5 (Workforce):

The panel recommended that the MSB Group undertake further work including a full workforce risk assessment to ensure that no other parts of the hospital group or general workforce would be compromised by the numbers of staff moving to specialist centres, or moving into new roles or new rotas including nursing and Allied Health Professional staff, but also including the potential impact on general rotas

from a medical perspective.

Recommendation 6 (Communication and collaboration between work streams):

The panel recommended that in order to minimise risk to patients the MSB Group should ensure there was a robust process for clinicians in each work stream to regularly engage with, and share information regarding the developing proposals and implementation plans with colleagues from other work streams to help understand any potential impact across the system.

The recommendations above should be read in the context of the broader, and positive, findings of the respective clinical review panels and their recognition of the significant progress that had clearly been achieved.

End.

1. Foreword by Clinical Senate Chairman

It was a pleasure to be involved in arranging and delivering another independent clinical review for the Mid and South Essex STP team. It is clear that they have undertaken a huge amount of work and have made significant progress. It was also clear that they are increasingly working more as a single team across the three main hospital sites.

They have many difficult challenges to tackle including rising demand, work force shortages, increasing sub-specialisation, new treatments and pathways and significant constraints regarding their estates and transport. It was clear to all the panels (the specialty panels and overarching panels) that significant change was required and it was agreed that the case for change was well made.

Developing and delivering major changes to service delivery are always challenging. There is often considerable resistance to change, for many understandable reasons, from the population, patients, staff and indeed politicians who wish to retain as many local services as possible. Usually however there is also agreement that to travel further for demonstrably better care and outcomes is worthwhile. On occasions it can also be difficult to articulate the sometimes complex clinical reasons that support such changes. Appropriate consultation with the public, patients, staff and other key stake holders is vitally important and has been undertaken, but unfortunately the panel could not review the results of the recent public consultation due to restrictions regarding its release date.

The panels felt there were many positives that they wished to feed back to the MSE team including obvious team work across the three current trusts, a positive approach, a clear desire to improve services, a desire to standardise care and embed quality improvement, a desire to consolidate where this would benefit patients and determination to address inequalities in outcomes. Most of the proposals were strongly supported. There were however some proposals that weren't as consistently presented across the written submissions, verbal presentations and during question and answer sessions and it was clear that in some cases work streams didn't talk together as much as they could. The intention to separate emergency and elective work was supported but the panels felt that at this stage insufficient evidence was presented to assure that this ambition would be delivered.

The one main area of concern was regarding the plans to move emergency surgical services including inpatient beds from the Basildon site. There was support for the consolidation of services including emergency surgical and specialist surgical services to help ensure that robust, high quality and sustainable consultant lead teams delivering specialty and subspecialty care could be available 24/7.

It was however felt that moving such services from the Basildon site with a proposed continued 24/7 unselected Emergency Department, and it being the proposed centre or hub for interventional radiology, cardiothoracics, cardiology, vascular surgery, and renal medicine was a potential significant safety risk. More information was provided to support this proposal, with evidence to mitigate risk and it was clarified that the consolidation of emergency services was scheduled to take place towards the end of the reconfiguration plans. An additional sub-panel, reconvened a few days later on 1st May, did not however feel that the additional information and clarification completely removed this risk.

The panels felt that the Basildon site was one that would appear to be well suited to host consolidated emergency surgical services given the co-dependent specialties. The panels also felt that the MSE team should consider diverting patients referred by GPs and those transported by ambulances after paramedic assessment to a site with full emergency surgical services if the index of suspicion was high for an acute surgical diagnosis. The panels felt that before the implementation phase of the acute surgery element of the plans begins, there would be benefit in clinical senate undertaking another independent review of this part of the proposals.

I would like to again stress the many positives that the panels wished to convey regarding this challenging work and the significant progress the MSE team has made. I would also like to thank the MSE team for being so helpful to all of the panels. Finally I would like to thank the experienced and varied panel members, including clinicians and experts by experience, for giving up their time and engaging with this important review in a positive, thoughtful and patient focused manner.

Dr Bernard Brett

East of England Clinical Senate Chair and clinical review panel Chair

2. Advice request, background and scope of the review

2.1 The East of England Clinical Senate has to date reviewed emerging proposals for the Mid and South Essex STP (formerly Success Regime) on four separate occasions:

- In June 2016, which focused on the early emerging thinking,
- In October 2016, which considered in more detail the five potential configuration options that subsequently fed into the Programme's formal options appraisal process,
- In September 2017, when the panel conducted a preliminary review of the programme's final pre-consultation proposals and
- In October 2017 when the panel carried out a more in-depth review of the proposals for stroke services.

2.2 The Mid and South Essex Sustainability and Transformation Partnership (MSE STP) has refined its proposals for reconfiguration of acute hospital services to improve care for people in mid and south Essex and is ready to proceed to a 'Stage 2' Assurance Check [1]. An independent clinical review of the proposals by Clinical Senate is required as part of the evidence for NHS England.

2.3 The scope of this clinical review panel was again on acute reconfiguration options which included the following services: urgent and emergency care (including treat and transfer); vascular services; general surgery; trauma & orthopaedic surgery; respiratory services; cardiology services; urology; gynaecology surgery and renal medicine.

2.4 Initially gastroenterology services were also included in the scope of the review, but the MSE team advised the clinical review panel that the three gastroenterology teams have been exploring, and continued to explore, options for greater cross site collaboration, including improvement opportunities in terms of endoscopic

[1] NHS England Planning, assuring and delivering service change for patients' NHS England October 2015

retrograde cholangiopancreatography (ERCP) services, the management of pancreatitis and a shared Gastrointestinal (GI) bleeds rota. This notwithstanding, it is not felt at this stage that plans were sufficiently advanced to allow for the presentation of a detailed 'Stage 2' case to Clinical Senate. The panel was further advised that given the intention to maintain the majority of gastroenterology services at each site in any event, it considered that the impact on the overall modelling of capacity across the three sites was not considered to be significant.

2.5 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. This review was also not intended to review progress on recommendations of previous reviews.

3. Methodology and Governance

3.1 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. There was a mix of panel members who had sat on earlier clinical review panels, and panel members who had not. All panel members signed conflict of interest and confidentiality declarations (Appendix 3)

3.2 Terms of Reference for the review were agreed between the Mid and South Essex STP team and Dr Bernard Brett, Chair of East of England Clinical Senate and Senate Council appointed Chair of clinical review panel.

3.3 Due to the large number of service areas in the review, it was agreed to make up five panels of two clinical service areas on the first day with an 'overarching' panel on a second day to review the findings and recommendations of the first day and consider the system impact of the proposals.

3.4 Pre panel teleconferences to prepare panel members and discuss potential key lines of enquiry were held two weeks prior to the review panels. Panel members received the evidence packs two weeks prior to the pre panel calls. In addition, panel members were provided further supporting evidence (from the MSE team) as key lines of enquiry emerged during the pre-panel calls.

3.5 It was agreed with the MSE STP team that a site visit would help to triangulate the evidence provided for the panels. A small site visit team of four people visited Basildon & Thurrock Hospitals Trust on 12 April 2018 – a copy of the report of that site visit is included at Appendix 5 of this report.

3.6 The clinical review panels took place on 25 and 26 April 2018. The MSE STP team gave an overview and context setting presentation to the whole group on 25 April and followed up with presentations to the respective clinical review panels. The MSE team did not join the panel for the overarching panel discussion on 26 April but a teleconference was held during the day with two members of the team to clarify some issues that arose during discussion. During discussion at the

overarching clinical review panel on 26 April, the clinical review panel agreed that there were still some outstanding issues on the general surgery proposals and requested further information and evidence. It was agreed that a short follow up clinical review panel would be convened to assure the clinical review panel on some aspects of the proposals for general surgery. This clinical review panel was held by teleconference on Tuesday 1 May 2018.

3.7 Sections of the draft report were sent to clinical review panel members for review and confirmation of accuracy and to MSE team for review for points of accuracy.

3.8 The final draft of the report was due to be submitted to a specially convened meeting of the East of England Clinical Senate Council on 16 May 2018 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. However, due to iterative process on agreeing points of accuracy taking longer than planned, MSE STP team and Clinical Senate agreed that the timeline for agreement of the draft report would be extended. The Senate Council meeting was cancelled.

3.9 A draft report was provided to Mid and South Essex STP team on 23 May 2018 in order for it to be available for the Clinical Board meeting. At its meeting on 13 June 2018, Clinical Senate Council reviewed the final draft report and confirmed that the clinical review panels met the terms of reference for the review. Senate Council had no other comments to add.

3.10 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.

3.11 The East of England Clinical Senate would like to acknowledge the support and cooperation of the MSE team in bringing together these panels, with providing evidence in a timely way and programming the site visit on 12 April 2018. It would also like to congratulate the team on the evidence provided and professional presentations and responses to panel questions.

4 Summary of overarching key findings and recommendations

Key findings:

Presentation to the full panel on 25 April 2018

4.1 The panel found the presentation from the MSE STP team helpful in having laid out the context, the case for change, the key principles of the proposals for reconfiguration of acute services across mid and south Essex and the proposed changes for each of the three main hospitals.

4.2 The presentation also helpfully addressed key lines of enquiry raised during the pre-panel calls for the respective clinical review panels, including the development of a transport service, some of the out of hospital, primary care and community work streams not included in the terms of reference for this review and equality impact assessments.

4.3 With respect to the transport service, this was put into the context of the treat and transfer model. The panel was advised that there was still a lot more work to be undertaken including further audits of patient transfers, modelling of transfer needs to services and the development of a service specification prior to a formal procurement process. Work had already begun on developing a colour coded acuity system to help stratify the level of clinical support required during transport depending on the suspected diagnosis and acuity of the patient.

4.4 With respect to equality impact assessments, the MSE team explained that the initial assessments had been undertaken for the public consultation exercise which had completed late March 2018. The panel heard that once the feedback from the consultation exercise was published (after local election results in May), the equality impact assessments would be reviewed and updated accordingly.

4.5 The panel was also given information on the plans for three underlying key enablers that would be crucial to the implementation of the proposals – workforce, estates and digital solutions. Each had separate work streams or programmes of activity overseen through the STP.

4.6 The panel agreed that the presentation and short discussion session had been helpful and thanked the MSB Group for its level of transparency and openness around the proposals and its commitment to the clinical review. The panel also acknowledged the input of the commissioners. Following a short question and answer session, the panels moved to their respective clinical areas.

Key Findings – overarching clinical review panel 26 April 2018

4.7 There were some key findings that were common to all or most of the panels and the recommendations found below apply across the majority of the clinical work stream proposals. Service specific recommendations can be found within the key findings section of this report for each of the respective service areas.

4.8 The panel agreed that the MSE team had presented as a coherent, patient focused team providing clear clinical leadership and a real desire to work together to improve services for patients across the three trusts. Panel members that had sat on previous clinical review panels for MSE STP proposals agreed that the members of the team were definitely more aligned in their ambition and thinking. The team were positive and enthusiastic to improve outcomes and impressed the panels with their level of knowledge and informed response to questions.

4.9 There was clearly a desire to standardise processes and raise standards across the three trusts which was strongly supported by the panel. The case for change was good for all of the areas, although could be strengthened with more information regarding projections for future demand.

4.10 The majority of proposals were well thought through with a clear evidence base and the panel supported the general direction of travel. It agreed that the benefit to patients had been thought through as demonstrated in the evidence. The panel members did comment that the proposals could have been better articulated particularly with a few example case studies to clearly demonstrate particular patient journeys. It was felt that thinking about the patient journeys may also help identify any gaps or areas for more work. The MSE team was aware that this had been identified during some of the pre- panel teleconferences, but had insufficient time between it being raised by the pre-panel calls to work up the detail for the panels.

4.11 There were some examples where it appeared there had been insufficient communication between work streams, in particular the plans for the consolidation of emergency surgery and the associated implications did not seem to be well understood by the other panels.

4.12 The panel commended the team on its proposals to provide inter-hospital transport for patients' relatives and carers and the potential to develop this further. In particular the panel stressed the need to ensure that there was sufficient timely transport including evenings and weekends and that there was clear communication and information for patients and relatives and carers regarding what was available and how to access it.

4.13 The panel also recognised that a work stream was looking at emergency transfers and repatriation; although it was clear that much work had already been undertaken, further work was planned and was needed. The panel heard of the plans to develop a robust service level agreement to ensure that a service provider could be selected and appropriately performance managed to ensure that timely transfers occurred to ensure patient safety – the panel was strongly supportive of this.

4.14 The panel was also supportive of the proposed colour coded system to help classify the acuity of an individual patient for transfer to help ensure that an appropriate transfer team with relevant competencies was arranged.

4.15 Further information was provided around how the estimated average of approximately 15 additional patients per day requiring transfer (the panel heard that currently there were around 14 per day taking place) was derived. The panel however did not feel that this figure for additional patient transfers was at this stage as reliable as it could be and further work should be undertaken as pathways become more developed. The projections should ideally include the numbers broken down by condition, acuity and time of day including, where possible, some understanding of the potential peaks and troughs. The possibility of more than one urgent transfer being required simultaneously from different hospitals needed to be explored. Repatriation numbers of patients and also of staff should also be included.

4.16 A more prolonged prospective audit, which the panel heard was planned, should assist with firming up these figures and the panel felt that it was important that the projections including those for mimic conditions (i.e. presentations where the ED assessed the patients as potentially suffering from a particular condition that required transfer but subsequently the final diagnosis was different, for example stroke mimics). This additional information would then help inform the service level agreement for the transfer provider and the level of need for the availability of transfer staff of differing competencies.

4.17 The panel heard the rationale for removing gastroenterology services from this review. However panel discussions around the proposals for general and acute surgery highlighted the importance of including the ambition for this service into the overall picture. The panel felt that understanding the location, availability, activity and workforce of gastroenterology services and patient pathways for those with gastrointestinal disorders in the overall picture would have been helpful. The panel recommended that the MSB Group develop these proposals at pace and integrate them into the system proposals.

4.18 The panel had heard that there was now a common PACS (picture archiving & communication system) across all three hospital sites. Patient records were not currently compatible across the three sites or with the community, primary care mental health or social care providers. The site visit team had heard about the digital tracking system that would be implemented across the three hospitals that should enable real-time sight of bed availability across the MSB Group. The MSE team had acknowledged that there was still significant work to be done on digital compatibility and solutions to enable real time patient information sharing. Without exception the criticality of a common system to move / share relevant patient across the MSB Group was raised, particularly with respect to transfer of patients for either specialist or emergency care as well as during transfer. This included timely access to diagnostic information. The panels unanimously supported the need to prioritise this work.

Recommendations

Recommendation 1 (Acute surgical services):

4.19 **General Surgery:** Whilst the vast majority of the written and verbal evidence was of a high quality and was consistently delivered, there were inconsistences in the evidence submitted regarding emergency surgery. This included differences between the written submission and the presentations to the respective panels. Furthermore the main panels had several concerns regarding the proposed move of complex general surgical emergency activity from Basildon, to Broomfield and Southend Hospitals. The panel felt that this hospital site, with a fully functional ED accepting unselected patient cases, and with the Cardiothoracic centre, vascular hub and interventional radiology hub on site (along with other services out of scope of this review such as obstetrics, paediatrics and gastroenterology) would benefit from having full emergency surgery services on site from a patient safety and quality outcomes perspective. The panel was of the view that the published evidence regarding the reconfiguration of multi-site single service was limited overall and in particular there was no evidence to support or refute the model proposed.

4.20 The panel gave verbal feedback highlighting those differences to the MSE team and they recognised the need to provide further evidence to provide clarification. The panel agreed that the most appropriate way forward was to arrange a follow-up sub-panel to review this addition information before the report was finalised. The reconvened sub-panel, held on 1 May 2018, agreed that several of their concerns were addressed at least in part, it was however not fully reassured by the proposals. The panel recognised that further work was planned and that this element of the proposals was planned to be implemented a little way into the future. Given the potential impact on other services, the panel felt that this recommendation should be included with the overarching recommendations.

4.21 The panel recommended that the MSB Group:

a) focus on the reconfiguration of emergency surgical services, as a key priority, it reconsiders alternative options, provides more evidence regarding why its final option is chosen and work up the finalised proposals in more detail, including refinement of supportive data;

b) request a further independent clinical review from the Clinical Senate, of this element of the plans before full implementation; and

c) consider gathering data and evidence before, during and after implementing its final model for a future research publication for the benefit of the wider NHS.

Recommendation 2 (Separation of elective from emergency care):

4.22 The panel heard that where possible, the MSB Group would aim to separate services for elective patients from services of emergency patients and indeed this was an objective of the MSB Group and was described in 'Principle 4' of the public consultation document.

4.23 Evidence was provided demonstrating patient benefits in terms of outcomes if this approach was successfully implemented. The panel fully supported this principle. Some evidence was presented demonstrating how this would be delivered. The panel felt that although there was some limited evidence provided to suggest that this would be achieved, at least in part, it did not believe at this stage there was enough in the plans to demonstrate that this would be sufficiently achieved.

4.24 The panel recommended that further work be undertaken to enable a greater proportion of elective care to be separated from emergency care to help improve patient access to services.

Recommendation 3 (Outcomes):

4.25 Whilst the panels acknowledged that patient benefits had been considered, evidence had been provided to each of the panels in both written material and verbal presentations and there was a clear clinically lead ambition for better care for their patients, the panels agreed that some of the outcomes could be more ambitious, and better defined. The panels, for example, felt that a clear time line for reducing waiting times for vascular interventions, waiting times for transfers, impact on four-hour targets should be developed. Some panels had also raised the need for clear key performance measures indicators (KPIs) and process measures for services, particularly as standardised operating procedures were developed and implemented; these should have a thread back to the intended high level outcomes.

4.26 In summary it was felt that there should be more certainty overall regarding the outcomes the MSB Group wished to achieve and how it could demonstrate it had succeeded.

4.27 The panel recommended that the intended patient focussed outcomes for each of the services be reviewed with a view to being more ambitious and with the subsequent development of clear, robust high level outcomes and key performance indicators to assess and measure both their impact and progress. These should include service level outcomes, real time KPIs and patient related and reported outcomes.

Recommendation 4 (IT Systems):

4.28 IT Systems: the panel recommended that the MSE team develop a robust IT plan to ensure first the easy access to clinical information across the three main hospital sites (preferably all using the same IT system) with a follow-on plan to ensure access between acute hospitals and community providers, mental health providers and ideally primary care and social care.

Recommendation 5 (Workforce):

4.29 **Workforce:** The panel agreed that the proposals had included clear indications of workforce in terms of recruitment and planned training and development to enhance retention and attract staff to specialist centres. The panel congratulated the MSB Group on its plans for new and enhanced roles and also noted the recent significant successes in recruitment.

4.30 However the **panel recommended** that: the MSB Group undertake further work including a full workforce risk assessment to ensure that no other parts of the hospital group or general workforce would be compromised by the numbers of staff moving to specialist centres, or moving into new roles or new rotas including nursing and Allied Health Professional staff, but also including the potential impact on general rotas from a medical perspective.

Recommendation 6 (Communication and collaboration between work streams):

4.31 The panel heard about the governance structure for the proposals, and the trusts in general, and realised that there was a programme management office supporting the work. However it felt that it did not see any sufficient evidence of how the clinicians in the respective clinical work streams cross referenced with each other to understand potential impact across the system. While there was clearly strong clinical leadership for the proposals and a shared ambition to improve, the panel recognised that the primary focus of the clinicians on their own work stream, as experts in their own field, could overlook a potential impact on another speciality that they would not be so familiar with.

4.32 T**he panel recommended** that in order to minimise risk to patients, the MSB Group should ensure there was a robust process for clinicians in each work stream to regularly engage with, and share information regarding the developing proposals and implementation plans with colleagues from other work streams to help understand any potential impact across the system.

Section end.

5. Panel1: General surgery and trauma & orthopaedic surgery: Summary of key findings and recommendations

Key findings:

General Surgery

5.1 The panel heard that, with a staged implementation, there would be no elective inpatient surgical beds at Basildon Hospital although day case procedures and procedures where the patients were expected to stay less than 48 hours would continue. In addition there would be no emergency laparotomy procedures undertaken at Basildon Hospital and potentially further down the line such procedures would be consolidated on to a single site at Broomfield Hospital. All three hospitals would continue to take trauma patients, except trauma patients that might require vascular surgery who would go to Basildon Hospital. Major trauma cases would still be taken to the regional major trauma centres.

5.2 The panel agreed that in broad terms, the proposals were a sensible direction of travel; that the general model was good for both general surgery and trauma and orthopaedic surgery[2]. The plans to consolidate specialities, develop a single team to cover each speciality across all sites and the aim to standardise procedures and processes were also supported. The exception was regarding the plans for emergency surgery including the ability to perform laparotomies not being available at all three sites except in exceptional circumstances. This was despite all three sites continuing to have 24/7 unselected ED with an obstetrician lead maternity service (maternity services were out of scope of this review)

5.3 The panel had some significant concerns for patient safety following the panel on 25 April and requested further supporting evidence and some examples of patient pathways. A subgroup of the surgery panel, including clinicians from other specialities and panels, would convene to review this. The MSB Group provided

[2] the proposals and scope of this review do not include paediatric trauma and orthopaedic or paediatric general surgery

further evidence and the clinical review panel convened on 1 May 2018 – see para 5.18 below.

5.4 Currently all three hospital sites provide inpatient elective and emergency general surgery and have a 24/7 on-call rota. The departmental teams compromise of general surgeons who subspecialise in lower gastro-intestinal (GI), upper GI, breast and vascular surgery. In the majority of cases the surgeons currently all formed part of the emergency on-call rota at all three sites. The three sites' departments are all medium sized in comparison to other units in England.

5.5 The three sites currently have variations in service provision, capacity and outcomes. The panel heard that the case for change for general surgery was based upon the need to deliver a number of improvements to patient care. All three trusts are currently failing to deliver on some national targets, including meeting the 18 week waiting times for referral to treatment; there were significant variations in National Emergency Laparotomy (NELA) data across the trusts, and an inability to deliver NICE guidelines for hot laparoscopic cholecystectomy service across trusts. Despite having an elective upper GI centre at Broomfield Hospital, it was not sufficiently resourced to accept upper GI emergencies from across the MSE STP area.

5.6 The panel heard that there was poor management of complex referral pathways, for example pelvic floor, with patients often seen generically and then requiring a second consultation.

5.7 The panel heard that there was a need to retain and professionally develop middle grade staff and develop AHP / surgical care practitioner role with appropriate career progression.

5.8 Under the proposals for change for general surgery, in the short term all three sites would continue to manage emergency care locally. Patients attending the emergency department (ED) who met the criteria for the Emergency Surgical Ambulatory Unit (ESAC) within the emergency care hub would be streamed into the ambulatory care pathway.

5.9 The panel heard that the ESAC service had reduced the number of out of hours patents awaiting surgical consultation but was not yet established across all sites

and the proposals included the implementation of a standardised ESAC model across all three sites as a core priority.

5.10 The longer aspiration for general surgery was for one specialist centre for emergency and elective general surgery and another for cancer surgery, but there was not currently theatre or ICU capacity to locate this centrally. As an interim step, surgeons would be looking to initially concentrate complex general surgical emergency activity across two sites – Broomfield and Southend Hospitals. This could only be put in place after the movement of complex lower GI inpatient work from Basildon to Southend Hospital. As noted at para 5.3 above, the panel expressed some patient safety concerns related to this proposal and it was further discussed at a reconvened panel on 1 May 2018 – see para 5.18 below.

5.11 The panel heard that under the proposals, routine outpatients and patients having day surgery for general surgery would continue to be available at all three sites for both emergency and planned care. Some of the information suggested there would be no inpatient surgical beds at the Basildon site, but some of the information suggested that in addition to day cases, short stay cases with an expected patient stay of up to 48 hours would continue at the Basildon site long-term.

5.12 In the medium term, elective inpatient surgical patients who would need to stay in hospital over 24 hours (potentially over 48 hours – see para 5.11 above) would see their care being consolidated onto two hospital sites – Broomfield Hospital and Southend Hospital.

5.13 The panel was advised that a 'hot laparoscopic cholecystectomy' service (surgical procedure for removal of gallbladder via keyhole surgery) would be established across all sites with a Standard Operating Procedure to allow patients to be transferred between sites for emergency and prompt surgery with one list a week at each site. The panel expressed some concern about a three site model for this service without full GI backup at each site. The panel recognised that most laparoscopic cholecystectomy patients could be managed with very short lengths of stay, but a small number would require longer stays particularly if they were unfortunate enough to suffer from complications.

5.14 The panel also expressed concern around the scenario of a very sick patient not being fit for transfer to a specialist unit and remaining under the care of a potentially less experienced surgeon. It recommended that in such cases, the model allowed for the specialist surgeon to travel to the patient (subsequent clarification at the reconvened panel confirmed that this was planned).

5.15 National guidance required that a patient should be seen by the surgeon within 13 hours of presentation at ED. With an ED at all three hospitals but emergency surgery at just one site, the panel questioned whether there was a patient safety risk in terms of time taken to treat and complete the patient transfer from one hospital site to the emergency surgery receiving hospital site?

5.16 The panel heard that the number of emergency surgeons in the trusts remained an issue, with most preferring to largely work within their specialist area rather than on the emergency rota. The MSB Group advised that it was looking at potential options to support surgeons remaining in their specialist areas but still provide some rota cover.

5.17 The panel agreed that the proposals, including the consolidation of specialities into larger teams, should improve access to care and that standardised operating procedures across the three hospitals should reduce unwanted variation of outcomes. However the success of the proposed changes was dependent upon physical and workforce capacity.

GENERAL SURGERY RECONVENED REVIEW PANEL 1 May 2018

5.18 The clinical review panel for general surgery was reconvened on Tuesday 1 May 2018 (Membership at Appendix 2) to consider the additional evidence provided by MSB Group in respect of the proposed move of complex general surgical emergency activity from Basildon, to Broomfield and Southend Hospitals, and subsequent withdrawal from Southend Hospital (with Southend Hospital becoming the centre for cancer surgery) with full consolidation onto the Broomfield site in the longer term.

5.19 The MSB Group had provided further information on workforce and a number of example emergency surgery patient pathways, with evidence to support the proposed centralised emergency surgery model.

5.20 The panel noted that the proposal now included a second on-call general surgeon out of hours for those patients that would be too unwell to travel – the surgeon would travel to the patient. The panel agreed that from the evidence it was unclear whether the on-call surgeon would be a surgeon normally based at Basildon Hospital or whether the on-call rota would include surgeons from across the three sites' surgical team.

5.21 NB: As this was of some concern to the panel, this matter was followed up with the MSE team who advised that with the merger of the three trusts and one team approach, the general surgical team will move from the current site based rota to a sub-speciality based rota, working as a networked team across all sites (not just for on-call). All general surgeons will take part in the on-call rota – and will not have an elective list for the week they are on-call. The second on-call surgeon referred to in the additional evidence would not therefore be one of the full general surgical team.

5.22 With emergency laparotomy and GI procedures being consolidated at Broomfield and Southend Hospitals, the panel felt there was a risk that the day-time Basildon based on-call surgeon might not always have recent or adequate experience in these particular procedures to ensure the best outcome for the patient (*the subsequent information provided did give some reassurances in this regard – see*

para 5.21). The out-of-hours on-call surgeon may be less familiar with the theatre, equipment or staff working at the Basildon site, again potentially impacting on the quality of care for the patient (*again the additional information provided suggested that they would have some familiarity*). The after-care of patients operated on in Basildon could be sub-optimal without the nursing care offered by experienced gastrointestinal surgical nursing staff familiar with caring for patients undergoing major gastrointestinal surgery and in addition there may not be the continuity of medical care provided by an experienced surgeon that the panel felt would optimally be the case (depending upon rotas etc).

5.23 The panel felt that the estimated number of procedures for the emergency surgery pathways had been under-estimated, whilst recognising that these had been derived using the best data currently available to the MSB Group. Even if these estimates were accurate, collectively they (and other pathways not included in the evidence) could still provide some challenge to the system and the panel recommended that further modelling be undertaken to understand the potential impact across the system should there be a combination of rare events occurring, or for example in a time of winter pressures.

5.24 The panel was concerned that there could be a potential risk to those patients in specialist units (e.g. cardiac patients in cardiothoracic centre) that may require emergency surgery out of hours, requiring them to either be transferred to Southend or Broomfield and so away from the ongoing specialist care for the patient's original condition or be operated on at Basildon without the optimal aftercare described above (see 5.22).

5.25 The panel agreed that communication with patients needed to be clear to avoid any impression of a patient receiving a 'second class service' at Basildon Hospital. For example, a patient presenting at Basildon ED is assessed and then advised that they need to be transferred for emergency surgery. It then materialised that there was no bed / theatre capacity and they were subsequently advised that the surgery would take place in Basildon Hospital.

5.26 The panel also raised the increasing prevalence of 'silver' trauma patients who were often difficult to accurately assess, on initial assessment, their level of injury

or severity of illness could be underestimated due to frailty and / or having other conditions and so the potential need for emergency surgery may not be apparent. Once in the system these patients were often difficult to move, or indeed the patient themselves may be understandably reluctant to move.

5.27 The panel agreed that while a safe and staged implementation plan was supported, some elements in to the longer term plan of ten years was too distant and potentially less likely to happen and recommended that consideration be given for the timeline for some elements to be considerably reduced.

5.28 While the panel fully supported the proposal to consolidate emergency surgery, to enable adequate numbers of appropriately trained and experienced specialists and sub-specialists to provide optimal patient care, it had significant concerns for patient safety under the current proposal. With Basildon Hospital retaining a fully functioning unselected 24/7 ED and with it being identified as the intended 'hub' location for a range of emergency and high risk elective patients and specialist interventions (including vascular surgery, the CTC, renal service and interventional radiology) but without a full emergency surgery facility available this could impact on patient care. In addition to patients admitted as an emergency there was therefore also a risk to Basildon Hospital inpatients who might need unplanned general surgery.

5.29 The panel felt that whilst recognising a variety of constraints, given the consolidation of other services onto the Basildon site, it might be a better location for the consolidation of emergency general and gastrointestinal surgery.

Recommendation:

5.30 This recommendation for general surgery is found in para 4.19 of the overarching recommendations as the panel considered it to be of impact across the proposals for acute reconfiguration.

5.31 **General Surgery:** Whilst the vast majority of the written and verbal evidence was of a high quality and was consistently delivered there were inconsistences in the evidence submitted regarding emergency surgery. This included differences between the written submission and the presentations to the respective panels. Furthermore the main panels had several concerns regarding the proposed move of complex general surgical emergency activity from Basildon, to Broomfield and Southend Hospitals. The panel felt that this hospital site, with a fully functional ED accepting unselected patient cases, and with the Cardiothoracic centre, vascular hub and interventional radiology hub on site (along with other services out of scope of this review such as obstetrics, paediatrics and gastroenterology) would benefit from having full emergency surgery services on site from a patient safety and quality outcomes perspective. The panel was of the view that the published evidence regarding the reconfiguration of multi-site single service was limited overall and in particular there was no evidence to support or refute the model proposed.

5.32 The panel gave verbal feedback highlighting those differences to the MSE team and they recognised the need to provide further evidence to provide clarification. The panel agreed that the most appropriate way forward was to arrange a follow-up sub-panel to review this addition information before the report was finalised. The reconvened sub-panel, held on 1 May 2018, agreed that several of their concerns were addressed at least in part, it was however not fully reassured by the proposals. The panel recognised that further work was planned and that this element of the proposals was planned to be implemented a little way into the future. Given the potential impact on other services, the panel felt that this recommendation should be included with the overarching recommendations.

5.33 The panel recommended that the MSB Group

a) focus on the reconfiguration of emergency surgical services, as a key priority, it reconsiders alternative options, provides more evidence regarding why its final option is chosen and work up the finalised proposals in more detail, including refinement of supportive data;

b) request a further independent clinical review from the Clinical Senate, of this element of the plans before full implementation; and

c) consider gathering data and evidence before, during and after implementing its final model for a future research publication for the benefit of the wider NHS.

Trauma and orthopaedic surgery

5.34 All three hospital sites currently offer a wide range of inpatient, outpatient and day case orthopaedic services but there are wide variations in waiting times for admission and lengths of hospital stay.

5.35 Trauma cases currently present at all three sites and are routinely seen and treated locally. The three sites' departments are all small to medium sized in comparison to other units across the UK, and some activity volumes are low, particularly in upper limb procedures.

5.36 The panel heard that staff had become more sub-specialised in their work and as three separate middle sized orthopaedic units this meant that at any one site there is only a very small number of surgeons who are able to treat some conditions, leading to long waits.

5.37 Broader bed and theatre capacity issues can also lead to long waits, in some cases over 52 weeks, and the panel heard that over the last five years elective joint surgery has been stopped on all three sites every winter due to capacity issues.

5.38 Under the proposed model of care all three sites would continue to offer routine trauma care including outpatient provisions such as fracture clinics and day cases. Out-of-hours trauma patients requiring immediate surgery, for example supracondylar fractures, who present at Southend Hospital would be transferred to either Basildon or Broomfield Hospital for more complex care. Major trauma would continue to be delivered outside of Essex as it currently is (Addenbrooke's Hospital in Cambridge for mid Essex and Royal London Hospital for Basildon and Southend).

5.39 Elective inpatient surgery would be consolidated at Broomfield Hospital, including Braintree Community Hospital, and Southend Hospital. The panel heard that clinical pathways were being developed to further consolidate specific procedures at each site. Specialist low volume procedures such as wrist, ankle, shoulder and elbow replacements were likely to be consolidated on a single site for each procedure. Primary hip and knee replacements activity would take place on two elective sites due to the volumes required. Standard operating procedures and pathways would be developed and there would be joint multi-disciplinary teams.

5.40 Elective day cases would be undertaken on all sites with an aim to increase the percentage of trauma and orthopaedic procedures happening as day cases. The panel heard that there would initially be 16 elective surgery beds in Braintree Community Hospital with one theatre; staff would come with the surgeon to Braintree Hospital. The beds in Braintree Hospital would serve mid Essex patients.

5.41 The panel heard that there would likely be a pooling of surgeons, primarily for hip and knee surgery, and while this was not commonplace, it was already happening. The panel raised the question of the medico-legal implications and were advised this was being considered by the MSB Group.

5.42 The panel heard that a musculoskeletal (MSK) hub for all GP referrals for surgery was fundamental to the success of the model in triaging patients and managing the number of elective patients reaching surgery. There was currently a triage service for patient referrals although each hospital currently had a different provider. The MSB Group was keen to consolidate this into a single pathway,

however as it stood it was for the CCGs / STP to commission the service and there was no clarity on the actual or potential timeframe for this.

5.43 The panel expressed its concern that failure to address this matter was a key risk to the success of the proposals and recommended that the MSB Group resume discussion with STP to move forward on this as a matter of urgency. Whilst recognising that this was outside of the direct remit of this clinical review panel, the panel wished to recommend that the CCG / STP decide as a matter of urgency if this is to be passed to the MSB Group or not.

5.44 The panel heard that there was variation across the three sites for the frailty pathway and step down models. The panel encouraged the MSB Group to take the opportunity to innovate across the health system in developing this model and ensure there is consistency across the three sites.

5.45 With respect to workforce, as with general surgery, the panel heard that recruitment was challenging and there were particular issues with nurses moving to more specialist roles for example ICU. The panel heard that there were plans to improve recruitment and retention for more junior team

Section end.

6. Panel 2: Respiratory and cardiology services: Summary of key findings and recommendations

Key findings:

6.1 The panel was generally supportive of both pathways, although agreed there needed to be more robust planning for workforce, skill mix and staff numbers; particular detail applied to retention of staff when moving services from one site to another.

Cardiology:

6.2 The panel heard that the main proposal was to accelerate access to specialist care for non-ST-segment elevation myocardial infarction (NSTEMI) – a type of heart attack – by providing a treat and transfer model to the Essex Cardiothoracic Centre (CTC) for all patients that require urgent diagnostics or interventions across the three mid and south Essex hospitals.

6.3 Currently some patients could experience significant delays in their treatment beyond timeframes set out in national guidance. Due to a lack of out-of-hours cover at each hospital site, patients presenting at Southend or Broomfield ED on a Friday afternoon could potentially have to wait until Monday for specialist review in order to confirm diagnosis and request an inter-hospital transfer potentially resulting in a delay to treatment. There was significant delay in referral time of non-ST-segment elevation myocardial infarction (NSTEMI) and acute coronary syndrome (ACS), and the aim of the proposals was to improve access to care for patients with NSTEMI patients being treated within 72 hours of admission and patients with life threatening arrhythmias that required pacing being treated within 24 hours.

6.4 The panel heard that the proposal was to increase the range of conditions treated via a treat and transfer model into the Essex Cardiothoracic Centre (CTC) at Basildon Hospital. As the CTC was the only facility able to offer a 24/7 on-call rota, the proposal was that patients with acute coronary syndrome (ACS) follow the treat and transfer model that was already in place for emergency coronary patients.

6.5 Emergency, non-complex elective, diagnostic and outpatient cardiology services would continue to be delivered locally at all three hospitals. Each of the hospitals in the STP has its own cardiology department which will see elective and non-elective patients. Elective patients will normally have a day case procedure at the respective hospital (angiography or insertion of a non-complex pacemaker). The proposals do not include any changes to any of the elective treatment.

6.6 The panel heard that the proposals should lead to a reduced time between admission and intervention and an overall length of stay for patients, improving both clinical outcomes and experience. However implementation of the proposals would require increased staffing and work was underway to look at the use of nurse practitioners and / or associate physicians. The cardiology team expressed confidence that as the service developed with more specialised procedures it would become a more attractive place to work.

6.7 The CTC, having been established as a specialist centre for heart and lung problems for over ten years, provides acute care for the sickest cardiology patients whose condition is severe. They may be taken directly to the CTC by ambulance or through an existing treat and transfer model from other hospitals across Essex including Colchester University Hospital and Princess Alexandra Hospital Harlow, both of which are outside of the MSE STP area. The panel heard survival rates for the CTC were one of the best in the country.

6.8 The panel agreed that the proposals were a sensible direction of travel. However whilst the pathways and service models for other conditions were well established, the details of the new service model for patients with NSTEMI and arrhythmias at weekends was not clear at the time of the panel. It was reported that the model was likely to be based on provision of an emergency or 'on call' sessions rather than a full seven day service and patients may be transferred in a planned manner from a ward rather than direct from the ED. One of the main drivers for the new pathway was the failure across the STP to meet the national guidance for ACS coronary angiography (with follow on percutaneous coronary intervention (PCI) if necessary) within 72 hours.

6.9 The panel found that the data provided for current time to treatment unclear, with each hospital appearing to use a different start point and the worst performing

hospital appeared to be Basildon which is the location of the CTC, rather than the sites referring in. MSE STP team explained that Basildon patients were admitted to the CTC immediately an NSTEMI was confirmed. Patients that were referred from other centres were not transferred until a slot was confirmed for them in the CTC catheter lab, they were then transferred shortly beforehand. Hence the Basildon patients would spend more time at the CTC. The panel still expressed some concern that there may be other bottle necks in the system that had not been revealed or were not being addressed and suggested that this was reviewed.

6.10 Information for existing patient and carer groups was very clear, and the panel heard that as well as general information, there were information packs for specific BME and non-English speaking groups of patients. This included information about transfer across the hospitals and could be extended to include the new conditions to be treated at CTC.

6.11 It was stated that the majority of patients would be discharged directly from the CTC with only around 20% requiring repatriation to their local hospital. The CTC has an established model for repatriation which could be used for the additional pathways.

6.12 The transfer model presented was for MSE STP and the panel sought assurance that an equivalent pathway would be available to patients accessing services from Colchester University Hospital and Princess Alexandra Hospital outside the STP footprint.

6.13 The panel expressed some concerns about the proposed model of non-interventional senior decision maker at each site. It was unclear if this role would be available on a 24 hour basis (as proposed in the written document) or seven day basis (limited hours as suggested in the presentation to the panel). The MSE team suggested that in the first instance this role could be filled from the existing complement of cardiology clinical nurse specialists. However this raised issues of competency and capacity as well as how this role would link to the medical team responsible for the patient's overall care.

6.14 It was suggested that if the role were to be nursing, it would need to be that of an Advanced Practitioner rather than clinical nurse specialist and that in the interim the referring hospital medical team may be better equipped to take on the role with specialist support.

6.15 The panel raised concern about the ability of the service to recruit and retain staff in the other hospitals as the CTC took on more procedures, and especially more complex procedures, potentially making it a more attractive place to work, with more opportunities for training and development. It needed to ensure that there would be sufficient cover at all three sites with all staffing groups including, for example, radiographers and AHPs. At the time of the site visit on 12 April 2018, the team heard that beds in the CTC were closed due to staff shortages.

6.16 The panel agreed that while it was generally supportive of the proposed model, there needed to be more work on the staffing models at both the referring sites and the CTC. The panel considered that the timescale was challenging, particularly given workforce issues and recommended that this be reconsidered alongside the development of clear workforce planning, recruitment and retention across all three hospital sites.

Respiratory

6.17 The proposal was to maintain the majority of services for respiratory care at all three hospital sites, with the expansion of a specialist respiratory ward at Basildon Hospital.

6.18 Basildon and Southend hospitals already have established domiciliary non-invasive ventilation (NIV) set up in place. NIV is a lifesaving treatment for respiratory failure. Currently Broomfield Hospital was not equipped to provide the level of care and as a result patients requiring complex or domiciliary NIV were transferred out of area to either the Royal Papworth Hospital in Cambridgeshire or Royal Brompton Hospital in London.

6.19 Pleural infection is a common complication of pneumonia and can result in long hospital stays and may require surgical intervention with a thoracic surgical team. Patients with complex pleural disease were currently cared for on all three hospital sites, however patients often require subsequent onward transfer to Basildon for access to the thoracic surgery team.

6.20 The panel heard that all three hospitals would maintain a service, with some centralisation and the expansion of the specialist respiratory ward at Basildon Hospital. Broomfield patients requiring complex or domiciliary NIV would transfer to Basildon or Southend Hospital rather than Royal Papworth or the Royal Brompton Hospitals and so remain in the local area. However, it was acknowledged that Basildon and Southend are Level 2 centres and if Level 3 care was required patients would need to be treated out of area.

6.21 The panel agreed that there was clearly a benefit to those patients that would be able to have care closer to home by not travelling to Cambridgeshire or London for treatment. In addition the co-location of the service with CTC would be beneficial for patients with complex pleural disease requiring surgery.

6.22 In response to a question to understand the reasoning for continuing with two centres, MSB Group advised that it was keen to keep the local facility in Southend as this is a well established service and it was considered that, given the population demographics, the need for domiciliary and NIV was likely to increase in future. However the panel felt that the case for maintaining two NIV centres within the STP was not robust and a preferable model would be to centralise inpatient services on the Basildon site and provide outpatient follow up at local hospitals.

6.23 The MSB Group also discussed proposals for greater specialisation of services once adequate consultant recruitment had been achieved; for example developing an interstitial lung disease service. Whilst being supportive of this, the panel highlighted that full multi-professional support, including radiology, would be required for this.

6.24 The respiratory service currently had consultant, middle and junior grade doctor vacancies, and up to an additional five whole time equivalent nursing staff would be required for the new model. The MSB Group considered that changes to the service could improve staff recruitment and retention, in particular the development of outpatient clinics and links to the community to provide specialist clinics.

6.25 Overall the panel supported the proposals but considered that, although sensible, were relatively small scale changes and rather unambitious. The panel agreed that the MSB Group could be more ambitious, particularly in developing the NIV specialist service and interstitial lung disease service and bronchiectasis services.

Section end.

7 Panel 3: Urgent & emergency care (Treat and Transfer) and vascular services: Summary of key findings and recommendations

Key Findings:

Urgent and emergency care (UEC) and Treat & Transfer (T&T) model

7.1 The panel heard that all three hospitals currently have 24/7 emergency departments (ED) with some specialist services going directly to specialist units, for example burns patients. With currently around 960 attendances per day on average across the three EDs increasing demand on the service, all three hospitals currently perform below the national average for seeing ED patients within four hours (Basildon 83%, Southend 84% and Broomfield 79%, compared to 85% across England –*data provided by MSE*).

7.2 In addition, there is currently significant variance in patient outcomes across the three hospitals due to variation in pathways and processes.

7.3 At present all three sites have an emergency hub, although not all providing the same services. The multi-disciplinary teams from all three sites meet regularly.

7.4 The panel agreed that the case for change had been well made and supported with robust evidence. There had clearly been some progress already, as seen by the site visit team on 12 April 2018 (see Appendix 5).

7.5 The proposed model of care would see all three sites having 24/7 consultant led EDs providing core emergency care services with no plan to divert patients or ambulances for specific conditions or presentations beyond current practice. At the core of the proposals was the creation of emergency care hubs with a range of specialist areas and teams at each of the three hospitals, fully integrated within the local health and care system.

7.6 The three hubs would all include urgent care centres and GP streaming, medical and surgical ambulatory care units, frailty assessment, medical and surgical assessment units, paediatric and gynaecology assessment units. The three hubs would have standardised pathways, procedures and key performance measures (KPI).

7.7 The panel heard there was an ambition that mental health services would be co-located in all three hubs as, although there was a single mental health provider across mid and south Essex, there was significant variation across the three hospitals regarding pathways for patients presenting with acute mental health conditions or indeed with combined mental and physical health concerns. The panel also found that an Adult Matron had recently been appointed for each of the three sites to provide adolescent mental health support.

7.8 The panel agreed that once fully functioning, the proposed three emergency care hubs with joined up ambulatory care would improve early diagnosis and treatment, should avoid unnecessary inpatient admissions and reduce length of stay for those admitted. In addition, the proposal for a consultant acute physician within each hub to take direct calls from primary care, the ambulance service and potentially other sources (as opposed to a 'bleep' system) should lead to a more timely response and ensure the most appropriate management advice including advice regarding assessment. This should ensure that patients were assessed and treated in the most appropriate place if required and so further reduce inpatient admissions and speed up optimal care to reduce length of stay admitted.

7.9 The panel agreed that assessment and treatment flow in the ED appeared to be good, and the proposed changes should have some impact to further improved flow. There was less clarity around managing patient demand and flow within the hospitals and particularly back out into the community. The panel recognised that some of the broader STP work was referenced during the presentations and was outside the immediate scope of this review. None the less, **the panel recommended** that further work on the pathways with primary care, community services, mental health services and social care needed to be progressed to ensure there was sufficient pre-hospital care and good patient flow across the system in order that admission avoidance and early appropriate discharges were optimised.

7.10 The panel also recommended that consideration be given to the development of pharmacy services support in the emergency care hubs – access to emergency TTO (to take out) patient medicines would likely be a key component of assess, treat and early discharge and admission avoidance.

7.11 Although there were already some standardised key performance measures (KPI) for patient outcomes, the panel recommended that this be extended to all three emergency care hubs having a shared set of KPIs both for day to day and week to week monitoring and also clear targets for the STP to meet in order to demonstrate the success of its proposals. With reference to the treat and transfer model, the panel particularly recommended that the MSB Group should put in place hospital sensitive key performance measures around the time patients arrived at the ED to the time the decision is made to transfer the patient.

7.12 The panel further recommended that a measure to record the time from the request for a patient transfer to the transfer having taken place and the patient safely handed over (transfer provider sensitive) be included in the service specification for procurement and service level agreement with the patient transfer provider once the service has been procured.

7.13 The panel was pleased to hear (as also heard by the site visit team) that the trust had recently successfully recruited additional interventional radiologists and ED consultants to the service. However the overall workforce and ED consultant numbers were still relatively low and supported by several locum doctors and the panel considered this still to be a risk to the emergency and urgent care service proposals.

7.14 Nursing vacancies were relatively low with again improved recruitment. The panel cautioned that although it supported the proposal to upskill Operating Department Practitioners (ODP) and nurses, including Intensive Care Unit (ICU) nurses, to support new roles including a transfer team, the proposal needed to be balanced against leaving other units in the hospital vulnerable with the loss of these skilled staff. There was a risk for examples that the MSB Group might not be able to replace the subsequent ODP, staff grade nursing and ICU nursing vacancies.

7.15 Although it heard some positive progress and suggestions around workforce, the panel felt that the MSB Group could be more ambitious in its approach. For example covering the ED overnight with combined rotas with acute physicians (potentially enabling a 24/7 consultant presence) and developing new roles.

7.16 *NB: the panel's findings and comments in respect of a patient transfer service apply across all proposals and can be found at paras 4.13 to 4.16.*

Vascular services

7.17 The panel heard that emergency specialist vascular services were currently not always available on all hospital sites. Specialist emergency care rotated between the three hospital sites plus Princess Alexandra Hospital in Harlow; meaning that patients are currently transferred to whichever hospital was providing specialised vascular expertise on the day they require admission. The model is not compliant with national standards and not supported by commissioners.

7.18 In addition, interventional radiology cover is not always available at the right hospital and may result in some patients having to undergo open surgery because trained staff were not available to support minimally invasive alternatives.

7.19 The proposals were for the creation of a single arterial centre for vascular services for planned and emergency complex vascular services to be consolidated at Basildon Hospital, co-located with the existing Essex Cardiothoracic Centre (CTC) and the 24/7 interventional radiology hub planned for October 2018. This proposal would eliminate avoidable open surgery in hours and out of hours. There would be a single clinical team ensuring more robust and sustainable rotas and on-call arrangements seven days a week.

7.20 The proposals also included the provision of local outpatient clinics and rehabilitation facilities that patients could be repatriated to and long term on-going care can be delivered from.

7.21 In an emergency situation, patients would go to their local ED for assessment and stablisation, then transfer to the vascular hub for specialist surgery where it was expected they would stay for up to four days post operatively. After that the patient would either be discharged from hospital or repatriated to their local hospital for further recovery and support.

7.22 Routine outpatient and day case non-arterial surgery would continue to be available at all three main hospitals for both emergency (within normal working hours and potentially extended normal working hours) and planned care.

7.23 The panel supported the proposal for vascular services and agreed that case for change was well made; with a mid and south Essex population of around 1.2million, and the current and expected numbers of aortic aneurysm and carotid endarterectomy operations and procedures, the proposal followed national direction and met the Vascular Society of Great Britain agreed standards and also NHS England Specialised Commissioning service specification. The panel agreed that co-location with CTC and interventional radiology made good clinical sense.

7.24 The presenting team demonstrated a shared vision for the vascular medicine and a real desire to provide a high class vascular service; continuing professional (staff) development (CPD) had been well articulated. The panel agreed that there were some areas that required further clarification or development.

7.25 The presence of vascular surgeons at the spoke hospitals across five days needed more clarity as it was advised they would be available to see emergency patients in hours or in extended working hours. The panel wondered how this would be balanced against the surgeons' own elective commitment on each site and in particular how that availability would be job planned. The panel noted the lack of any plans to offer any availability at spoke hospitals during weekends.

7.26 From the discussion, the panel was unsure where repatriated post-operative patients would be cared for, e.g. general surgery, care of the elderly, diabetes and particularly those with co-morbidities and agreed this needed a clear common protocol with clear medical and nursing responsibilities.

7.27 The panel felt that careful consideration should be given to a range of patient pathways including those who for example develop ischaemic colitis following vascular interventions.

7.28 The panel agreed that some more robust data would have been helpful, for example the mortality data presented was based on elective mortality but could have included emergency mortality information.

7.29 The panel recommended that an ambitious set of waiting time targets driving improvements over coming months for procedures such as carotid endarterectomy and AAA repair should be developed with the aim to remove current inequity across the system and deliver national waiting time targets soon than in the proposed model. The panel recognised that there would be a three phase approach to this but suggested with a focus on a unified cross-system approach the waiting times could and should be driven down more rapidly than completion of all three phases.

Section end.

8 Panel 4: Urology and Gynaecology (surgical) services: Summary of key findings and recommendations.

Key findings:

Urology

8.1 The panel heard that areas for improvement had been identified in urology services at all three MSB Group hospitals in terms of patient access, emergency readmissions, length of stay (LoS) and unwarranted variation in practices and pathways. The urology clinical leads from the three hospitals had been discussing ways to improve services since 2016 and had a shared vision of the future for the urology services.

8.2 Currently elective and emergency urology surgery, inpatient care and outpatients clinics are offered on all three hospital sites. The three sites' urology departments are all small to medium sized, the smallest being at Basildon Hospital. Southend and Broomfield hospitals have dedicated urology wards, Basildon urology patients can be on a number of wards throughout the hospital.

8.3 Since 2016, Southend Hospital has been the regional specialist urological cancer centre; patients already travel to Southend for this service and this will continue. More recently some more complex elective inpatient procedures have started to be performed at Broomfield Hospital, (percutaneous nephrolithotomies, pyeloplasty and adrenalectomies) from Southend Hospital as part of starting to work collaboratively as a single urological team across the three hospitals.

8.4 The proposal for the urology service was that all patients presenting with a urological emergency would be assessed in the local emergency hub and those patients requiring admission would be treated and transferred to Broomfield Hospital. To minimise admissions and transfers, when clinically appropriate, patients would be seen through the ambulatory urology pathway at their local hospital. Local diagnostics, outpatients, day cases and ambulatory care would remain at each site.

8.5 The panel commended the team on the level of engagement in developing the proposal. It agreed that the plan was well thought out with good governance and good levels of clinical engagement from all three sites and with Primary Care and community services to inform the proposals.

8.6 The panel agreed that the team had provided evidence to indicate that the proposal would reduce variation in outcomes to the benefit of patients, and raise standards across the urology service.

8.7 The panel also noted that the proposed model could have a positive impact on workforce with the consultant on-call rota moving from the current 1:4 to 1:16 subject to the successful recruitment of additional middle grade and junior staff. There was a good plan to develop specialist nurses for the service and specialisation for nurses on the urology ward at Broomfield Hospital. Recruitment to this service has been challenging, although the panel heard that consolidating the service and expanding training opportunities could provide a more attractive proposition for staff.

8.8 The panel noted that whilst all three hospitals had interventional radiology support in hours, out of hours and weekend support was available only from Basildon Hospital which would potentially require patient transfer for patients presenting in Broomfield Hospital. The panel recommended that a standard operating procedure be agreed for complex patients at Broomfield Hospital requiring interventional radiology at the weekend.

8.9 The panel heard that urology had clinical co-dependencies with other services, including uro-gynaecology services the proposals for which were also to be heard by this clinical review panel.

Gynaecology

8.10 All three hospitals currently provide general gynaecology services and most consultants work across gynaecology and obstetrics. Emergency gynaecology surgery and the majority of 'general' elective gynaecology surgical procedures are performed at all three sites – complex gynaecology surgery normally falls under one of two sub-specialities – gynae-oncology or uro-gynaecology.

8.11 Variation in pathways and practices across the three hospitals for these services had been identified including access to gynaecological oncology services, issues with recruitment, particularly sonographers, lack of timely access to senior clinical input at Broomfield Hospital and variable access to key service co-dependencies, for example interventional radiology.

8.12 As part of the STP proposal, it was agreed that Southend Hospital would be the regional specialist centre for gynaecology oncology. Patients who require radiotherapy after surgery already travel to Southend for this and would continue to do so. Currently mid Essex grade 3-4 gynaecology patients (verbally advised circa 90 per annum) travel to Ipswich Hospital for specialist surgery, if they required radiotherapy following surgery they would receive this at Southend Hospital.

8.13 The proposals and focus of the panel was on three specific services: uro-gynaecology, gynae-oncology and early pregnancy assessment units (EPAUs). No changes were proposed to the current gynaecology emergency pathway and most elective services would continue to be provided locally including any day cases and outpatient services.

Uro-gynaecology

8.14 The proposal was to build and strengthen the existing multi-disciplinary team (MDT) approach already in progress between the three hospitals and establish a uro-gynaecology network service to all three hospitals.

8.15 The panel heard that given the sub-speciality of uro-gynaecology was dependent on other surgical specialities, such as urology, colo-rectal and plastic surgery, the proposed location of these specialities steered somewhat the location for some uro-gynaecology procedures. The remainder of complex gynaecology procedures that make up the small group of patients which account for LoS exceeding 72 hours would be transferred to Southend Hospital for their procedures and care.

8.16 The panel felt that there was lack of clarity on which services were currently being delivered at each of the sites. MSE team made reference to urology being consolidated at Southend and Broomfield Hospitals but the urology team referred only to consolidation at Broomfield Hospital.

8.17 However, the panel agreed that the strengthened MDT approach was good, and that the proposal to consolidate the services into two sites should increase staff competency. Enabling patients to be treated closer to home could only be beneficial.

Gynaecology Oncology

8.18 The panel supported the proposal for a gynaecology oncology centre at Southend Hospital; the evidence had showed a fragmented service with different levels of care provided at the different sites. The proposal to provide care for patients within the area rather than having to travel should improve patient experience.

8.19 The panel agreed the clinical model was sound and robust and the evidence had demonstrated good collaboration in developing the proposal.

8.20 The panel recommended that for both uro-gynaecology and gynaecology oncology services it would be beneficial to undertake further modelling in relation to theatre and bed capacity.

Early Pregnancy Assessment Unit (EPAU)

8.21 The EPAU at each hospital site acted as a gateway into the emergency gynaecology service; these currently operate under different standards and procedures. NICE guidelines recommended a seven day service for early pregnancy problems and chaperoned sonography for all scanning. There have been historical issues with recruiting sonographers to the area and there was variable competency amongst the medical staff to perform scans.

8.22 While the panel agreed that standardisation and more consistent cover was necessary, it agreed that this proposal was less well developed than the proposals for the uro-gynaecology and gynaecology oncology services. There was lack of clarity from the team as to the 24/7 proposal i.e. whether it was a 24 hour service or a seven day service at one or across three sites on a rotation basis, with inter-hospital transfer of patients from the emergency department if necessary. The panel agreed that rotation of access could be confusing for patients with risk implications and would require very clear communication.

8.23 The panel recommended that the team develop a better articulated service proposal with intended benefits and improved outcomes for patients. In the view of the panel, the proposals as they stood for EPAU were not yet sufficiently robust and required more modelling on demand, capacity, provision and access as well as workforce modelling, particularly given the issues with recruitment and the requirement for training and development (for scanning).

8.24 The panel agreed that the team did not appear to have a full understanding of the services currently available at each site and recommended that further information on the demography, current service activity and pathways be analysed to support subsequent further development of the proposals for all three hospitals prior to implementation.

Section end.

9. Panel 5: Renal medicine: Summary of key findings and recommendations

Key Findings:

9.1 The panel heard that renal services in the mid and south Essex area had evolved in the three hospital sites; acute renal services for each of the three sites were currently located on mixed general medical wards at the three sites. The renal service was currently experiencing variations in quality as well as workforce challenges. The renal team recognised that new technologies and advances were not being exploited and agreed that reconfiguration of the service provided the opportunity to adapt the services to provide consistent, high quality care across the area.

9.2 The proposal was for the development of a renal hub and spoke model for the mid and south Essex area comprising a dedicated acute specialist renal unit at Basildon Hospital. The unit would be supported by spoke sites at Broomfield and Southend Hospitals, providing outpatient clinics and dialysis, ensuring patients have routine care close to home. The acute renal hub would also provide specialist advice and guidance to Primary Care and community teams, supporting improved management of chronic renal conditions out of hospital.

9.3 The panel understood that the proposal would increase acute renal services from a five day service across three sites to a single seven day service, with the potential for reduced variation across the area. Co-location of the renal patients on an acute renal ward would result in increased availability of consultant renal support for routine patients receiving dialysis.

9.4 The panel agreed there was a strong clinical case for centralisation of acute renal services and supported the proposal for a single hub, acknowledging the potential for improved patient outcomes including reducing patient length of stay.

9.5 The panel agreed that the presenting team came across as credible, patient focussed and enthusiastic. The team answered the questions from the panel confidently and had provided clarification on points raised which the panel found extremely helpful in understanding the proposals.

9.6 The panel agreed that standardised treatment protocols should be in place across the three hub and spoke sites; and that locally agreed protocols and robust surgical and interventional radiology cover arrangements should be in place at the Basildon hub.

9.7 The panel further agreed that in order to eliminate disconnect between the hub and community services, clear patient pathways should be developed and integrated with primary and community care services. This applied also to repatriation and extra-regional referrals.

9.8 Hearing that an additional two junior grade Doctors would be required to run the proposed acute renal ward with 24 hour junior doctor cover, the panel recommended that new models of workforce, for example advanced clinical practitioners and physician associates, would be crucial to the successful delivery of the model. The panel advised the MSB Group to ensure it factored in the necessary time for workforce training and development. It also agreed that further detailed modelling would be needed to fully understand any potential impact on medical staffing in the base hospitals particularly in relation to the medical rota and need for on–call provision for general medical physicians.

9.9 The panel commended the team on the level of patient engagement carried out as part of the existing and proposed service development.

Section end.

APPENDIX 1: Terms of Reference for the review

East of England Clinical Senate

Stage 2 Assurance Review of proposals for reconfiguration of acute services for the

Mid and South Essex Sustainability & Transformation partnership

25 & 26 April 2018

Terms of Reference

CLINICAL REVIEW: TERMS OF REFERENCE

Title: Mid and South Essex Sustainability and Transformation Partnership (MSE STP)
Sponsoring bodies: Mid and South Essex Sustainability and Transformation Partnership (MSE STP)

Terms of Reference agreed by: Dr Celia Skinner
Signature

Dr Celia Skinner, Chief Medical Officer, on behalf of Mid and South Essex Sustainability and Transformation Partnership (MSE STP)
And

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

Date: 11 April 2018

Attending 25th April ***note changes made – see appendix 2 panel membership***

Mid and South Essex STP - representatives

Dr Anita Donley, Independent Chair of STP
Dr Donald McGeachy, Medical Director for the STP Local Health & Care programme
Dr Ronan Fenton, Medical Director for the STP In-Hospital programme
Charlotte Williams, Group Director, Strategy & New Care Models, MSB Group
Dr Celia Skinner, Chief Medical Director, MSB Group

Panel 1: Gen surgery & T&O

1. Mr Greg Packer, Clinical Lead (T&O) and Consultant Orthopaedic Surgeon, SUHFT
2. Ms Jo Francis, Co-Clinical Director and Lead Nurse, Orthopaedics, MEHT
3. Ms Emma Gray, Clinical Lead (General Surgery) and Consultant General Surgeon, SUHFT
4. Dr Ellen Makings, Medical Director and Consultant Anaesthetist, MEHT

Panel 2: Respiratory & Cardiology

1. Dr Huw Steven Jenkins, Respiratory Consultant, MEHT
2. Lisa Ward, Respiratory Nurse Manager, SUHFT
3. Dr Stuart Harris, Clinical Lead (Cardiology) and Consultant Cardiologist, BTUHFT
4. Dr Donald McGeachy, STP Medical Director

Panel 3: UEC, treat & transfer and Vascular

1. Dr Ronan Fenton, Medical Director for the STP in-hospital programme
2. Dr Eddie Lamuren, Clinical Director, Emergency Medicine, BTUHFT
3. Dr Hagen Gerofke, Clinical Lead, Acute Medical Units and Ambulatory Emergency Care, and Acute Medicine Consultant, BTUHFT
4. Jenny Frost, Head Nurse, Emergency Department, SUFHT
5. Mr Vijay Gadhvi, Clinical Lead, Vascular Surgery and Vascular Consultant Surgeon, BTUHFT

Panel 4: Gynae & Urology

1. Colleen Begg, Clinical Director and Head of Midwifery & Gynaecology, SUHFT
2. Mr Chris Spencer, Consultant Gynaecologist, MEHT
3. Mr Peter Acher, Clinical Lead (Urology) and Consultant Urological Surgeon, SUHFT
4. Jo Shingler, Consultant Nurse and Co-Clinical Lead (Urology), MEHT

Panel 5: Renal

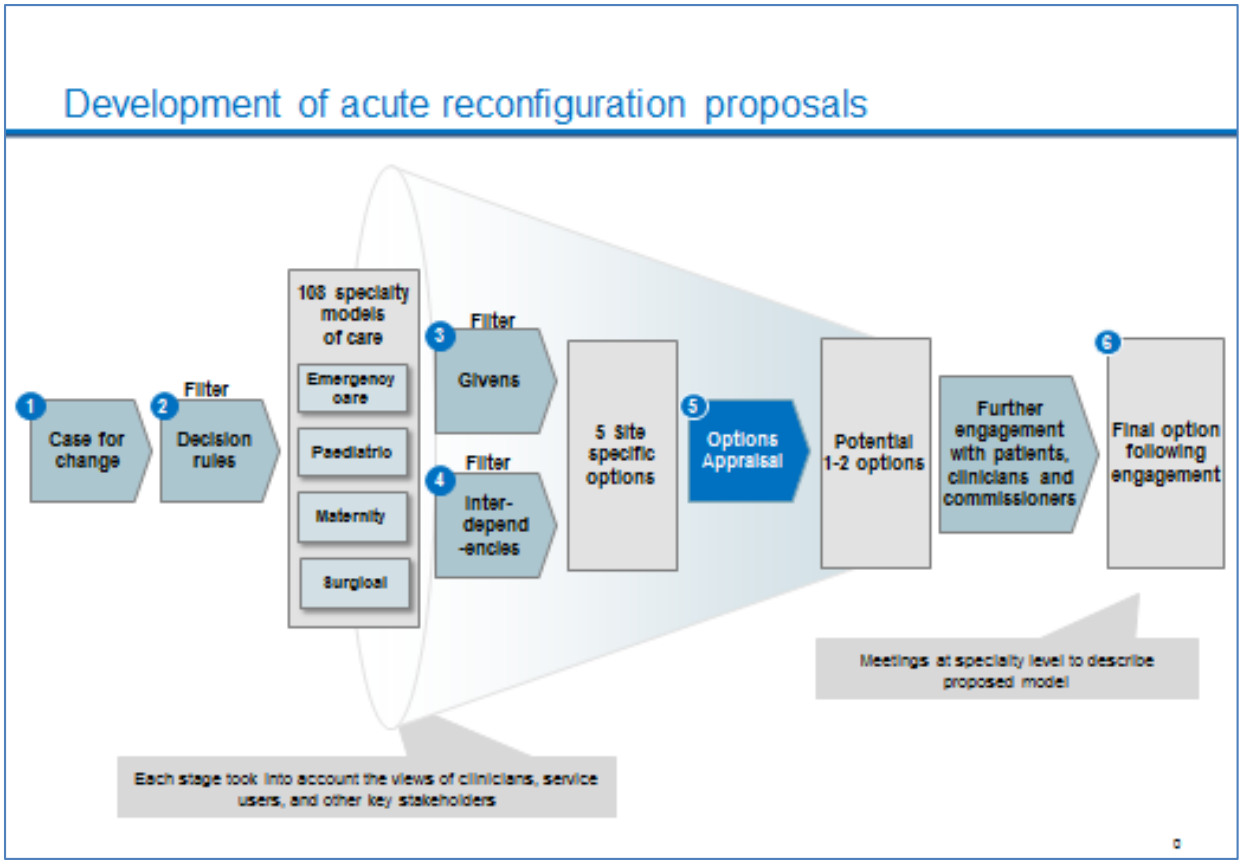
1. Dr Celia Skinner, Chief Medical Director, MSB Group
2. Dr Gowrie Balasubramaniam, Clinical Lead (Renal) and Consultant Nephrologist, SUHFT
3. Dr Aroon Lal, Consultant Nephrologist, BTUHFT
4. Dr Georgia Winnett, Consultant Nephrologist, BTUHFT

Aims and objectives of the clinical review

As part of the Mid and South Essex STP, clinical leaders have been developing proposals for potential acute services reconfiguration which have been out to public consultation from 30 November 2017, initially until 9 March 2018 but subsequently extended to the end of March 2018.

The proposals consider the clinical services provided by the three main hospitals within the STP footprint – Basildon & Thurrock University Hospitals NHS FT, Southend University Hospital FT and Mid Essex Hospital Services NHS Trust (Broomfield Hospital).

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 for patients by consolidating some clinical services. The clinical model has been developed and iterated over the last two years; the following exhibit gives an overview of the process.



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

- In June 2016 which focussed on the early emerging thinking.
- In October 2016 which considered in more detail the five potential configuration options that subsequently fed into the programme's formal options appraisal process.
- In September 2017, a review of changes to the proposed clinical models in response to feedback from public, stakeholder and clinicians prior to submission for NHS England Regional Assurance checkpoint review.
- Interim further review of the stroke pathway proposals on 17 October 2017.

The programme now requests Clinical Senate to undertake a full 'Stage 2'[3] review of the final proposals to support the consultation evidence which will be considered by the STP Clinical Cabinet on 24 May 2018 and the CCG Joint Committee, prior to any final decision on configuration being taken in summer 2018.

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 services, locality development, frailty, maternity, cancer, end of life and dementia services. However the scope of this review is the proposed changes to acute hospital services only. All other services are out of this review, although any impact on these will be taken into consideration.

There are a number of services about which proposals are currently being put forward and will be included in the remit of this review by Clinical Senate; being

- Cardiology
- Emergency Hub / Treat & Transfer
- General Surgery
- Gynaecology
- Renal
- Respiratory
- Trauma and Orthopaedics
- Urology and
- Vascular

As Mid and South Essex Stroke services have been the subject of a previous detailed review and interim panel in October 2017, it is not expected that Clinical Senate will undertake any further detailed review of stroke service proposals at this review. However, information will be provided about those proposals as they are clearly relevant to, inter-dependent of and illustrative of the overarching clinical principles and model of care proposed.

The remit of this review is not to review progress or changes from previous panels or use evidence provided for earlier panels. The proposals and evidence put forward will be reviewed on their own merit.

The Clinical Senate is being requested to review the available evidence, discuss this with members of the programme and make appropriate recommendations to the programme from its findings.

The central questions Clinical Senate is being asked to address in this review are:

a. **Do the proposed model and pathways make clinical sense and, based on the evidence presented, will be likely to result in safe and high quality services and outcomes for patients once implemented?** and
b. **Does the clinical model form a robust basis for moving to a more detailed development and implementation across the three Mid and South Essex STP hospital sites?**

[3] 'Planning, assuring and delivering service change for patients' NHS England October 2015

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

- The principle of consolidating high risk / low volume services on a smaller number of sites
- Observations on the proposed model of 'triage, treat and transfer' for some patients on an emergency pathway needing more specialist care
- The robustness of the clinical pathways/blueprints that have been developed and their monitoring / evaluation
- Observations on the anticipated activity volumes
- Observations on the access implications for patients
- Observations on the workforce implications.

Evidence gathering – local site visit

In order to better inform the review panel and assist in the reviewing of evidence about proposals, a site visit for a small group of panel members (three) will be held at Basildon & Thurrock University Hospital FT on Thursday 12 April 2018. This will give the panel an opportunity to hear overall proposals and 'walk through' the emergency hub, treat and transfer, cardiology and vascular pathways. The findings of the site visit will be reported back to the review panels on 25 April 2018.

General information

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

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

The clinical review panel is not expected to advise or make comment upon any issues of the NHS England assurance process that will be reviewed elsewhere (e.g. financial elements of risk in the proposals, patient engagement, GP support or the approach to consultation). However, if the panel felt that there was an overriding risk this should be highlighted in the panel report.

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

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

mitigate identified risks?

- Do the proposals demonstrate good alignment with the development of other health and care services, including national policy and planning guidance?
- Do the proposals support better integration of services from the patient perspective?
- Do the proposals consider issues of patient access and transport? Is a potential increase in travel times for patients outweighed by the clinical benefits?
- Will the proposals help to reduce health inequalities?
- Does the options appraisal consider a networked approach - cooperation and collaboration with other sites and/or organisations?

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

Timeline

The clinical review panels will be held on the 25 and 26 April 2018, a site visit will take place on 12 April 2018 (see above). A draft report will be provided to MSE STP by 3 May 2018 for checking for matters of accuracy.

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. A meeting for this purpose has been scheduled for 16 May 2018.

Methodology

The Mid and South Essex team will provide written evidence packs for the respective panels and an overarching pack with information common to all areas. This will be received by 28 March 2018. Panel members will have the opportunity to undertake a desk top review of the evidence prior to joining a pre panel teleconference arranged to have a preliminary discussion of the evidence and develop key lines of enquiry for the review panels themselves (i.e. the agenda).

The clinical review will include a site visit on 12 April for information gathering and five clinical review panels on 25 April with an 'overarching' clinical review panel on 26 April 2018. The five clinical review panels to be held on 25 April will be

- Panel 1: General Surgery and Trauma and Orthopaedics
- Panel 2: Respiratory and Cardiology Services
- Panel 3: urgent and emergency Care, Treat and Transfer and Vascular services
- Panel 4: Urology and Gynaecology (surgical) services
- Panel 5: Gastroenterology and Renal (medicine).

Services have been combined into panels (as above) in order to complete the panels in one day and reduce the resources required.
The review panel on 26 April will receive comments and the advice and recommendations of each of the review panels held on 25 April 2018 by a combination of desk top review of documentation, a pre panel teleconference to identify the key lines of enquiry and a review panel meeting to enable presentations and discussions to take place.

Report

A draft report will be made to the sponsoring organisation for fact checking prior to publication by 8 May 2018. *(Note change from 3rd to 8th was agreed)*
Comments/ correction must be received from the sponsoring organisation within **three working days (11 May 2018)**.

Final report will be submitted to Clinical Senate Council on 16 May 2018 at a specially convened (teleconference) meeting to ensure the review panels have met the agreed Terms of Reference and to agree the report.

The final report will be submitted to the sponsoring organisation following the Council Senate Council meeting of 16 May 2018.

Communication and media handling

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

Resources

The East of England Clinical Senate will provide administrative support to the review panel, including setting up the meetings and other duties as appropriate. The clinical review panel may request any additional existing documentary evidence from the sponsoring organisation. Any requests will be appropriate to the review, reasonable and manageable.

Accountability and governance

The clinical review panel is part of the East of England Clinical Senate accountability and governance structure. The East of England Clinical Senate is a non-statutory advisory body and will submit the report to the sponsoring organisation.

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

Functions, responsibilities and roles

The **sponsoring organisation (MSE STP)** will

i. provide the clinical review panel with the a full evidence set including the case for change, options appraisal and relevant background and current information, identifying relevant best practice and guidance. Background information may include, but is not limited to:
    - relevant public health data including population projections, health inequalities, specific health needs,
    - activity date (current and planned)
    - relevant impact assessments (e.g. equality, time assessments),
    - relevant workforce information (current and planned)
    - evidence of alignment with national, regional and local strategies and guidance (e.g. NHS Constitution and outcomes framework, Joint Strategic Needs Assessments, CCG two and five year plans and commissioning intentions, STP implementation plans).

MSE STP will provide any other additional background information requested by the clinical review panel.

ii. respond within the agreed timescale to the draft report on matter of factual inaccuracy.

iii. undertake not to attempt to unduly influence any members of the clinical review panel during the review.

iv. Arrange and bear the cost of suitable accommodation (as advised by clinical senate support panel) for the panel and panel members

Clinical Senate Council and MSE STP will

i. agree the Terms of Reference for the clinical review, including scope, timelines, methodology and reporting arrangements.

Clinical Senate Council will

i. appoint a clinical review panel this may be formed by members of the Clinical Senate Council and Assembly, external experts, and / or others with relevant expertise. It will appoint a Chair of each of the review panels

ii. consider the review recommendations and report (and may wish to make further recommendations)

iii. provide suitable support to the panel and

iv. submit the final report to the sponsoring organisation.

Clinical review panels will

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

ii. follow the report template and provide the sponsoring organisation with a draft report to check for factual inaccuracies.

iii. submit the draft report to Clinical Senate Council for comments and will consider any such comments and incorporate relevant amendments to the report. The panel will subsequently submit final draft of the report to the Clinical Senate Council.

iv. keep accurate notes of meetings.

Clinical review panel members will undertake to

i. Declare any conflicts of interest and sign a confidentiality agreement prior to having sight of the full evidence and information

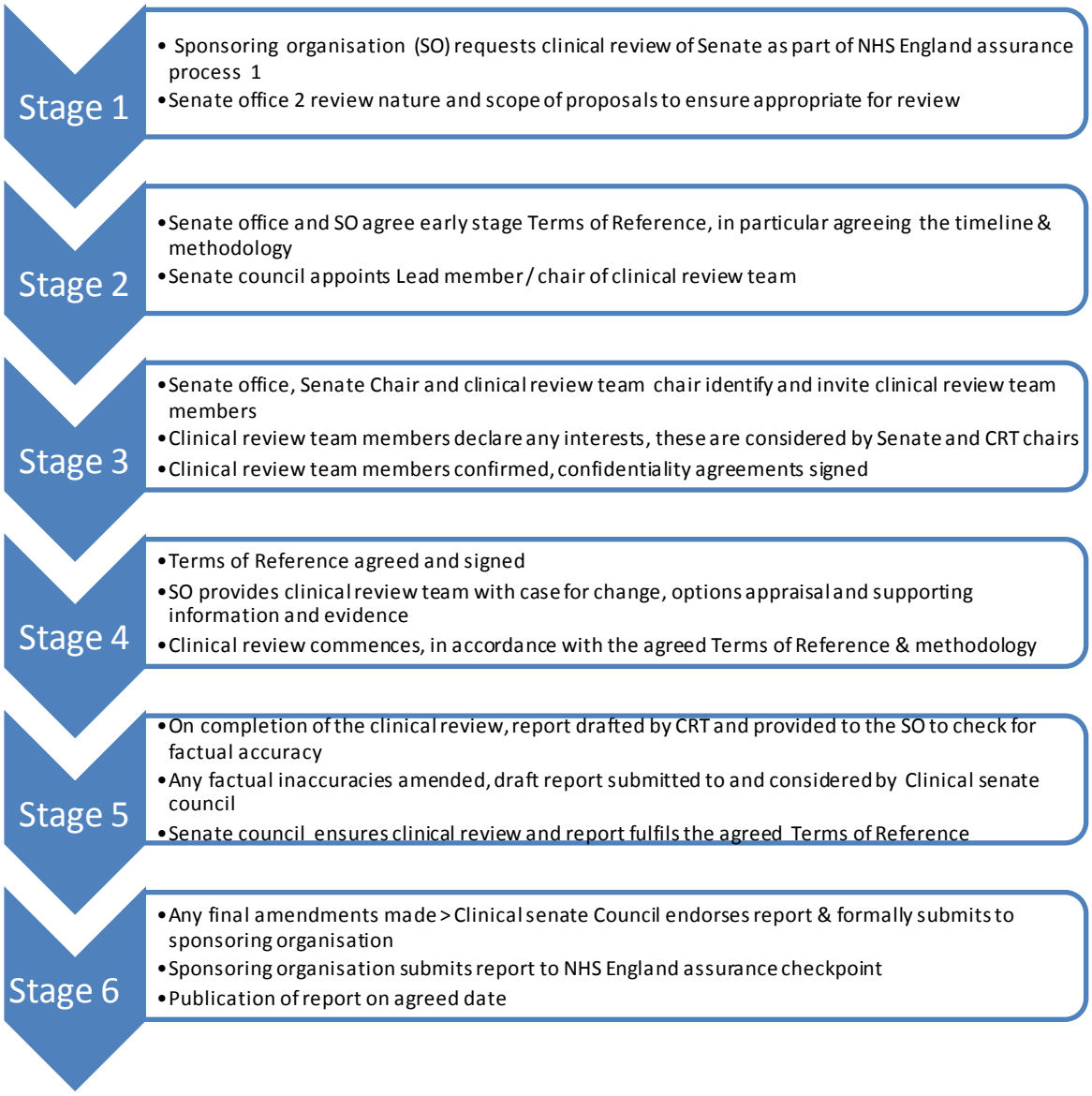
ii. commit fully to the review and attend all briefings, meetings, interviews, panels etc. that are part of the review (as defined in methodology).

iii. contribute fully to the process and review report

iv. ensure that the report accurately represents the consensus of opinion of the clinical review panel

v. comply with a confidentiality agreement and not discuss the scope of the review nor the content of the draft or final report with anyone not immediately involved in it. Additionally they will declare, to the Chair of the clinical review panel and the Head of Clinical Senate, any conflict of interest that may materialise during the review.

Summary of process



APPENDIX 2: Membership of the clinical review panel

Clinical Review Panel Members:
Panel 1 - Clinical Review Panel Chair:

Joanna Douglas
Chief Executive Officer, Allied Health Professionals Suffolk CIC
Jo has led the service throughout its journey to form a social enterprise. She is a Chartered physiotherapist and continued with an element of clinical practice until recently. She has 35 years of NHS experience and has senior management level experience within the NHS for the past 15 years, working in a variety of clinical and organisational settings. Jo has been a Clinical Senate Council member since 2013.

Panel Members:

Louise Connolly
A senior allied health professional working in a large Community NHS Trust. She is an Occupational Therapist specialising in Neurological Rehabilitation with over seventeen years of operational management experience managing a range of specialist and generalist multidisciplinary teams. Having recently completed her MSc in Senior Healthcare leadership at the NHS Leadership academy, she is currently Clinical Quality Lead in Herts Community NHS Trust facilitating the continued embedding of evidence based practice into front line community teams and supporting the strategic development of Community and Rehabilitation Services.

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

Following the trust merger has recently been appointed as Head of Nursing for Surgery and is responsible for Nursing and AHP's in Surgery for 3 sites.

Dr Emma Gent
Worked as a specialty doctor in Anaesthetics at Queen Elizabeth Hospital King's Lynn since 2010. Emma has an interest in preoperative assessment and improving communication between primary and secondary care. After a secondment as a research fellow she became the local lead for the 'Perioperative Quality Improvement Programme' and is currently working to improve the local management of preoperative anaemia.

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

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

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

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

Jonathan Wells
A qualified social worker who has had a 34 year career in health and social care in mental health services, mostly in Cambridgeshire and Hertfordshire. He is now very active locally in public engagement roles, including as a Director of Healthwatch Cambridgeshire and Peterborough and chair of Rethink Carer Support in the same area. He believes strongly in the role of experts by experience in improving NHS services.

Mr Richard Wharton
A colorectal surgeon at the Norfolk and Norwich University Hospital, having been in post since 2004. He trained in London, including the Royal Marsden and St. Marks'. Richard's research interests include colorectal cancer and circulating tumour cells. He is an honorary senior lecturer at the University of East Anglia and he is currently the Clinical Director of Directorate of General Surgery at the NNUH.

Dr Mai Luen Wong
Liaison Psychiatry, Cambridgeshire & Peterborough NHS Foundation Trust (CPFT).
Worked as an Associate Specialist at the Addenbrooke's Hospital Liaison Psychiatry Services. Interested in service development and design, specifically, strategies and initiatives for providing equitable distribution of high quality sustainable healthcare.

Alongside her clinical post, she was a Fellow of the National Institute for Health Research's Collaboration for Leadership in Applied Health Research and Care (NIHR CLAHRC, 2011). Worked with the Engineering Design Centre at the University of Cambridge to study frequent attenders to the Emergency Department at Addenbrooke's Hospital.

Mr David Yeoh
A consultant in trauma and orthopaedics (hand, wrist & elbow specialist) at the Norfolk and Norwich university hospital. He undertook his higher surgical training in the South East of England rotation. He followed this with fellowships in Auckland, New Zealand and Southampton.

David has an interest in teaching and hold posts as an Associate Lecturer at the University of East Anglia and as Associate Professor for St George's medical school (Grenada). He is also an ATLS instructor and an AO faculty member.

Reconvened Panel 2 (1 May 2018) Clinical Review Panel members:

Joanna Douglas, chair
Dr Emma Gent
Mr Nadim Noor
Mr Raaj Praseedom
Linda Purdy
Hanna Stevens
Caroline Smith
Mr Richard Wharton

Panel 2 - Clinical Review Panel Chair:

Dr Dee Traue
Consultant in Palliative Medicine, East & North Herts NHS Trust
Senate Council member
Involved nationally in the palliative and end of life care arena, working for the charity *Help the Hospices* and as part of the Association for Palliative Medicine executive committee and a member of the RCP Joint Specialty Committee for Palliative Medicine.

Panel Members:

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

Dr Enrico Dippenaar
A medical and rescue flight paramedic for the United Arab Emirates national helicopter search and rescue service. Whilst living and working in Dubai he furthered his studies by completing a MSc and PhD in Emergency Medicine. He joined Anglia Ruskin University in a full-time academic position to further strengthen the professional education of paramedicine.

Dr Charles Haworth
A Director of the Cambridge Centre for Lung Infection at Papworth Hospital. He trained at the Manchester Adult Cystic Fibrosis Centre, the Royal Brompton Hospital and at Hammersmith Hospital, before moving to Cambridge in 2003. He is also a member of the BTS bronchiectasis and ERS bronchiectasis guidelines committees. He collaborates with Professor Andres Floto at the University of Cambridge on NTM related studies and is a member of the European Union funded “Inhaled Antibiotics in Bronchiectasis and Cystic Fibrosis (*iABC*)” and “CFMATTERS” consortia. He is co-chief investigator of three current international novel therapy clinical trials in people with bronchiectasis. He is also the site Principal Investigator for the European Cystic Fibrosis Society Clinical Trials network, a member of the ECFS Scientific Committee, a member of the CF Trust Strategic Implementation Board and a member of the CF Foundation Data Safety Monitoring Board.

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

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

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

Dr Mary Lynch
A consultant cardiologist at The East & North Herts Trust since 1997, based at The Lister Hospital in Stevenage. Her subspecialty interests are in cardiac imaging and heart failure. Mary has a major interest in medical education and is the undergraduate tutor at her Trust. She also has research interests in heart failure and lipids.

Dr Linda Pearce
A respiratory consultant nurse at West Suffolk NHS Foundation Trust. Her interest in respiratory health started as an occupational nurse and progressed through practice nursing. She completed a Doctorate in Nursing at Essex University which looked at non drug management of COPD. She has held a number of positions including clinical lead for Suffolk COPD services, clinical lead for East of England Respiratory Clinical Network, lecturer at Essex University, member of British Thoracic Society Asthma guidelines review group. She regularly writes respiratory articles for General Practice Nursing journal.

Ahmed Razavi
An academic clinical fellow in Public Health currently based at the MRC Epidemiology Unit, Cambridge. Ahmed has been working in Public Health for 3 years prior to which he did his Foundation Training in Wales. He studied Medicine at UCL, graduating in 2013.

Dr Nick Screaton
An experienced consultant radiologist specialising in cardiothoracic radiology. He was Radiology Clinical Director in Papworth Hospital 2004 - 12 and President of the British Society of Thoracic Imaging 2009 – 13. He currently sits on the British Thoracic Society Bronchiectasis Guidelines development group, National Institute of Clinical Excellence Idiopathic Pulmonary Fibrosis Quality Standards Committee, National Institute of Clinical Excellence Guidelines Updates Standing Committee, and National Clinical Commissioning group for Specialised imaging (stakeholder representative), European Society of Thoracic Imaging Jury Committee and is Eastern Region Group lead for British Institute of Radiologists.

Clare Young
The Lead Nurse for Cardiology at East and North Herts NHS Trust. In addition to managerial responsibility for the Acute Cardiac Unit and Cardiac Catheter labs, she also has a clinical nurse specialist role working mainly in heart failure and arrhythmia management. Clare was directly involved in the setting up of the PPCI service within the Trust and the moving of services cross site following the reconfiguration of services within the Trust in the last four years.

She has a broad experience of clinical nurse specialist roles within cardiology over a number of years and has previously worked as ward sister in a number of Coronary Care Units.

Panel 3 - Clinical Review Panel Chair:

Dr Bernard Brett
Consultant in Gastroenterology at Norfolk and Norwich University Hospitals NHS FT.
Clinical Senate Chair
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:

Andrea Assan
With a background of 20 years Local Government experience in Adult and Children's services, Andrea has been a board member of the local HealthWatch since it was established in 2013. Her eldest daughter has learning and physical disabilities and because of her experiences, having left work, she decided to do voluntary work to try to make a difference to help improve both health and social care in our area. As part of her HealthWatch role she sits on a number of boards including Bedfordshire Child Death Overview Panel, East of England Ambulance Trust Community Engagement Group, Carers Partnership Board, Royal College of GP's Faculty board and Integrated Pain Service User Group.

Dr David Gaunt
A Consultant in Emergency Medicine at Watford General Hospital for the past 15 years, and has a passion for pre-hospital emergency care and major trauma. He is Associate Medical Director for IM&T, and has been a Clinical Leader in his Department since 2006. Performed an integral part in the reconfiguration of Hemel Hempstead General Hospital A&E Department and the creation of the Acute Admission Unit at Watford.

Natasha Green
Regional Clinical Co-ordinator, East of England Ambulance Service NHS Trust.
Natasha joined the ambulance service in 2005, becoming a paramedic in 2007, working across Bedfordshire. She moved to the Emergency Clinical Advice and Triage (ECAT) team in 2017, becoming a Clinical Coordinator a few months later. She is responsible for the clinical welfare and safety of all 999 and urgent patients, ensuring ambulance responses are sent to those most in need and signposting patients to alternative care pathways where appropriate. Also has responsibility for the Hear and Treat clinicians in the Emergency Operations Control rooms and provides Clinical Advice to operational crews when required.

Mr Nadim Noor
A consultant vascular and endovascular surgeon, with a keen interest in healthcare management with a view to improve quality and patient experience. Current financial climate but more importantly volume-outcome relationships require that we find new healthcare models to achieve this

Mr Paul Tisi
Appointed as a Consultant Vascular and General Surgeon in 2001 at Bedford Hospital with outreach sessions at Luton & Dunstable Hospital. With development of the vascular service the unit evolved into a regional designated arterial intervention centre. After undertaking a number of internal leadership roles he was appointed as Medical Director and Responsible Officer in 2016. His clinical practice is now predominantly in treatment of venous disease. He is one of the two Midlands and East representatives on the national Clinical Reference Group for Vascular Surgery. He is also an Editor for Cochrane Vascular.

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 patient's 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 prescribe. 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.

Karen Smith
A 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's most recent role has been Head of Patient Safety and Clinical Effectiveness at the two Suffolk Clinical Commissioning Groups, as a member of the Chief Nursing Officer team. She recently retired from this post and remains passionate about continuing to support the enhancement of quality and patient safety and the continuous improvement of services.

Panel 4 - Clinical Review Panel Chair:

Dr Gillian Bowden MBE
Clinical Psychologist
A Clinical Psychologist working with the University of East Anglia as a Clinical Lecturer. Her interests are in primary and community mental health services and in developing and researching new approaches to service delivery which engage with people in the context of their communities. Gillian is also interested in wellbeing at work and how people manage demanding aspects of work and which factors they find rewarding or protective against stress. Gillian worked in various NHS mental health and learning disability services since 1984 initially in South London and moving to Norfolk in 1998. She recently retired from her position as a Consultant Clinical Psychologist and Lead Clinician with Norfolk and Suffolk NHS Trust. Awarded an MBE for services to mental health in Norfolk in 2009.

Panel Members:

Dr Suzanne Hamilton
Attended Edinburgh University and obtained her medical degree in 1989. Suzanne was part of the South East Scotland rotation in Obstetrics and Gynaecology and received her CCT in 2003. She then took up the post of Consultant Obstetrician and Gynaecologist in Hinchingbrooke Hospital. Her areas of interest are fetal and maternal medicine. Suzanne also worked at Addenbrooke's hospital doing specialist clinics in diabetes in pregnancy. Locally she has held the positions of clinical director, labour ward lead and college tutor.

In April 2017, Hinchingbrooke merged with Peterborough City hospital and became North West ANGLIA Foundation Trust. She was appointed as Deputy Medical Director in July 2017.

During the past few years she has been involved in and chaired a variety of regional groups - high risk obstetric forum, fetal and maternal medicine group and clinical directors' forum. Over the past two years has been heavily involved in the Cambridgeshire STP for Maternity services. More recently she has been appointed as the joint chair for the Local Maternity System. Suzanne also sits on the Clinical Advisory group for Cambridgeshire.

Miss Fatemeh Hoveyda
Consultant Obstetrician, Rosie Maternity, Addenbrooke's Hospital, Cambridge.
She was Lead Obstetrician for delivery unit, lead for Obstetric risk and Lead Obstetrician for CNST for 12years. Her main areas of interest are Early Pregnancy and Emergency Gynaecology Scanning, running joint hypertensive antenatal clinics and preterm surveillance clinic.

Serena McLean
Programme Manager for the Performance, Appraisal and Revalidation Team, NHS England, Midlands and East (East). She is a registered Midwife and registered Nurse, and was an appointed Supervisor of Midwives for the East of England Local Supervising Authority. Prior to her current role, Serena was a midwifery sister for 14 years and most recently project managed the setting up of a Homebirth Team, where she was team leader and a case loading midwife.

Dr Marcelle Michail
Deputy Chief Medical Officer and Consultant Anaesthetist at The Princess Alexandra Hospital NHS Trust (PAH), Harlow, Essex.
Appointed as a Consultant anaesthetist with a special interest in obstetric anaesthesia in 2000. Having completed her training in London, moved to Hertfordshire and has been working in West Essex since 2000. Her previous roles include Clinical Director for Surgery and Critical Care Directorate, Associate Medical Director for Surgery and Critical Care Healthcare Group.

In the past two years, she has started working with the strategy team for the Trust as the Deputy Chief Medical Officer leading on pathways and partnership development.
Marcelle is currently leading on a number of large scale strategic projects as part of the STP for Hertfordshire and West Essex as well as the ACP for West Essex.

She is passionate about the sustainability and transformation of health and care services in order to promote better health outcomes for the population.

Mr Nimish Shah
A Consultant Urologist at Cambridge University Hospitals NHS Trust since 2004, having qualified and trained in London. His expertise is in Prostate cancer and is the lead Robotic prostate surgeon in Cambridge.

Anne-Marie Smith
Member and past Acting Chair of HPFT MH Trust Carers Council and also sits on the Patients Care and Environment Committee for Lister Hospital, N.&E. Herts Acute Hospital. She sits on a committee for NHS England and trains the new Leadership on patient and carer issues in the Nye Bevan initiative. A member of the Citizens' Senate for East Anglia.

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

Nikki Young
Nikki's area of patient expertise is Multiple Sclerosis which she has lived with for 30 years. She has been the lead for East Anglia (Norfolk, Suffolk, Cambridgeshire inc. Peterborough) since 1995. She is in contact with patients across Europe, USA, NZ and Australia through her participation in Sailing Sclerosis and Oceans of Hope. Nikki is a member of the England Council MS Society. She also has some patient expertise on Thyroid conditions in particular Hashimoto disease and has knowledge and experience of PTSD and its treatment. She has a particular interest in bladder issues and treatment.

Panel 5 - Clinical Review Panel Chair:

Professor Asif Zia
Executive Director, Quality & Medical Leadership
Hertfordshire Partnership University NHS Foundation Trust
Worked as a consultant psychiatrist for learning disabilities both in the community and on an acute assessment and treatment units and has been involved in service development and quality improvement activities in his Psychiatrist career. He has presented and organised various international, national and regional conferences, on service delivery models, quality standards, service users' engagement, managed clinical networks, and on clinical topics such as intellectual disability and mental health, epilepsy and autism. He is also the author of a book on Intellectual disability for GPs and medical students and contributed a chapter to the Royal College of Psychiatrists Seminar series. He has been a Regional Advisor for the last three years. Before that he was a Speciality advisor in the Eastern Region.

Panel Members:

Dr Juliet Draper
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 Kathryn Faulkner
A public health registrar in the East of England. Her background is in working with young people in the field of sexual and reproductive health. She was a topic expert in the 2017 NICE guidelines on Sexually Transmitted Infections; condom distribution schemes. Kathryn completed her PhD at the School of Social Policy, University of Edinburgh, on young people's participation in public decision making.

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 senor 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 Praveen Jeevaratnam
A Nephrologist who commenced his consultant post in 2013 at Lister Hospital East North Herts NHS Trust (ENHT). His training was across the pan North Thames renal training centres, with a research degree in rare lysosomal storage disorders completed at the UCL/Royal Free Hospital. His clinical work and expertise is in renal access intervention and maintenance for haemodialysis patients, and he runs the renal access multidisciplinary service at ENHT with the vascular team and interventional radiologists at ENHT.

Mr Raaj Praseedom
A Consultant Hepatobiliary, Pancreatic and Transplant Surgeon at Addenbrooke's Hospital, Cambridge since August 2000. He was the East of England Lead for Hepatobiliary Pancreatic services from 2000 to 2014. Currently Raaj is the Living Donor Liver Transplant Lead at Addenbrooke's Hospital.

He is the East of England representative on the National HPB CRG since the reorganisation of NHS England and also represents Liver transplantation in the National Transplant Commissioners Group. Raaj's other interests lie in post graduate surgical training and serve as the Regional Training Programme Director and Member of the National Specialist Accreditation Committee.

Lesley Standring
Lesley has spent her entire career working in the NHS. A qualified nurse who has worked in secondary care in nursing and operational roles. Recently completed a MSc in Healthcare leadership at the University of Birmingham. She has a passion for service transformation and integration and now works in a joint transformation team across the west of Suffolk aiming to deliver the Alliance and five year forward view agenda.

Overarching Panel 6 - Clinical Review Panel Chair:

Dr Bernard Brett – Panel Chair	Serena McLean
Dr Gillian Bowden	Mr Nadim Noor
Joanna Douglas	Mr Raaj Praseedom
Dr Dee Traue	Linda Purdy
Louise Connolly	Anne-Marie Smith
Julie Draper	Caroline Smith
Janet Driver	Karen Smith
Dr Praveen Jeevaratnam	Lesley Standring
Dr Mary Lynch	Hanna Stevens (attended 26 April only)

Panel Members (Biographies as above except for Hanna Stevens):

Hanna Stevens
Employed by the East of England Ambulance Service for ten years and currently working at the Chelmsford Training Centre as an Education and Training Officer. She is responsible for the delivery of core clinical training to existing staff and new employees of varying clinical grades. Hanna is a registered paramedic and still regularly works in the frontline operational setting in the South East Essex area. Hanna is an experienced practice educator and thoroughly enjoys supporting new and existing staff to provide a high level of patient centred care in the pre-hospital environment.

Site Visit Team 12 April 2018 (Biographies as above)

Mike Hewins
Serena McLean
Karen Smith

Sue Edwards – site visit team support

In attendance at the panel.
Mid & South Essex STP Team:

Dr Anita Donley	Independent Chair, Essex Success Regime
Dr Celia Skinner	Chief Medical Director, MSB Group
Dr Ronan Fenton	Medical Director for the STP in-hospital programme
Dr Donald McGeachy	STP Medical Director
Ms Jo Francis	Co-Clinical Director and Lead Nurse, MEHT
Ms Emma Gray	Clinical Lead & Consultant General Surgeon, SUHFT
Dr Ellen Makings	Medical Director and Consultant Anaesthetist, MEHT
Mr Greg Packer	Clinical Lead and Consultant Orthopaedic Surgeon, SUHFT
Dr Stuart Harris	Clinical Lead and Consultant Cardiologist, BTUHFT
Dr Marcus Pittman	Respiratory Consultant, BTUHFT
Lisa Ward	Respiratory Nurse Manager, SUHFT
Jenny Frost	Head Nurse, Emergency Department, SUFHT
Mr Vijay Gadhvi	Clinical Lead, Vascular Consultant Surgeon, BTUHFT
Dr Hagen Gerofke	Clinical Lead, Acute Medical Units & Ambulatory Emergency Care and Acute Medicine Consultant, BTUHFT
Dr Eddie Lamuren	Clinical Director, Emergency Medicine, BTUHFT
Timothy Lee	Occupational Therapist, BTUHFT
Mr Peter Acher	Clinical Lead and Consultant Urological Surgeon, SUHFT
Colleen Begg	Clinical Director and Head of Midwifery & Gynaecology, SUHFT
Jo Shingler	Consultant Nurse and Co-Clinical Lead, MEHT
Mr Khalil Razvi	Consultant Gynaecologist, SUHFT
Dr Gowrie Balasubramaniam	Clinical Lead and Consultant Nephrologist
Dr Aroon Lal	Consultant Nephrologist, BTUHFT
Dr Georgia Winnett	Consultant Nephrologist, BTUHFT
Chris Cheyne	PA Consulting

Clinical Senate Support Team:

Brenda Allen	East of England Clinical Senate Project Officer
Jacky Dixon	Senior Programme Manager, Mid & South Essex STP
Nina Crawford	Executive Assistant to the CEO, AHP Suffolk
Sue Edwards	East of England Head of Clinical Senate, NHS England
Emily Frain	Team Administrator, Basildon & Thurrock University Hospital
Dawn Monaghan-Patel	Senior Administrator/Project Officer, Diabetes Clinical Network

APPENDIX 3: Declarations of Interest

All panel members were required to declare any interests. With the exception of Hanna Stevens, who declared that her partner is employed by the Mid & South Essex STP as a Project Manager who is currently working on clinical re-design projects including Stroke and Gynaecology, all panel members claimed to have no a) Personal pecuniary interest b) Personal family interest c) Non-personal pecuniary interest or d) Personal non-pecuniary interest.

APPENDIX 4: Review panel agendas

NHS East of England Clinical Senate

INDEPENDENT CLINICAL REVIEW PANEL

For NHS England 'Stage 2' Service Change Assurance

Sponsoring body: Mid and South Essex Sustainability & Transformation Partnership

A G E N D A – UPDATED 24/4/18

Information for all panels

Date: Wednesday 25 April 2018

Time: 09.15 to 17.00hrs for panel members &

Mid & South Essex team from 09.00hrs to 13.00 hrs

Venue: Curtis Room, Hallmark Hotel Bar Hill Cambridge CB23 8EU

Clinical Senate has been asked to:

Review the evidence and provide an independent clinical opinion, advice and recommendations on

a) **whether the proposed model and pathways make clinical sense and, based on the evidence presented, will be likely to result in safe and high quality services and outcomes for patients once implemented?** and

b) **whether the clinical model form a robust basis for moving to a more detailed development and implementation across the three Mid and South Essex STP hospital sites?**

Time	Item
09.15 – 09.30	**Registration & arrival – panel members**
09.30 - 09.40	Welcome & outline of the proceedings for the review panel from panel chair Dr Bernard Brett *Note Due to large number, full introductions will be made in the separate review panels,*
09.40 – 10.15 **10.15 – 10.25**	Overview presentation 40 mins by Mid & South Essex team to full panel Feedback from site visit to Basildon & Thurrock Hospital on 12 April 2018
10.25 – 11.00	General questions from panel to Mid & South Essex team
11.15	Break into service specialty panels Welcome from panel chair & introductions *Note –all panels will have their own agenda from this point onwards – this agenda is provided as a general guide. Panel agendas will include panel membership and key lines of enquiry*
11.15 – 11.30	Clinical specialty specific presentations to respective panels from Mid & South Essex team
11.30 – lunch as below	Questions from panel to Mid & South Essex team
12.30 – 13.20	Lunch 35 minutes *(note start time staggered across the panels)*
End of lunch as above – 16.00	(note timings as relevant to finish time above) Panel discussion (panel only)
16.00 - close	Panel summary – key findings and recommendations

Next steps – information for clinical review panel members:

1) An 'overarching' clinical review panel will be held the day after this panel (26 April); it will receive a report from each of the five clinical review panels held on 25 April 2018. The 26 April clinical review panel will consider the impact of the proposals across (and outside of) the Mid & South Essex Health system.

2) A draft report will be sent to Mid & South Essex team and clinical review panel members for points of accuracy check no later than 8 May 2018 with 48 hours turnaround for panel members and five day turnaround for Mid & South Essex team.

3) Final draft report will be provided for specially convened Clinical Senate Council meeting on 16 May 2017 for Council to confirm that the clinical review panel(s) 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.

4) Final report provided to Mid & South Essex STP by 18 May 2019.

INDEPENDENT CLINICAL REVIEW PANEL

For NHS England 'Stage 2' Service Change Assurance

Sponsoring body: Mid and South Essex Sustainability & Transformation Partnership

A G E N D A

Date: Thursday 26 April 2018

Time: 09.00 to 17.00hrs &

Mid & South Essex team from 12.00hrs to 13.00 hrs

Venue: Premier Room 4, Hallmark Hotel Bar Hill Cambridge CB23 8EU

Clinical Senate has been asked to

Hear the evidence from the five clinical review panels of 25 April 2018 and provide an independent clinical opinion, advice and recommendations on

c) **whether the proposed model and pathways make clinical sense and, based on the evidence presented, will be likely to result in safe and high quality services and outcomes for patients once implemented?**

d) **whether the clinical model form a robust basis for moving to a more detailed development and implementation across the three Mid and South Essex STP hospital sites? and**

e) **consider the impact across the mid and south Essex health and care system of the overall proposals and provide any advice and recommendations on the impact of the proposals on the wider health and care system (i.e outside of mid and south Essex).**

Time	Item
09.00 – 09.15	**Registration & arrival – panel members**
09.15 - 09.30	Welcome, introductions & outline of the proceedings for the review panel from panel chair Dr Bernard Brett
09.30-11.15 09.30 - 09.50 09.50 - 10.10 10.10 - 10.30 10.30 - 10.50 10.50 - 11.15	Report back on findings and recommendations of previous days' panels from respective panel Chairs' or nominated spokesperson Panel one Panel two Panel three Panel four & Panel five
11.15- 11.30	Break
11.30 – 12.00	Preliminary discussion – prepare any questions for Mid & South Essex Team (to join by telecon)
12.00- 13.00	Telecon with Mid & South Essex team
13.00 – 13.30	Lunch
13.30 – 16.00	Discussion on overarching impact
16.00 – close	Panel summary – key findings and recommendations

Next steps – information for clinical review panel members:

5) A draft report will be sent to Mid & South Essex team and clinical review panel members for points of accuracy check no later than 8 May 2018 with 48 hours turnaround for panel members and five day turnaround for Mid & South Essex team.

6) Final draft report will be provided for specially convened Clinical Senate Council meeting on 16 May 2017 for Council to confirm that the clinical review panel(s) 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.

7) Final report provided to Mid & South Essex STP by 18 May 2019.

Clinical Review Panel members 26 April 2018		
Name		25 April panel
Dr Bernard Brett – Panel Chair	Consultant in Gastroenterology and General Internal Medicine based at the Norfolk and Norwich University Hospitals NHSFT, Clinical Senate Chair	Chair panel 3
Dr Gillian Bowden MBE	Clinical Psychologist working with the University of East Anglia as a Clinical Lecturer, Clinical Senate Council Member	Chair Panel 4
Joanna Douglas	Chartered physiotherapist, CEO Allied Health Professionals Suffolk Clinical Senate Council Member	Chair Panel 1
Dr Dee Traue	Consultant in Palliative Medicine at East & North Herts NHS Trust based at the Lister Hospital in Stevenage. Clinical Senate Council Member	Chair Panel 2
Louise Connolly	Clinical Quality Lead, Therapy, Hertfordshire Community NHS Trust	Panel 1
Julie Draper	Expert by Experience	Panel 5
Janet Driver	Head of Nursing (Surgical) North West Anglia NHS FT	Panel 1
Dr Praveen Jeevaratnam	Consultant Nephrologist, East & North Herts NHS Trust	Panel 5
Dr Mary Lynch	Consultant Cardiologist, East & North Herts NHS Trust	Panel 2
Serena McLean	Programme Manager, Performance NHS England (Midwife)	Panel 4 **& Site Visit**
Mr Nadim Noor	Consultant Vascular Surgeon, Luton & Dunstable University Hospital NHS FT	Panel 3
Mr Raaj Praseedom	Consultant HPB-Transplant Surgeon, Addenbrooke's Hospital	Panel 5
Linda Purdy	Nurse Consultant, Acute Medicine, Queen Elizabeth Hospital Kings Lynn NHS Trust	Panel 3
Ann-Marie Smith	Expert by Experience	Panel 4
Caroline Smith	Expert by Experience	Panel 1
Karen Smith	Quality Improvement Nurse,	Panel 3 **& Site Visit**
Lesley Standring	Integrated lead for Medicine, West Suffolk Hospital NHS FT	Panel 5
Hanna Stevens	Education & Training Officer (Paramedic) EEAST	NO
Brenda Allen	Clinical Senate Project Support - Note taker & panel support	
Sue Edwards	Head of Clinical Senate – Note taker & panel support	
Mid and South Essex panel members (by teleconference)		
Dr Celia Skinner	Chief Medical Director, MSB Group	
Charlotte Williams	Group Director - Strategy & New Care Models, MSB Group	

APPENDIX 5: Site visit report

Mid & South Essex Sustainability and Transformation Partnership

Summary report of clinical review panel site visit to Basildon & Thurrock University Hospital NHS FT held on 12 April 2018 *(to be included in the report of the clinical review panel of 25 & 26 April 2018)*

Glossary of abbreviations used in the report

A&E	Accident and Emergency
CTC	Cardiothoracic Centre (Basildon Hospital)
ED	Emergency Department
EEAST	The East of England Ambulance Service Trust
ENT	Ear, Nose & Throat
HASU	Hyper Acute Stroke Unit
MSE STP	Mid and South Essex Sustainability and Transformation Partnership
NSTEMI	Non-ST-segment elevation myocardial infarction
STP	Sustainability and Transformation Partnership
24/7	24 hours a day, seven days a week.

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1. ADVICE REQUEST & SCOPE OF THE SITE VISIT

1.1 The East of England Clinical Senate has to date reviewed emerging proposals for the Mid and South Essex STP (formerly Success Regime) on four separate occasions:

- In June 2016, which focused on the early emerging thinking,
- In October 2016, which considered in more detail the five potential configuration options that subsequently fed into the Programme's formal options appraisal process,
- In September 2017, when the panel conducted a preliminary review of the programme's final pre-consultation proposals and
- In October 2017 when the panel carried out a more in-depth review of the proposals for stroke services.

1.2 The Mid and South Essex Sustainability and Transformation Partnership (MSE STP) has refined its proposals for reconfiguration of hospital services to improve care for people in mid and south Essex and is ready to proceed to a 'Stage 2' Assurance Check [4]. An independent clinical review of the proposals by Clinical Senate is required as part of the evidence for NHS England.

1.3 Clinical Senate and MSE STP agreed that in addition to the usual panel format review, a site visit would be beneficial in demonstrating that the review of the proposals had been as robust as possible and that the evidence provided had been triangulated to some degree. The site visit would be carried out by a small team of three members.

1.4 The panel members' scope and focus of the site visit was to

a) triangulate the evidence provided with the activity, layout (estates), workforce and other factors in the trust and

b) gain an idea of the degree of understanding and involvement from across the workforce of the proposed changes, and potential impact and/ or improvement for services of those changes on patients, carers and the staff themselves.

[4] NHS England Planning, assuring and delivering service change for patients' NHS England October 2015

1.5 Discussion with any staff member would be informal, it was not a 'test' of their knowledge or how well the Trust had engaged with staff. Staff members would not be quoted or named in either the report or feedback to the MSE team or any pressure placed upon them to speak to the team.

2. METHODOLOGY & GOVERNANCE

2.1 The site visit was covered under the Terms of Reference for the review, provided in full as Appendix 1 in the final report of the clinical review panel.

2.2 Members of all the clinical review panel members (Appendix 1) from within and outside of the East of England Clinical Senate signed conflict of interest and confidentiality agreements. Members were invited to volunteer to be on the site visit team, MSE STP stated it preferred no more than three members. Three members volunteered. The Chair of Clinical Senate would like to express his sincere gratitude to the three site visit members for their time and commitment to this site visit as part of the overall review.

2.3 The agenda for the day was agreed between Clinical Senate and the MSE STP team (Appendix 2). The agenda included structured walk through of three of the proposed pathways on one site and time to meet with staff. A question proforma was developed to help guide the team and to ensure that the conversations generated a rounded understanding to enable the constructive development of this report, although it was not expected that all staff spoken with would be asked all questions on the proforma.

2.4 The site visit took place on Thursday 12 April 2018. A draft report by members of the review team was provided to MSE STP and will be reported to the clinical review panels on 25 April 2018. The report will be included in the full and final report of the clinical review panels and governance arrangements for this report will fall into the arrangements for the final report.

2.5 East of England Clinical Senate would like to acknowledge the support of the MSE STP team in co-producing this site visit and would especially like to thank all the staff who gave their time to talk to the site visit team. The site visit team and Clinical Senate recognise that staff took time out of their busy day and clinical workload to support this site visit and their co-operation was greatly appreciated.

3. SUMMARY OF FINDINGS

Key findings:

3.1 The findings and comments below refer directly to those of the site visit team. More detail on the proposals for the clinical areas covered in the site visit can be found in the full clinical review panel report, together with the respective findings and recommendations of the clinical review panel. It is recommended that the full report is read in conjunction with this site visit report in order to ensure a more comprehensive picture.

3.2. **Urgent and Emergency Care:** details of the proposals are covered in the full report.

3.3 The team heard that emergency care hubs were designed to draw specialist input into ambulatory units and specialist 'hot' clinics at each hospital site, to provide timely access to specialist input and avoiding unnecessary admissions, with prompt access to senior clinical decision makers. The site visit team heard that in times of extreme pressure in the ED when patients had been waiting in ambulances for admission, senior clinicians had been able to assess patients and admit them directly into the ambulatory care area from the ambulance, thus reducing the waiting time for the patient, freeing up ED bed space and releasing the ambulance back into the system. The team heard that GPs, paramedics and other health care professionals were able to call the ambulatory care centre direct for advice and an initial assessment. Access to this resource had been successful in reducing ED attendances and supporting patients to be managed at home or in the community.

3.4 The team visited the Ambulatory Emergency Care Unit, located on the Acute Medical Unit East recently newly furbished to be able to provide an assessment and treatment area open 14 hours daily, Monday to Friday, although shorter hours at weekends. The team heard that treating patients in this unit had already had a positive impact in reducing hospital admissions. The team congratulated the Trust on the facility.

3.5 **Cardiology**: details of the proposals are covered in the full report.

3.6 During its walk through the team heard that the cardiology team took a proactive approach to managing its beds and waiting lists i.e. once bed became vacant, the cardiology team contacted patients on the waiting list to ensure the bed position was managed appropriately.

3.7 **Vascular services:** details of the proposals are covered in the full report.

3.8 The team agreed that the vascular services staff team brought the proposals explained in the presentation to life during the walk through and were clear about improving the patient experience and intended outcomes.

Key Findings

3.9 **General comments across the three clinical areas:** The site visit team (the team) agreed that the MSE STP team had a clear vision for the three clinical areas covered on the site visit (urgent and emergency care, cardiology and vascular services). The staff from those areas came across as enthusiastic and ambitious to develop the services to high standards for their patients. They had started to see progress and were keen to continue and move the changes forward at a pace.

3.10 The team heard that the workforce situation had much improved in the clinical areas covered on the site visit, particularly in emergency hub nursing team in Basildon Hospital where nursing vacancies are now at their lowest level of vacancies for some time. The Trusts were confident that as services continued to develop and provide more specialist and sub-specialist procedures and training opportunities, it would become a more attractive place to work and recruitment, and more importantly retention of staff, would become less and less of an issue.

3.11 The team agreed that the presentations and explanations on the day corresponded with the evidence sets provided for the clinical review panels. The team felt however that while the proposals were aspirational and the presentations and discussion provided some detail, neither the evidence set nor the discussion provided the detail of how the proposals would be achieved. Whilst there were milestones for the proposals, the panel did not see evidence of detail behind that.

3.12 The team felt that detail on the patient journey for each pathway or at least key example pathways and an emphasis on the patient experience would benefit the proposals and evidence and bring them more to life.

3.13 It would appear from the conversations with staff, that there was little distinction in the minds of for many of them between the formal merger of the three trusts and the proposals for service change, and they appeared to be one and the same thing.

3.14 There was a common comment from many of the staff the site visit team spoke with, that initially there was a lot of general information about the proposals for service change across the three acute hospitals but the majority of people the team spoke with felt it had gone quiet and there had been very little detail coming through recently. The team heard that there was a daily early morning briefing for anyone to attend in the café which covered all relevant topics and provided an opportunity for staff to raise any issues. The site team agreed this was a good opportunity, and understood that it was widely advertised across the Trust. The site visit team noted that there did not appear to be any supporting literature, posters or leaflets around the café or hospital generally providing any information about the proposals or merger and that this could be a missed opportunity. *NB The MSB Group subsequently advised that as the formal consultation period had closed, the advertising literature had been removed to eliminate confusion around the merger and the proposals for service change.*

3.15 The team agreed that although there was clearly enthusiasm among the staff in the clinical areas visited, it appeared that outside of that group there was general support from staff for improving services but a feeling that it had all gone quiet. There was some anxiety among those spoken with around what the changes meant for their jobs, and specific mention was made of the remaining uncertainty

about whether they would need to travel to different sites and how that would be supported. The team recognised that it had met with only a very small number of staff in drawing together these findings and readily acknowledged the challenges in reaching such a large number of staff. It did though raise a question for the site visit team that if that was how staff in Basildon Hospital felt where changes were perhaps happening at greatest pace, what was the level of support and understanding across the workforce in Southend and Broomfield hospitals?

3.16 Some staff also pointed out that there were three separate patient record information systems and that it would require time and money to train people either across all three or bring to one system across all three sites.

3.17 The team congratulated the Trust on its recent Staff Innovation Fellowship programme which had received 32 applications from staff across the trusts with proposals for consideration.

3.18 The team was advised of the changes to the Quality and Safety and Governance arrangements and reporting, bringing together information, in a common format, for all three sites and reporting into a joint Board and agreed that these were positive steps in supporting the quality and safety of clinical services and patient outcomes across the three acute hospitals.

3.19 The team heard about proposals for Tele-tracking of patients across the three sites, with the aim of reducing length of stay and bed days.

4. Recommendations

4.1 The site visit team would like to make the following recommendations:

Recommendation 1

4.2 The site visit team would like to recommend to the Clinical Review Panels that they explore with the MSE STP team:

- How the respective services are ensuring variation of pathways across the sites is being reduced or eliminated i.e. progress of standardising pathways and protocols where appropriate;
- How consideration of successful recruitment of staff is built into timelines for 'milestones'; and
- How the level of resilience is being assured for the services as the proposed service changes are implemented.

Recommendation 2

4.3 The site visit team would like to recommend to the MSE STP / MSB Group team that for the clinical review panels:

- It considers providing a short patient case study for each of the respective clinical services under review, illustrating the patient journey and intended patient experience and outcome benefits.
- It assures the respective clinical review panels of the detail / project plans underpinning the milestones for the proposed service changes and subsequent modelling.

Recommendation 3

4.4 The site visit team would like to recommend to the MSE STP / MSB Group that it uses every opportunity to engage with staff perhaps through different mediums to provide information on (and differentiation of) the proposed service changes and merger of trusts.

End.

APPENDIX 1: Membership of the clinical review panel

Mid and South Essex STP Clinical review panel site visit members	
*Mike Hewins	Expert by Experience
*Serena McLean	Programme Manager, Performance NHS England (Midwife)
*Karen Smith	Quality Improvement Nurse
Sue Edwards	Head of Clinical Senate – team support
Biographies can be found in the full panel report	

APPENDIX 2: Site Visit agenda

East of England Clinical Senate Basildon site visit to support Mid & South Essex 'Stage 2' Clinical Review Panels – 12 April 2018

Timing	Venue	Format	Msb attendees
10:00-10:30	CTC Meeting Room	1. Welcome & Introductions 2. Summary of case for change and proposals	• Ronan Fenton • Charlotte Williams • Nursing lead (tbc)
10:30-12:30	Basildon Emergency Hub (with access to meeting room)	1. Walk over & introduction to clinical staff within ED & Emergency Hub 2. Physical walk-through of the 'Emergency Hub' model – A&E, assessment units, transfer and repatriation – 60 mins (A&E CD) 3. Q&A session in meeting room –30 mins 4. Tour/chat to other staff as required and walk back – up to 20 minutes	• Ronan Fenton • A&E and emergency hub staff (medical, nursing, operational leads) – Hagen Gerofke • EEAST representative • Staff side representative
Lunch – 12:30-13:15 CTC Meeting Room			
13:15-14:15	CTC Meeting Room	1. Visit to CTC and walk-through of the proposed expanded role for the CTC for complex cases across M&SE – 30 mins (Cardiology Clinical Lead) 2. Q&A session – 10 mins 3. Tour of the CTC – 20 mins	• Cardiology dept staff (medical, nursing, operational leads) led by Stuart Harris • Staff side representative
14:15-15:15	CTC Meeting Room	1. Virtual walk-through of the proposed vascular hub – 30 mins (Vascular CD) 2. Q&A session – 30 mins	• Vascular dept staff (medical, nursing, operational leads) led by Shiva Dindyal • Interventional radiologists • Staff side representative
15:10- 16.00	CTC Meeting Room	1. Coffee and wrap-up discussion with review panel members	• Ronan Fenton • Diane Sarkar • Charlotte Williams • Staff side representative
16.00-17.00	CTC Meeting Room	1. Panel time only	N/A

APPENDIX 6: Summary of documents provided by Mid and South Essex STP and Specialised Commissioning as evidence to the panel

1. MSE STP Clinical Senate Submission document
2. Improving Care for People in Mid and South Essex – Reconfiguration of hospital services – Activity and Capacity modelling summary
3. Updated External Stakeholder evidence – 23.4.18
4. Letter to Dr Bernard Brett from Caroline Rassell dated 34.4.18 re M&SE Acute Reconfiguration Proposals.
5. Addendum 1.1 Letter of support from Malcolm McCann dated 21.3.18 Essex Partnership University NHS FT.
6. Addendum 1.2 Letter of support from John Brouder dated 23.3.18 NELFT
7. Appendix 4 Summary of clinical evidence
8. Appendix 5.1 A model of care for Cardiology Services
9. Appendix 5.2 A model of care for General Surgery Services
10. Appendix 5.3 A model of care for Gynaecology Services
11. Appendix 5.4 A model of care for Renal Services
12. Appendix 5.5 A model of care for Respiratory Services
13. Appendix 5.6 } A model of care for Stroke Services
14. Appendix 5.6 } Improving Care for People in Mid and South Essex Proposed future service model – Stroke Pack 7.10.2017
15. Appendix 5.7 A model of care for Trauma and Orthopaedic Services
16. Appendix 5.8 A new model of care for Urgent and Emergency Care
17. Appendix 5.9 A model of care for Urology Services
18. Appendix 5.10 A model of care for Vascular Services
19. Appendix 6 STP Consultation Document – Your care in the best place (30.11.2017 – 9.3.2018)
20. Getting it Right First Time – Vascular Surgery – East & North Hertfordshire NHS Trust and Princess Alexandra Hospital NHS Trust – Feedback Report 17.06.2016
21. Getting it Right First Time – Vascular Surgery – Basildon & Thurrock, Southend, Mid Essex (Broomfield) Networks – Observation Report 14.09.2016.
22. Specialised Vascular Surgery – South Essex, Hertfordshire and West Essex 10.04.2018.
23. A04/S/a - 2013-14 NHS Standard Contract for Specialised Services – Vascular Surgery (Adults) Schedule 2 – The Service, A – Service Specification.